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S 000	Initial Comments Complaint Investigation: 2512482/IL188657	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3)5) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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accident, injury or change in condition at the time 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:

2) All treatments and procedures shall be administered as ordered by the physician.

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

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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 dressing changes and wound assessments were completed as ordered, failed to ensure a dressing was in place, and failed to identify a wound prior to it becoming an advanced stage for 2 of 3 residents (R1, R5) reviewed for wounds in the sample of 8.

This failure resulted in R1 being sent to a local hospital and admitted to the hospital with a diagnosis of wound infections to his bilateral lower extremities.

The findings include:

1. R1's Admission Record, provided by the facility on 3/25/2025, showed he had diagnoses including, but not limited to, end stage renal disease, stage 5, dependence on renal dialysis, type II diabetes mellitus with diabetic neuropathy (a type of nerve damage that can occur with diabetes causing pain or numbness in the legs or feet), chronic diastolic heart failure, atherosclerotic heart disease, pain in right thigh, pain in right hip, anemia, primary generalized osteoarthritis, chronic peripheral venous insufficiency, lumbago with sciatica (a condition where pain in the lower back radiates down one or both legs), peripheral vascular disease, chronic pain, and muscle spasm of back. R1's facility assessment dated 5/5/2024 showed he is cognitively intact, requires substantial/maximal staff assistance for upper body dressing, and

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partial/moderate staff assistance for lower body dressing.

On 3/24/2025 at 11:47 AM, V9 (Dialysis Center Administrator) said on 3/18/2025 R1 received dialysis at the dialysis center. V9 said she saw R1's wound dressing on 3/18/2025. It was dirty and smelled like rot. V9 said one of the nurses drew a picture on the wound dressing on 3/18/2025 to see if it would be changed when he came to dialysis two days later. V9 said when R1 returned two days later, the same dressing was on him and the drawing was still on the dressing. V9 said R1 told dialysis staff on 3/20/2025 that he asked the nurse to change his dressing, and they either refused or ignored his request.

On 3/25/2025 at 11:25 AM, V9 (Dialysis Center Administrator) said R1 did not show up for dialysis that day (3/25/2025) because the facility sent him to the hospital due to his leg wounds on 3/24/2025. V9 said R1 was admitted to the hospital.

On 3/25/2025 at 11:37 AM, V10 (Assistant Director of Nursing-ADON) said R1 was sent out the previous day (3/24/2025) to a local hospital. V10 said V16 (R1's daughter) had called her the previous Thursday (3/20/2025) about his wounds. V10 said V16 wanted to see wound care for R1. V10 said she told V16 that she had already done the dressing change for R1 that day with a police officer present, and the next time the dressing was scheduled to be changed was on Monday 3/24/2025. V10 said V16 took pictures of R1's wounds and sent the pictures to the Nurse Practitioner (NP-V20) that R1 was seeing from the wound care clinic. V10 said based on the pictures that V16 sent the NP, the NP wanted R1 sent to a local hospital for a vascular workup. V10

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said the local hospital admitted R1 to the hospital. V10 looked at R1's progress notes in his electronic medical record and said the notes showed R1 was admitted to the hospital with a diagnosis of wound infection. V10 was asked to provide surveyor with R1's last three wound assessments. V10 provided the last three assessments to this surveyor. The wound assessments provided to this surveyor were dated 3/24/2025, 3/20/2025, and 1/20/2025. V10 was asked to provide the wound assessment prior to 3/20/2025. V10 looked through R1's electronic medical record and said she did not see any wound assessment for R1's leg wounds that were completed between the 1/20/2025 and the 3/20/2025 wound assessments. V10 said R1 was not followed by the wound doctor in the facility. He wanted his wound doctor at the wound clinic. V10 was asked when was the last time R1 was seen by his wound clinic doctor. V10 said she was not sure and would look into it further. V10 was asked to provide the notes from R1's last visit with the wound clinic doctor/NP (these notes were not provided prior to exiting the facility on 3/26/2025). V10 said the nurses working the floor do the dressing changes and the skin checks. V10 said the skin checks are not full assessments of the wound and do not document the wound measurements or characteristics of the wound. V10 was asked to bring up R1's electronic Treatment Administration Record (TAR) for March 2025 on her computer. V10 said she did the dressing changes to R1's bilateral leg wounds on 3/20/2025 and 3/24/2025. V10 said R1's March 2025 TAR showed the dressing changes were not signed off as being completed on 3/10/2025, 3/14/2025, and 3/17/2025. V10 said the order is to do the dressing changes every Monday and Friday. V10 said, "It is important to make sure that the dressing changes

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and wound assessments are being completed as ordered, because we need to know if the wound is improving, or if there have been any changes, like signs of infection. To see if what we are doing is helping, or if we need to update the doctor and make changes."

