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S 000	Initial Comments Complaint Investigation: 24810043/IL182227	S 000		
S9999	Final Observations Statement of Licensure Violations: 340.1500a) 340.1500c) 340.1570a)1) 340.1800d)3) 340.1800e)1) Section 340.1500 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician, which reflects the philosophy of care provided, the policies relating to this philosophy, and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. c) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 340.1570 Personal Care a) Personal care, as defined in Section 340.1000,	S9999		

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shall be provided on a 24-hour, seven-day-a-week basis, as needed by the resident. This shall include, but not be limited to, the following:

1) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to any treatment ordered by the physician.

Section 340.1800 Resident Record Requirements
d) Record entries shall meet the following requirements:

3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.

e) An ongoing resident record, including progression toward and regression from established resident goals, shall be maintained.

1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to assess R1's skin before applying and after removing compression wrap garments. The facility failed to offload R1's heels to prevent pressure wound from developing. The facility

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also failed to follow their policy and procedures for a new skin wound and obtaining a wound care treatment order which affected one (R1) resident in the sample of 3 residents reviewed for improper nursing care. These failures resulted in R1 developing a Stage 3 pressure ulcer wound to the left heel and transfer to the hospital with subsequent debridement of R1's left heel pressure wound.

Findings include:

On 1/6/25 at 12:33 pm, V13 (R1's Power of Attorney/POA) stated R1 was sent from the facility to the hospital on 11/30/24 with "huge bed sores" on R1's feet.

R1's hospital records, dated 11/30/24, document, in part, that R1 was admitted to the hospital with diagnosis of "heel ulcer" which required debridement of "all non-viable tissue to the left heel" by V18 (Podiatry Surgeon/Hospital Physician).

R1's Admission Record documents, in part, diagnoses of Alzheimer's disease, hypotension, bradycardia, aortic aneurysm, urinary incontinence, muscle weakness, lack of coordination, abnormalities of mobility and gait, spinal stenosis lumbar region without neurogenic claudication.

R1's Minimum Data Set (MDS), dated 11/25/24, documents, in part, that R1's Staff Assessment for Mental Status indicates that R1 has short- and long-term memory problems with R1's cognitive skills for daily decision making is "moderately impaired-decisions poor; cues/supervision

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required." R1's Functional Abilities for Mobility for rolling left and right in bed indicates "substantial/maximum assistance-helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort." R1's Skin Conditions indicates that R1's determination of pressure ulcer/injury risk is based on formal assessment (such as Braden Scale) and clinical assessment with R1 being at risk for developing pressure ulcers/injuries with a score of 0 (none present) for unhealed pressure ulcers/injuries (Stage 1 through 4 or unstageable), venous and arterial ulcers, or open lesions on the foot.

On 1/8/25 at 11:13 am, V7 (Registered Nurse/RN) stated that V7 was familiar with R1, and R1's care needs increased in November 2024 when R1 "wasn't totally with it." When asked about R1's increased care needs, R1 stated that R1 was "total care, 2 person assist" and that R1 was "no help" with R1's ADL's (activities of daily living). V7 stated, "We had to turn (R1) in bed." When asked could R1 move R1's legs freely in bed, V7 stated, "No, not spontaneously." V7 stated, "(R1) was not actively moving. (R1) would stay in the position that we would put (R1) in." V7 stated that R1 did not have a pressure reducing mattress, like a low air loss mattress, in the facility. V7 stated that V7 was R1's nurse on 11/29/24, and when V7 started the shift at 7:00 pm, V7 stated that V7 was informed by the day shift nurse that R1 still needed R1's bath. V7 stated that prior to 11/29/24, there was no report of R1 having any skin alterations. V7 stated that V7 informed V8 (Agency Certified Nursing Assistant/CNA) about R1's pending bath. V7 stated that on 11/29/24 around 8:30 to 9:00 pm, V8 came out of R1's room and asked about taking off R1's lower leg compression garments

