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| S 000 | Initial Comments<br><br>Annual Licensure and Certification Investigation of Facility Reported Incident of 12-14-2024/IL182534 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations 1 of 2:<br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)5)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each | S9999 | | |

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resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure preventive measures are in place to prevent developing of new skin impairment and deteriorating of current pressure ulcer to resident who is at high risk. This deficiency affects one (R139) of three resident in the sample of 32 reviewed for Pressure Ulcer Prevention management.

This failure resulted in R139 developing a new moisture associated skin disorder (MASD) to bilateral buttocks and deteriorating pressure ulcer on sacrum area to unstageable.

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| S9999 | Continued From page 2<br>Findings include:<br><br>On 1/7/25 at 11:30AM, R139 lying in bed with her V13 Family member/daughter and V14 Caregiver at bedside. V13 stated that she has concern regarding poor nursing services provided to her mother. V13 stated that they arrived today around 8:30AM and found R139 soaked with urine and feces. R139's bed was wet from her upper back/shoulder down to her both ankles. V13 stated that she called and showed observation to V11 ADON (Assistant Director of Nursing). V13 stated she presented concerns of not providing incontinence care to R139 from night shift until morning shift. V13 stated that R139 developed pressure ulcer in her sacral area in the facility and deteriorating. V13stated that R139 has a stage 3 pressure ulcer on sacral area. R139 is on low air loss mattress with flat sheet and cloth pad over the mattress. She (R139) wears disposable adult brief.<br><br>On 1/9/25 at 12:30PM, R139 lying in bed with low air loss mattress. R139 is alert, oriented and can verbalize needs to staff. R139 stated that she developed bedsore in the facility and causing her pain on her buttocks area. R139 stated that the nurses are changing her dressing on her buttocks, but they are not changing her brief when she was soiled. R139 stated they do not answer her call light. R139 stated that her mattress had a problem, and they switched her bed with her roommate. R139's roommate was not in her room, but the roommates low air loss mattress is unplugged. Verified information given by R139 to V26 WCC (Wound care coordinator). V26 stated confirmed that they switched R139's bed with her roommate just 45 minutes ago.<br><br>On 1/9/25 at 12:40PM, V27 Wound care tech | S9999 | | |

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repositioned R139 on left side lying position. V26 WCC removed foam dressing on sacrum area. Observed R139 has moderate serous sanguineous with greenish wound drainage. V26 said that R139 has unstageable pressure ulcer on sacrum and MASD on bilateral buttocks. Observed multiple open wounds covered with white colored ointment. V26 said that R139 has 70% greenish slough formation attached to wound base, 10% eschar and 20% granulating tissues. V26 said that R139 is being seen by V30 Wound care Nurse Practitioner. V26 provided wound care to bilateral buttocks and sacrum. V26 said that checking resident every 2 hours for incontinence care, skin care after each incontinence episode, low air loss mattress and provided treatment as ordered are some of the wound care preventive measures the provided.

R139 is initially admitted on 3/6/24 and was re-admitted on 7/13/24 with diagnoses listed in part but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Pressure ulcer of sacral region stage 3 during stay, Type 2 Diabetes Mellitus (DM) with diabetic neuropathy, Obesity. Admission and current Braden/skin assessment indicated that she is at high risk for developing pressure ulcers/skin impairments. Active physician order sheet indicated: Bilateral buttocks cleanse with Hibiclens, apply triad wound paste, leave open to air everyday shift, and as needed for MASD. Air Mattress. Santyl ointment 250 unit/gm (Collagenase) apply to sacrum topically everyday shift for wound cleanse with normal saline cover with foam dressing. Right heel cleanse with normal saline apply betadine /gauze /abdominal pad wrap kerlix every day shift M-W-F for DTI (Deep tissue injury). Barrier cream to be applied after each incontinence episode may be

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applied by CNA and kept at bedside. Comprehensive care plan indicates that she has pressure ulcer on sacrum, right heel, venous ulcer to the right lower leg and is high risk for further pressure ulcers related to impaired mobility, decreased ROM, incontinence, history of right humerus fracture, right side hemiplegia related to CVA (Cerebrovascular accident), DM, Obesity and CHF (Congestive heart failure). Intervention: Follow facility policies/protocols for the prevention/treatment of skin breakdown. She has an ADL (Activity of daily living) self-care performance deficit and impaired immobility. Intervention: totally dependent on staff for toilet use. She is on low air loss mattress due to presence of skin breakdown and to prevent further skin breakdown. Intervention: Check for proper functioning and setting of low air loss mattress every shift.

