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S 000	Initial Comments Complaint Investigation 2561041/IL186006	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)5) 300.1220b)3) Section 300.610 Resident Care Policies 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. Section 300.1010 Medical Care Policies h) 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	S9999		

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S9999	Continued From page 1 of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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 resident to meet the total nursing and personal care needs of the resident. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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.	S9999		

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S9999	Continued From page 2 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to develop and implement skin and pressure relieving interventions, evaluate nutritional status, maintain wound dressings, and accurately document wound assessments for three (R1, R3, R4) of three residents reviewed for pressure ulcers in the sample list of four. These failures resulted in R4 developing a stage two pressure ulcer that deteriorated into an unstageable pressure ulcer. Findings include: The facility's Skin and Wound Management Guidelines dated April 2023 documents preventative measures will be implemented for residents who are at risk for developing wounds and aggressive wound management will be initiated for wounds/pressure ulcers. This guide	S9999		

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documents to complete Braden assessments upon admission and then weekly for four weeks, ensure the resident is added to the shower schedule and review shower documentation and weekly skin checks to ensure compliance and identify new wounds at an early stage. This guide documents to assess, measure, photograph and document wounds in the electronic software system, refer to the dietitian for recommendations for wound healing, obtain an order for wound physician consult and update the resident's care plan.

The facility's Pressure Injury Preventions Guidelines and Suggested Interventions dated April 2023 documents poor diet may cause pressure injuries and nutrition should be evaluated. This guide documents residents who are dependent on staff for assistance should e assisted to reposition at least every two hours or per plan of care, position the resident at a 30 degree angle when turning on one side or the other, and residents at risk should avoid sitting in a chair for long periods without repositioning.

On 2/18/25 at 10:37 AM V10 and V15 Certified Nursing Assistants (CNAs) entered R4's room and transferred R4 with a full mechanical lift from the bed to the shower chair. R4 had an open, pink/yellow wound, approximately quarter sized, that was not covered with a dressing. V15 stated R4 did not have a dressing over the wound since V15 came on shift and the dressing must have come off sometime on night shift.

On 2/18/25 at 11:26 AM V16 Licensed Practical Nurse stated no one had reported that R4's wound dressing had come off prior to R4's shower. V16 stated V16 would expect the CNAs to notify V16 when a dressing has come off so

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that a new one can be applied.

R4's Admission Minimum Data Set (MDS) dated 12/30/24 documents R4 has moderate cognitive impairment, impaired range of motion to one upper and one lower extremity, is dependent on staff transfers, requires substantial/maximal assistance from staff for turning in bed and bathing/showering, is always incontinent of urine. R4 has no pressure ulcers and is not on a turning and repositioning program. This MDS lists pressure relieving device for chair as the only skin/ulcer intervention. R4's MDS dated 1/24/25 documents R4 has moderate cognitive impairment, R4 is dependent on staff for turning in bed, transfers and bathing, and R4 has one stage three facility acquired pressure ulcer.

R4's Braden Assessment Dated 12/23/24 documents R4 is at moderate risk for developing pressure ulcers.

R4's Care Plan with initiated date of 12/24/24 and revised date of 2/5/25 documents R4 has potential for skin impairment related to decreased mobility, incontinence, and cerebrovascular accident, and R4 has a coccyx stage three pressure ulcer as of 1/16/25. This care plan documents an intervention dated 2/5/25 for turning and repositioning every two hours and as needed. R4's diagnoses include vascular dementia, type two diabetes mellitus, hemiplegia and cerebrovascular accident. There are no documented implementation of pressure relieving interventions on R4's care plan or in R4's medical record prior to R4 developing a pressure ulcer.

R4's ongoing weight log documents R4's weights as follows:
12/23/2024 160.2 pounds (Lbs.)

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12/31/2024 150.6 Lbs. (5.99% loss)
1/7/2025 147.5 Lbs.
1/14/2025 145.0 Lbs. (9.49% loss since 12/23/24)
1/21/2025 147.6 Lbs.
1/28/2025 145.4 Lbs.
2/4/2025 150.4 Lbs.
2/11/2025 148.8 Lbs.

R4's shower documentation for December 2024 and January 2025 was requested on 2/19/25. R4's Shower Sheets, provided by V2 Director of Nursing (DON) document showers were given/offered on 12/31/24 and then not again until 1/21/25 (3 weeks later).

R4's Weekly Skin Assessments dated 12/31/24 and 1/7/25 document R4 had no new skin issues and there are no preventative interventions marked as indicated, which includes a turning schedule, specialized mattress, positioning devices, and seating surface. R4's Weekly Skin Assessment dated 1/14/25 documents R4 had no new skin issues and "heels floated" was the only preventative intervention documented. R4's Weekly Skin Assessment dated 1/16/25 documents R4 had a 3 centimeter (cm) wide by (x) 1 cm long open sacral wound.