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(wrapped around R1's lower legs to feet). V7 stated that V7 told V8 that V7 would come into room with V8 and help to take the compression wrapped garments off R1. V7 stated that R1 had a physician order for the compression wrapped garments to be placed on R1's bilateral lower extremities (legs) in the morning and off at bedtime, and when "we take them off, we look at the skin." V7 stated that V7 removed R1's left lower leg compression wrap and sees a "foam dressing" on R1's left heel with no date, saying "it's blank." V7 stated that V7 removed the foam dressing to "see what was going on and it was a pressure wound. It looked like it's been there a couple of days." V7 stated that V7 observed R1's left heel wound as "whitish" open skin that's "breaking down" with redness and bleeding noted. V7 stated that V7 stepped out of R1's room to verify if R1 has "active orders to change it (foam dressing)" and asked V19 (RN) to also confirm R1's left heel pressure wound. V7 stated that there were no physician orders documented for a wound treatment order for R1's left heel wound despite R1 having a foam dressing present. V7 stated that V7 measured R1's left heel wound approximately 4 centimeters by 3 centimeters and notified V20 (Nurse Practitioner/NP) and V13 (R1's POA). V7 stated that V7 cleansed R1's left heel wound with normal saline (NS) and applied the treatment order of a foam dressing, and then placed a pillow under R1's lower left leg to elevate R1's heel off the mattress. V7 stated, "It was evident that it was a pressure injury." When asked about heel elevation boots for R1, V7 stated that R1 did not have heel elevation boots. When asked the process of assessing R1's skin, V7 stated that for R1's bed bath or shower, R1's compression garments are removed, the skin is cleansed by the CNA and the nurse is called into to assess

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R1's skin. V7 stated that if there is any new skin alteration noted during ADL care by the CNA, the CNA will inform the nurse who will then assess the new skin alteration. V7 stated, "If it's a daily remove compression, the (compression wrap garments) are removed and put on by CNAs."

R1's Progress Notes, dated 11/29/24 at 9:45 pm, V7 (RN) documents, in part, "During bed bath, (V8 CNA) asked this RN if (R1's) (compression wrap garments) to bilateral lower extremities can be removed. This RN removed (compression wrap garments) to BLE (bilateral lower extremities) and noticed a foam dressing to (R1's) left heal (sic. heel). This RN removed the foam dressing and noticed a wound on the heal (sic. heel). Skin is open and red with slight bleeding. Rough measurements of 4 cm (centimeters) x (by) 3 cm x 0 cm. No complaints of pain from the resident. This RN cleaned the wound with normal saline and applied a new foam dressing. Elevated feet on pillows to reduce pressure."

On 1/8/24 at 1:15 pm, when asked if a resident has compression wrap garments to lower extremities, does V8 remove them prior to giving a bed bath or shower, V8 (Agency CNA) stated, "I (V8) check in the nurse first. Sometimes the nurse doesn't want to have it removed. Every situation is different." V8 stated that during the bed bath or shower, V8 will do a full skin assessment that is written down on the shower sheet. V8 looks for any type of skin breakdown, bed sores, or scars, and will notify the nurse. V8 stated that V8 will document on the shower sheet what type of care was performed in the bed bath or shower. V8 stated, "I have to sign the shower sheet. Signed by nurse also. If they (nurses) don't sign it, it's pretty much like it hasn't been done."

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R1's Shower Record/Skin Evaluation sheets from November 2024 were reviewed. For the dates of 11/1/24, 11/4/24, 11/8/24, 11/11/24, 11/15/24, 11/22/24, and 11/25/24, multiple CNA and nurse signatures were noted, and under the section "Note any skin problems by site and description: scratch, cut, reddened area, open area, non-blanching area, flaky scalp," all nursing staff documented that there were no new skin issues or skin problems. For the date of 11/29/24 during the 3 pm to 11 pm shift, V7 and V8's signage is noted for R1's bed bath with skin problems for "open wound on left heal (sic. heel)" with "removed ace wrap and found open wound to L (left) heal (sic. heel), had foam dressing there, no date, 4 (cm) x 3 (cm)."