On 1/9/25 at 1:16PM, Reviewed R139 medical records with V28 MDS/Resident assessment Coordinator. V28 stated that R139's MDS (minimum date set) admission assessment on 3/8/24 indicated that she was admitted with stage 2 pressure ulcer on sacral area. MDS assessment dated 6/1/24 indicated that her skin is intact. MDS assessment dated 8/19/24 indicated that she was re-admitted with stage 2 pressure ulcer on sacral area from the hospital. MDS assessment dated 10/9/24 indicated that she has stage 2 pressure ulcer on sacral area. MDS assessment dated 12/13/24 indicated a significant change of condition due to deterioration of sacral pressure ulcer from stage 2 to stage 3.

On 1/10/25 at 12:01PM, V11 ADON stated that she was called to R139's room on 1/7/25 by V13 Family member and showed her observation

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made that R139 was soiled with urine. V11 stated the bed was wet and soaked from upper back/shoulder down to lower extremities/ankles. V13 presented above concerns to her (V11). Informed V11 that the concern form that she completed dated 1/7/25 did not indicate concerns presented by V13 that incontinence was not done due to R139's bed was soiled from upper back/shoulder to lower extremities/ankles when they visited R139 on 1/7/25. V13 also concern that R139 has pressure ulcers that getting worse. V11 documented on R139's concern form dated 1/7/25 indicated: "Daughter expressed concern of her mother being soiled, states her mother is a "heavy wetter" and needs changing often. Daughter ensured rounds would be made on her mother every two hours and that a indwelling urinary catheter would be placed to ensure less moisture to her bottom." V11 said R139 should be check for incontinence every 2 hours. She said that resident who was left soiled for long period of time could developed pressure ulcer and deteriorate current pressure ulcer. Informed V11 that she did not investigate the night shift (11pm -7am) who worked on 1/6/25 and day shift 1/7/25 staff (nurse and CNA) who worked with R139 why she was soiled from upper back/shoulder down to lower extremities/ankles at 8:30am when V13 Family member and V14 Caregiver.

On 1/10/25 at 12:13PM, V26 WCC said that R139 developed new MASD on bilateral buttocks and was seen by V30 Wound care Nurse Practitioner. She said R139 should be check for incontinence care every 2 hours. She said that resident who had prolong exposed to soiled brief and bed could develop pressure ulcer and could deteriorate current pressure ulcer.

On 1/10/25 at 12:21PM, V30 Wound Care Nurse

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| S9999 | Continued From page 6<br><br>Practitioner stated that she has taking care of R139 since July 2024, presented with stage 2 pressure ulcer on sacrum area which now progressed to unstageable pressure ulcer. She recently examined R139 on 1/8/25 with new MASD (Moisture associated skin disorder) to bilateral buttocks. V30 said that she was not aware that R139 was left soiled in bed on 1/7/25 as witnessed by V13 Family member and V11 ADON. V11 stated that prolong exposure to soiled brief and bed from urine and feces are factors in developing new skin impairment and deteriorating current pressure ulcer. The facility should follow its wound/pressure ulcer prevention and management policies.<br><br>R139's Skin/Wound notes documented by V30 Wound care Nurse Practitioner on 1/8/25 indicated: 1. Sacrum- Unstageable pressure ulcer, measures 10.5cm x 7cm x 0.1cm, 90% slough, 10% granulation. 2. New Moisture Associated Skin Disorder (MASD) on bilateral buttocks, partial thickness, 100% epithelial, Dermatitis, exposed epithelium tissues. 3. Right heel pressure, DTI (Deep tissue Injury), measures 2.5cm x 3cm x 0cm, 100% epithelial. V30 documented: 12/23/24 Upon assessment, patient was noted to be on a deflated air mattress. Sacral worsening. 12/30/24 Patient on regular mattress today, RN to notify facility coordinator to get her another air mattress. Sacral wound worsening. Preventive measures: The resident is incontinent of bowel and bladder, thorough skin care with each incontinent episode. Continues alternating air/low mattress for pressure reduction.<br><br>On 1/10/25 at 12:53PM, Informed V1 Administrator and V2 Director of Nursing (DON) of above concerns and requested for Wound | S9999 | | |