R4's Wound Assessment Details Reports document the following: On 1/17/25 R4's coccyx stage two pressure ulcer measured 2.7 cm x 1 cm x 0.1 cm deep. On 1/24/25 R4's stage two pressure ulcer was 1.9 cm x 0.8 cm x 0.1 cm. On 2/6/25 R4's coccyx pressure ulcer as a stage three that measured 2 cm x 0.7 cm x 0.1 cm with 70% slough (dead tissue). On 2/13/25 R4's pressure ulcer as unstageable with 100% slough and the wound measured 1.6 cm x 1 cm x 0.1 cm.

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There is no documentation that R4's wound was assessed by V4 Wound Physician prior to 1/27/25, when R4's wound had declined to an unstageable pressure ulcer. R4's Wound Assessment and Plan dated 1/27/25, recorded by V4, documents R4's coccyx wound as an unstageable pressure ulcer with 100% slough and the wound measured 2 cm x 1 cm. R4's Wound Assessment and Plan dated 2/10/25, recorded by V4, documents R4's unstageable pressure ulcer was 100% covered with slough and measured 1.6 cm x 1 cm.

R4's Physician Order dated 1/28/25 documents to cleanse coccyx wound, pat dry, apply medicated honey gel and cover with a dressing daily and as needed.

R4's Albumin (protein found in the blood) level was 3.1 grams per deciliter (normal range 3.5-5) on 12/11/24.

There is no documentation in R4's medical record that R4's nutritional status was evaluated by a Registered Dietitian (RD) prior to and after 1/16/25 (when R4's pressure ulcer was identified). R4's Dietary Note dated 1/16/25 at 8:56 PM documents V7 RD evaluated R4's nutritional status and weight loss. This note documents R4 had no skin concerns, R4 was on health shakes twice daily, V7 had no new recommendations and to notify V7 with any significant changes.

On 2/18/25 at 11:37 AM V3 Assistant DON/Wound Nurse stated R4's wound was facility acquired and classified as a stage two on 1/17/25 and it worsened on 1/24/25 with slough present, but the 1/24/25 wound assessment incorrectly documents the wound was a stage

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two. V3 stated the wound was a stage three on 1/24/25, but the electronic software system does not allow amendments to V3's assessments. V3 stated R4's wound is currently an unstageable pressure ulcer. V3 stated R4's poor appetite was the cause of the wound and has contributed to R4's wound decline.

On 2/19/25 at 9:58 AM V3 stated R4 should be turned and repositioned every two hours and this should be documented on the CNA task charting and on R4's care plan. V3 stated R4 should have an at risk care plan with pressure relieving interventions if R4's Braden identified R4 to be at risk for pressure ulcers. V3 stated we review wounds weekly with V2 DON and follow up with the RD when wounds decline. V3 stated the RD is sent an electronic mail with any changes in condition. V3 was unsure if R4 has been evaluated by an RD after 1/16/25. V3 stated the facility recently changed RDs within the last month. On 2/19/25 at 1:03 PM V3 stated V3 has been the facility's wound nurse since January 2025.

On 2/18/24 at 3:47 PM V18 CNA stated the CNAs can view how much assistance residents need and pressure relieving interventions in their electronic charting system. V18 stated there is also a binder at the nurse's station that documents pressure relieving interventions. This binder was viewed with V18 and confirmed it did not contain information regarding R4. On 2/18/24 between 4:04 PM and 4:13 PM V20 and V21 CNAs stated they would look at the resident's care plan to determine what pressure relieving interventions are used.

On 2/19/25 at 10:58 AM V6 MDS/Care Plan Coordinator stated if the Braden determines the

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resident to be at risk for pressure ulcers, then there should be a care plan for pressure ulcer risk and pressure relieving interventions. V6 viewed R4's care plan and confirmed there were no documented pressure relieving interventions prior to R4's pressure ulcer. V6 confirmed the turning and repositioning intervention was not added until 2/5/25, after R4's wound had deteriorated to an unstageable pressure ulcer.

On 2/19/25 at 11:17 AM V2 DON stated V2 has not followed up with the RD for R4's wounds after 1/16/25. V2 confirmed 1/16/25 was the only documented RD evaluation for R4. At 1:45 PM V2 stated V2 had no other shower documentation to provide for R4 and confirmed missed showers between 12/31/24 and 1/22/25. V2 confirmed showers would be part of pressure ulcer prevention. At 3:50 PM V2 stated V4 Wound Physician was at the facility on 1/20/25, but we did not have a consent that day for R4 to be evaluated by V4, so R4 was seen by V4 on 1/27/25. V2 stated V2 would expect a wound consult to be ordered when wounds are showing a decline and no improvement.