On 1/7/24 at 1:11 pm, V17 (RN) stated that R1 was alert with R1's confusion varying day to day. V17 stated, "(R1) definitely assistance with everything" and had a recent decline where R1 was staying in bed more instead of getting up to the reclining wheelchair with each meal. V17 stated that V17 was R1's nurse on 11/30/24 day shift and received in nursing report that R1 had a left heel wound. V17 stated that V13 (R1's POA) arrived in the facility, 11/30/24 in the morning, and V13 was requesting to see R1's wound. V17 stated that V17 explained to V13 that V17 "looks at every section of R1's skin." V17 stated that upon viewing R1's left heel wound with V13, V17 observed an "open wound looks deep tissue injury, stage 3." When asked the descriptors of R1's left heel wound, V17 stated that it was had purple discoloration, redness, white border, and slough build up. V17 stated that there was serous drainage that was "malodor" from R1's left heel wound. V17 stated that V17 took pictures with V13's in-person permission. V17 stated that V17

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also observed dark redness to R1's right heel and moisture associated skin damage (MADS) to R1's sacrum. V17 stated that V17 answered V13's questions about R1's left heel wound, including the visible slough build up that would need to be removed, to prevent infection, and V13 requested R1 be transferred to the hospital. V17 stated that R1 was at risk for skin breakdown and that "when there is decreased blood circulation to a particular area of the body, it can cause necrosis (tissue death)." This surveyor requested to view V17's photographs of R1's wounds (11/30/24), and V17 showed this surveyor. R1's left heel wound was oblong, ping pong ball size (approximately) wound with red and white center, with adherent buildup of whitish slough and white border. V17 stated, "Frankly, I (V17) have been a nurse for a long time. When they take the (compression wrap garment) off, the nurse is to check the skin. This (R1's left heel wound) is not small." When asked about taking photographs of R1's wounds on 11/30/24, V17 stated, "I (V17) work here. I am obliged. I sent to V2 (Director of Nursing/DON). This is negligence. I don't come to work every day. It's 3 days a week for 12 hours. This (R1's left heel wound) didn't happen overnight. Slough looks like a couple of days sitting here." V17 stated that V17 had a conversation after sending R1's wound photographs to V2 and that V2 said it was a pressure ulcer wound. V17 stated that all nurses are responsible for assessing and identifying new skin alterations and notifying the charge nurse, wound care nurse, DON, family member and the physician; and the reporting nurse does the incident report of the new skin alteration.

In R1's Progress Notes, dated 11/30/24 at 10:10 am, V17 (RN) documents, in part, "Writer (V17) went to reassess wound on left heel, per

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assessment noted with open wound on left heel with loss of dermis and epidermis with slough and serous drainage with odor and necrosis approximately measurement of 5 cm x 4 cm. Right heel assessed noted deep red to purplish blanchable measurement of 4 (cm) x 3.8 cm approximately mushy to touch ... (V13) @ (at) bedside has been explained in detail about the wounds. (V13) requesting resident to be send to (hospital) for further evaluation and treatment ... (R1) awake and alert, unable to state needs effectively."

On 1/7/24 at 2:00 pm, V2 (DON) stated that V2 was the acting DON in the facility through December 2024 until V2's temporary leave of absence from work. V2 stated that that on 11/29/24, V2 was notified by nursing staff that R1 had "skin tear" on R1's left heel, and "the next call I (V2) received was on 11/30 when they decided to send (R1) out. The wound was smelly. I said, 'What do you mean. I was told it was a skin tear. I had no knowledge or wasn't aware of it (R1's left heel pressure wound)." When asked if V2 received photographs of R1's wounds taken by V17 on 11/30/24, V2 stated, "Yes. I saw an actual wound and it was not a skin tear." When asked in seeing the photograph of R1's left heel wound from 11/30/24, would this type of wound develop spontaneously, and V2 stated, "No. A wound like that takes time to develop. It's not like skin tear sheering form paper. If you do not do the offload pressure for it, it will get worse." V2 stated that nurses and CNAs are monitoring residents' skin, and a weekly skin evaluation is done if there are skin alterations. When asked the protocol for skin assessments, V2 stated that the CNA gives the showers or bed baths; before the CNA finishes, the CNA will get the nurse; the CNA and nurse will check the body skin together and will mark