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| S9999 | Continued From page 7<br>/Pressure Ulcer Management policy.<br><br>Facility's policy on Skin Care Regimen and Treatment Formulary Reviewed 1/24/24 indicated:<br>Policy statement: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown.<br>Procedures:<br>6. Residents who are not able to turn and reposition themselves will be turned and repositioned at least every 2 hours unless otherwise specified by the physician.<br>9. Residents with stage 3 or 4 pressure injuries will be placed in specialized air mattress like low are loss mattress<br>Facility's policy on Incontinent and Perineal Care Revised 7/31/24 indicated:<br>Policy statement: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident's skin condition.<br>Procedures:<br>1. Do rounds at least every 2 hours to check for incontinence during shift.<br><br>(B)<br>Statement of Licensure Findings 2 of 2:<br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the | S9999 | | |

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facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

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resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:
Based on interview and record review the facility failed to ensure safety interventions were in place for a resident who is at high risk and has history of falls. This deficiency affects two (R27 and R216) of three residents in the sample of 32 reviewed for fall prevention program.

This failure resulted in R216 falling and sustaining a laceration to his right eyebrow that required a visit to the hospital for suturing.

Findings include:

On 1/7/25 at 10:30AM, V2 Director of Nursing (DON) stated that R216 was discharged home from the facility on 10/27/24. V2 stated that V29 Agency nurse who worked with R216 on the day of his unwitnessed fall was no longer working in the facility, she was terminated.

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Per R216's medical record R216 was admitted on 10/11/24 with diagnoses listed in part but not limited to Displaced fracture of shaft of humerus right arm, history of falling, Dementia with Anxiety, Cataract, Glaucoma, Abnormalities of gait and mobility, lack of coordination, Weakness, Malaise, Malignant neoplasm of prostate. Fall admission assessment done on 10/11/24 indicated at high risk for falls. R216s Admission/Baseline care plan dated 10/11/24 identified fall risk but no intervention indicated. R216's Admission functional mobility assessment dated 10/11/24 indicated that he needs partial/moderate assistance with roll left to right, sit to lying, lying to siting on side of the bed, bed to chair transfer, toileting transfer.

R216's unwitnessed fall incident documented by V29 Agency Nurse on 10/11/24 at 7:30PM indicated: "V23 CNA notified writer that resident was noted sitting by edge of the bed and bleeding from his right eyebrow. Upon head-to-toe assessment resident was noted with laceration to right eyebrow. Resident denied Shortness of breathing or dizziness. Vitals: Blood pressure 134/72, Heart rate 90, Respiratory rate 18, Temperature 97.9F, 95% oxygen saturation on room air. Resident complained of pain at laceration site, right eyebrow. Per resident, he was trying to reach out to pick up his phone and he ended up on the floor. 911 was called and resident was transferred to the hospital for further evaluation.

R216's unwitnessed fall incident initial report was sent to the State Agency on 10/13/24 at 10:00PM. Final report was submitted to the State Agency on 10/19/24 at 10:00PM indicated: At approximately 7:30PM on 10/11/24, R216 was observed by V23 CNA sitting on the floor at the right side of the bed

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with blood coming from his right eyebrow. R216 stated that he was trying to answer the phone on the nightstand next to his bed when he fell over hitting his head on the nightstand. R216 was sent to the hospital for evaluation. R216 returned to the facility with sutures to the right eyebrow.

R216's hospital emergency department records dated 10/11/24 to 10/12/24 (7 hours) discharged summary indicated: Injury of head, Multiple falls, laceration of scalp, rapidly progressive Dementia. Procedure: Laceration repair of 4cm oblique V shaped partially avulsed laceration through right eyebrow. 4cm length and 4cm depth. 4 sutures. Patient states he was in bed reaching for a phone over his head and rolled out of bed. Patient had fell at home sustaining fracture humerus status post humeral fixation on 10/5/24. Patient was discharged to nursing home facility on 10/11/24 for rehabilitation where he fell. Patient has baseline confusion.