On 2/19/25 at 11:40 AM V5 Nurse Practitioner stated the facility's RD makes nutritional recommendations and a wound physician for wound evaluation and orders. V5 stated pressure relieving interventions would be individualized and based on the resident's mobility and if they get out of bed. V5 stated R4 should have had turning and repositioning by using wedge/pillows to offload pressure and laid down between meals, and R4's nutrition should have been evaluated prior to R4 developing the pressure ulcer. V5 stated the facility should develop a care plan once a stage one pressure ulcer is identified. V5 stated V5 believes R4's wound deteriorating so quickly

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into a stage three and unstageable pressure ulcer could have been avoidable. V5 stated not maintaining wound dressings can contribute to wound decline.

On 2/19/25 at 12:28 PM V4 Wound Physician stated the facility should follow their protocol when residents are at risk for pressure ulcers, they should develop a care plan and implement pressure relieving interventions. V4 stated it is better to prevent than to treat and pressure relieving interventions should be implemented ahead of time. V4 stated nutrition should be assessed and referred to the dietitian. V4 stated when wounds aren't covered urine and feces can get into the wound which could pose a risk of infection, and the potential of sheering from sheets that could cause a wound to worsen.

On 2/19/25 at 1:09 PM V7 RD stated V7 has been the facility's RD from June 2024 until the first week of February 2025. V7 works remotely and does not round at the facility. V7 stated V7 questioned whether there was a change in wound nurses since V7 used to receive updates from the former wound nurse, but in February V7 had to run a wound report and V7 thought R4's wound had improved. V7 stated V7 would appreciate being updated and notified of changes and declines in wounds. V7 confirmed R4's 1/16/25 nutritional evaluation was the only documented nutritional assessment. V7 stated V7 documents nutritional assessments in a progress note. V7 stated if V7 had been notified of R4's wound decline, V7 would have recommended adding double portions of protein during meals and additional protein snacks/foods since V7 was already on protein supplement, zinc, multivitamin, and health shakes.

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2.) On 2/19/25 at 9:30 AM V23 CNA assisted V3 Assistant DON with R3's pressure ulcer treatment administration. R3 had one open, pink/yellow wound to the left buttock with two small superficial wounds next to it. R3 had a wound on the coccyx that was deep, and the wound bed had pink and yellow tissue.

R3's Wound Summaries dated 2/18/25 document R3's coccyx pressure ulcer and left buttock pressure ulcers were unstageable between 12/18/24 and 2/13/25. These assessments do not match R3's wound assessments completed by V26 and V4 Wound Physicians.

R3's Wound Assessment and Plan dated 12/31/24, recorded by V26, documents R3 had a right buttock unstageable pressure ulcer and R3's coccyx wound was initially a stage two that had declined to a stage three. R3's Wound Assessment and Plan dated 1/6/25, recorded by V4, documents R3 had a left buttock unstageable pressure ulcer and R3's coccyx wound was a stage three.

On 2/19/25 at 9:58 AM V3 stated R3's coccyx wound was staged by prior wound nurse as unstageable on 12/18/24, but that was incorrect as V4 staged the wound as a stage two on 12/19/24. V3 stated the wound declined to a stage three on 12/31/24. V3 stated V3 completed R3's 12/27/24 coccyx wound assessment and it was a stage two at that time, but because it was previously entered as an unstageable the electronic software system would not allow V3 to change the assessment. V3 stated V26 had R3's left buttock pressure ulcer incorrectly documented as the right buttock.

3.) R1's Wound Assessment and Plan dated

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S9999	Continued From page 11 1/6/25 documents an order from V4 wound doctor, to initiate a low air loss mattress on R1's bed. R1's Wound Assessment and Plan dated 1/20/25 documents a preventative wound recommendation for an air mattress. R1's Wound Assessment and Plan dated 1/27/25 documents that an air mattress is recommended for wound prevention. R1's electronic medical record does not include any documentation that the low air mattress was initiated for R1. On 2/18/25 at 11:20 AM, V11, Certified Nursing Assistant (CNA) stated that she cared for R1 on a couple of occasions and doesn't recall if R1 had an air mattress on his bed. On 2/19/25 at 9:19 AM, V12 CNA stated she doesn't remember if there was an air mattress on R1's bed. On 2/19/25 at 2:00 PM, V2 Director of Nursing confirmed there was no documentation that an air mattress was implemented for R1. (B)	S9999		