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any findings. V2 stated that the wound care nurse (V5) does weekly wound assessments for residents with active wounds. V2 stated that prior to 11/29/24, V2 was not notified of R1 having an active wound. V2 stated upon V2 returning to work on 12/2/24, V2 "pulled every shower sheet from the last month and nothing was documented. Absolutely not a thing, nothing." V2 stated that V2 initiated an investigation for R1's left heel pressure wound saying "I (V2) was very alarmed. Not one note was on it. No one documented it, not one in there. Not one report." When asked with R1 having bilateral lower leg compression wrap garments, are the nursing staff to remove the ace wraps for bed baths or showers, and V2 stated, "Yes, most definitely." V2 stated that the staff must inspect the resident's skin after removing the compression wrap garments. V2 stated that the nurses and CNAs must off load the heels for R1.

On 1/7/24 at 9:58 am, when asked how V5 (Wound Care Nurse, RN) gets informed of resident having a new skin alteration, V5 stated, "I receive an email." V5 stated that when the CNA and nurses are doing the bed baths and showers, they check the skin and will report to me via email or talk to V5 in person. V5 stated that V5 will then assess the resident with another "set of eyes" by bringing in a CNA for the skin check. V5 stated that V5 will document the findings in the progress notes and weekly wound evaluations. V5 stated that the reporting nurse notifies the physician to obtain initial wound treatment orders, and will also notify the supervisor, DON, and the family member. V5 stated that an incident report is then done by the reporting nurse, and V5 receives a copy of the incident report for a new skin alteration. V5 stated that simple dressing changes, like for abrasions or skin tears, are

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performed by the staff nurses as ordered, and V5 will perform the "major dressings, like pressure ulcers." V5 stated that V5 and staff nurses place a date on the outside of the wound dressing to "make sure the dressing is being changed" to communicate to nurses the last time the wound dressing was completed. When asked when a resident's skin is to be checked, V5 stated that full skin assessments are done during bathing and showers.

On 1/7/24 at 11:02 am, in V5's follow up interview, V5 (Wound Care Nurse, RN) stated that V5 is the wound care nurse in the facility and works Monday through Fridays from 7:00 am to 3:00 pm. V5 stated that V5 worked with R1 for wound care needs in September and October of 2024 with all of R1's skin tears of the left arm, left 3rd toe, and bilateral anterior ankles healed by 10/31/24. V5 stated, "After (R1's) wounds healed, I never seen (R1) anymore" for wound care assessments or treatments. V5 stated that on 11/29/24 and 11/30/24, V5 was not working in the facility, so V5 did not see R1's left heel pressure wound prior to hospital transfer on 11/30/24. When asked about R1's left heel wound being observed by V7 (RN) on 11/29/24 with a foam dressing in place, V5 stated "Foam dressing needs an order (physician order)." When asked if a foam dressing can be used as a preventative measure, V5 stated, "It should be ordered anyway. Why are you putting a foam on intact skin? If there is something brewing under it (foam dressing), it should be reported. I am not sure why they were putting that foam dressing on there (R1's left heel)." V5 stated that there was no physician order for R1's left heel wound prior to 11/29/24; that V5 was not notified; that there was no incident report; and that there was no documentation of the wound in shower sheets.

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When asked how heel pressure ulcers are preventable, V5 stated that heels "should be off loaded, and heels should be hanging, not in friction on the bed." V5 stated that R1 did not have a redistribution surface on R1's bed.