On 1/9/25 at 9:52AM, Review of R216's medical records with V2 DON. V2 stated she (V2) is aware that R216 was at high risk for falls prior to admission due to clinical intake that she (V2) received from the hospital. V2 stated that R216 had an unwitnessed fall at home and sustained a right arm fracture. V2 stated that R216 was admitted to the nursing home facility for rehabilitation on 10/11/24 at 2:43PM. V2 stated R216 had an unwitnessed fall on the same day of admission at 7:30PM and sustained a laceration on his right eyebrow. V2 stated R216 was reaching out for his cell phone and fell from bed and hit his head on the nightstand. V2 stated R216 was sent to the hospital for evaluation. V2 stated that she (V2) was notified of R216's fall incident with laceration around 8:00PM. V2 stated she (V2) called the facility around 7:00AM on

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| | IL6012967 | A. BUILDING: _____ B. WING _____ | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA CHICAGO RIDGE | 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 12 | S9999 | | |

10/12/24 regarding the status of R216. V2 stated she was told that R216 returned on 10/12/24 at 3:59AM with sutures to his right eyebrow. V2 stated she submitted the initial report on 10/13/24 at 10:00PM. V2 stated that she (V2) is still in compliance of submission because it is within the 24-hour period from the time the resident came back to the facility. Surveyor informed V2 that R216 fall admission assessment dated 10/14/24 indicated at high risk. R216 admission baseline care plan identified him as fall risk, but no care plan intervention indicated. V2 stated that the admission nurse should indicate baseline fall interventions.

On 1/9/25 at 11:59AM, V23 CNA stated that she was the CNA assigned to R216 on 10/14/24 3-11 shift on the day R216 had the unwitnessed fall. V23 stated that she was aware that R216 is at high risk for falls as endorsed to her. V23 stated R216 has fracture of right arm and had bandage/dressing. V23 stated R216 is confused. V23 stated around 7:30pm after dinner, she (V23) observed R216 sitting on the edge of the bed with blood coming from is eyebrow. V23 stated she told R216 that he should not get up. V23 stated R216 stated that he was trying to answer his phone and fell when trying to reach the nightstand/bedside dresser. V23 stated that personal belongings such as cellphone should be placed within resident's reach.

Facility's fall prevention program guidelines revised 12/5/21 indicates:
Policy statement: Fall prevention program guidelines shall be implemented to promote safety of all residents in the facility. This program shall include measures to determine the individual needs of each resident by assessing the risks for fall and the implementation of

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evidence-based prevention interventions.
Procedures:
2. Safety interventions shall be initiated and implemented for each resident identified at risk for fall.
3. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained.

On 1/10/2025 at 1:00pm V2 (Director of Nursing-DON) stated that R27 is alert to name only is able to assist with turning and repositioning and needs one assist with bed activity of daily living-ADL'S. R27 did have a fall from the bed on 1/6/2025. V35 (certified nursing assistant-CNA) stated that R27 was too close to the edge of the bed when R27 was turned and R27's legs went out the bed and V35 slid R27 to the floor. V2 stated I asked V35 why she didn't reposition R27 before turning R27 and V35 stated I did not realize she was that close to the edge.

On 1/13/2025 at 12:30pm V35 (Certified Nursing Assistant-CNA) stated that R27 is alert but confused, can assist very minimal with turning and repositioning and that she (V35) considers R27 a total assist. V35 stated that she turned R27 to her stomach to clean her and R27 legs went out the bed and she lowered her to the floor. V35 stated I (V35) did not think R27 was that close to the edge to the bed that she needed to be repositioned. V35 stated she did not hurt herself she was sent out to the hospital to make sure she had no injury.

A care plan dated 12/13/2024 indicated that R27 has an history of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the left non-dominant side and a history of falls. A post

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| S9999 | Continued From page 14<br>fall investigation with an root cause analysis dated 1/9/2025 indicated that R27 was too close to the edge of the bed and that staff must ensure that R27 is in the center of the bed prior to starting activity of daily living -ADL care.<br>NO VIOLATION | S9999 | | |