R1's Braden Scale for Predicting Pressure Score Risk (dates 10/9/24 and 11/29/24) document, in part, that R1's Braden Scale scores are "at risk" for pressure ulcers. R1's "ability to respond meaningfully to pressure-related discomfort" is documented as R1 "cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities."

R1's Wound Evaluation Weekly, dated 11/29/24 at 10:54 pm, V7 (RN) documents, in part, that R1's new left heel wound was facility acquired with current preventative measures in place marked as "barrier cream."

R1's Treatment Administration Record (TAR) for November 2024 documents no active order treatment for R1's foam dressing to left heel which was observed by V7 on 11/29/24. A new left heel foam dressing daily and whenever needed for R1 is ordered on 11/30/24 (after being observed by V7 on 11/29/24).

R1's Physician Order Statement for active and discontinued orders (from admission to facility 9/18/23 to official discharge date of 12/6/24) lists all R1's orders with no order for redistribution bed surface or elevating heels while in bed (with only new order for "bunny boots" to bilateral heels after 11/29/24 observation of R1's new heel wound).

R1's Care Plan (date initiated 9/19/23)

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documents, in part, a focus of R1 "is at risk for pressure ulcer development r/t (related to) immobility and incontinence" with a goal of R1 having "intact skin, free of redness, blisters or discoloration," and interventions of "follow facility policies/protocols for the prevention/treatment of skin breakdown" and "(R1) needs assistance to turn/reposition at least every 2 hours, more often as needed or requested." R1's pressure ulcer risk care plan does not include an intervention for elevating heels to offload heel pressure while in bed.

R1's Care Plan (date initiated 9/19/23) documents, in part, a focus of R1's "impaired circulation r/t dependent edema" with interventions of bilateral compression garments placed on R1 on in the morning and off at bedtime and "inspect foot/ankle/calf skin for changes: maceration (white, wrinkly, moist), redness, purple tinge, blue, rust coloring, weeping, edema, puffiness, tenderness, areas with no sensation."

R1's Care Plan (date initiated 9/23/23) documents, in part, a focus of R1 having "limited physical mobility r/t weakness on LE (lower extremities), impaired gait, impaired transfers, impaired activity tolerance" with and intervention of "monitor/document/report PRN (whenever needed) any s/sx (signs/symptoms) of immobility ... skin-breakdown."

Facility policy titled "Wound-Pressure Ulcer Prevention" with revised date of 3/24/22 documents, in part, "1. Policy: RNs/LPNs (Licensed Practical Nurses), Physicians/CNPs (Certified Nurse Practitioners) will evaluate, document, and implement appropriate preventative measures ... 3. Procedure: A. The

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purpose of the recognition and assessment phases for resident who have not yet developed a pressure injury is to provide the framework for implementation of a prevention strategy that reduces the risk of pressure injuries. Pressure Injury-Prevention Measures: Create a turning and repositioning schedule that is based on the resident's individual risk factors. Reposition at least every 2 hours while in bed ... inspect skin during bathing and/or personal care ... position the resident to minimize pressure over bony prominences and shearing forces over the heels ... use appropriate offloading or pressure-redistribution devices ... F. Manage Pressure: Proper positioning, turning, and transferring techniques are important to manage pressure and shearing forces, ensure weight redistribution on support surfaces, and protect uninvolved skin ... 2. To assess the skin for tissue integrity, look for discoloration and changes in temperature or consistency. In light-skinned residents, relief of prolonged pressure from any area of the body will result in reddening as the blood rushes back into the tissues; this phenomenon, known as reactive hyperemia, is the earliest sign of tissue compromise. In healthy tissue, the skin will blanch when pressure is applied to a hyperemic area; in compromised tissue, the hyperemic area will not blanch. Non-blanching erythema is indicative of a Stage 1 pressure ulcer ... 5. Residents at risk of skin breakdown should be placed on a static support (e.g. {for example} foam overlay, foam mattress, statis flotation device) rather than a standard mattress. A dynamic surface is recommended when the resident cannot assume a variety of positions without bearing weight on a pressure injury, if the resident is fully compresses on a static surface ... 6. Residents who have or are at risk of

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developing heel injuries ... will require offloading or pressure-redistribution devise (e.g., heel boot, heel elevator, heel lift, suspension boot or a device that 'floats' the heel) to relive pressure on the heels and prevent skin breakdown."

Facility policy titled "Wound-Skin Record-Skin Eval" with a revised date of 11/3/22 documents, in part, "1. Policy: Residents will have skin evaluated to ensure areas of concern are addressed appropriately ... 3. Procedure: A. Nursing Staff will complete the shower record/skin evaluation (see attached) at least weekly during routine care/bathing and during any resident care when a skin problem is noted. B. Complete A-1 through 7. If member refused bath complete questions 1 and 2, sign and date form and give to resident's nurse. C. The nurse responsible for the resident must assess the skin issue noted on the sheet. D. The nurse responsible for the resident will document their response and interventions as a Progress Note in the Electronic Health Record. Care Plan/Kardex will be updated as needed. If condition is new, the nurse must notify the Physician/CNP responsible party and obtain an order for treatment. If area is a new bruise or skin tear, the nurse must complete an incident report and notify Physician/CNP and responsible party. Resident's nurse will complete sections B and C and document responses and interventions. E. Shower record form will be kept under the treatments tab in the chart. F. The nurse responsible for the resident will complete wound evaluation form under the Assessments/UDA form tab in the resident's health record."

Facility policy titled "Wound/Skin Care Pressure Ulcer - Staging" with a revised date of 3/24/22 documents, in part, " ... Definition: Stages of a

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Pressure Injury: Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The areas may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue ... Stage 1: Intact skin with non-blanchable redness of a localized area, usually over a bony prominence ... Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer, without slough ... Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present."

Facility policy titled "Braden Scale Predicting Pressure Score Risk" with a revised dated of 3/24/22 documents, in part, "1. Policy: To identify residents at risk for skin breakdown and initiate prevention plan and interventions ... 3. Procedure: A. Unit RN/LPN to complete a Braden Scale UDA on all residents on admission, every week x (times) 4 weeks (new admits) and then quarterly, annually, significant change in ADL (activities of daily living)/condition ... B. Score will be tabulated upon completion of the Braden Scale. C. Preventative Measures Checklist Care Plan will be done if Braden Score is 18 or less or as needed."

Facility policy titled "Wound/Skin Care-Pressure Ulcer Treatment Protocols" with a revised date of 3/24/22 documents, in part, "1. Policy: (Facility) has developed wound care protocols for pressure ulcers based on stage, phase of healing, and predominate condition of the wound base ... 3. Procedure: A. Notify Physician/CNP upon initial discovery of wound or worsening of wound. B. When the Physician/CNP orders wound care per

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S9999	Continued From page 16 Wound Care Protocol it must be documented on the Physician order sheet. Facility policy titled "Wound/Skin Care-Wound Treatment Plans" with a revised dated of 11/14/22 documents, in part, "1. Policy: RNs/LPNs, Physicians/CNPs will evaluate, document, and implement appropriate treatment measures ... 3 Procedure: ... B. When pressure injury treatment is initiated, it is important that the clinical team evaluate the treatment plan implemented and assess the wound weekly." Facility policy titled "Wound/Skin Care-Wound Cleansing & Irrigation" with a revised date of 11/14/22 documents, in part, "1. Policy: Wound healing is optimized and the potential for infection is decrease when all necrotic tissue, exudates, and metabolic wastes are removed from the wound ... 3 Procedure: General Instructions. A. All wounds should be cleansed initially and with each dressing change ... Cleansing: ... E. Cleanse wound area and apply wound treatment as ordered. All dressings must be signed & dated by nurse." "A"	S9999		