On 3/25/2025 at 4:20 PM, V16 (R1's daughter) said she called V10 (ADON) and asked her when she was going to do the dressing changes for R1 next because she would like to be present during the dressing changes. V16 said V10 told her that she had just changed the dressings on 3/20/2025 with V19 (Police Officer from a local police department) present, and the next dressing change would be on Monday 3/24/2025. V16 said she took pictures of R1's leg wounds because she did not like what the wounds looked like. V16 said the wound was open and it looked like raw meat. V16 said she had a cold, so she was not sure if there was any odor from the wound. V16 said she sent the pictures to V20 (Nurse Practitioner from wound clinic) and V20 called her and said this was terrible, she had never seen it that bad. V16 said V20 had been treating R1's wounds for about 15-20 years. V16 said R1 had not been going to see V20 for a while, but he was going to start seeing her again.

On 3/26/2025 at 10:05 AM, V16 (R1's daughter) provided photos of R1's bilateral leg wounds from 1/25/2024 and 3/5/2024 from his Wound Clinic visits with V20 (NP from wound clinic), as well as photos that were taken and sent to V20 (NP) on 3/24/2025 when she observed the dressing change done by V3 (ADON) in the facility. (note: No May 2024 photos were provided which was the last time V20 said R1 was seen at the wound clinic).

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On 3/26/2025 at 12:25 PM, V20 (NP from wound clinic) said she last saw R1 in May of 2024. V20 said the facility R1 was at was providing the wound care for him. V20 said on 3/24/2025 V16 sent her pictures of R1's wounds and she recommended R1 be sent to a local hospital to manage his vascular issues. V20 said based on the pictures V1 sent her, it looked like there were slough issues and blood circulation issues. V20 said based on the appearance of R1's wounds, dressing changes twice a week is not appropriate. V20 also said based on the pictures and V16's description of the wounds, she felt R1 should have been sent out sooner. V20 said it is important to do the dressing changes as ordered, and do wound assessments at least weekly or more often, to monitor the wounds and determine if the wounds are improving or declining, to monitor for signs/symptoms of infection, so a wound specialist or the resident's doctor can be updated to get a new order if needed.

On 3/26/2025 at 1:28 PM, R1 was observed at a local hospital. An IV (intravenous) pole was next to R1's bed with empty antibiotic and antifungal medications listed on the empty bags. R1 said the nurses at the facility were not changing the dressings on his leg wounds. R1 said he had been asking them to change his dressings because his legs were stinging and burning. R1 said the only reason they finally got changed was because they started noticing an odor. R1 said the facility nurses were not assessing his leg wounds either. R1 was not able to identify who all he asked to change his wound dressings.

On 3/26/2025 at 10:33 AM, V19 (Police Officer from a local police department) said she went to the facility on 3/20/2025 and went with V10 to see R1's wound dressings. V19 said when V10

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removed the dressing from R1's leg, there was a bad odor coming from the wound, even with a face mask on. (note: R1's Weekly Wound Assessment dated 3/20/2025 by V3 (ADON) documented no odors were present).

On 3/26/2025 at 1:40 PM, V22 (R1's nurse at the local hospital) said R1 was receiving two IV antibiotics and an oral antifungal medication for bilateral leg wound infections. V22 looked at R1's most recent wound notes in his electronic hospital medical record. The notes showed that the hospital was waiting on the final culture and sensitivity results before decreasing R1's IV antibiotic medications. V22 said she did not think R1 had osteomyelitis. The notes showed Proteus mirabilis and Staph Aureus as the organisms identified in R1's leg wounds.

R1's care plan initiated on 1/5/2025 showed he had right hip pain. R1's Risk of skin impairment care plan, initiated on 1/5/2025, showed he had a risk of skin impairment, had a diagnosis of peripheral vascular disease and had reopened stasis ulcers to his bilateral lower extremities. Interventions listed on the care plan showed to administer the treatment as ordered and monitor for effectiveness. The interventions showed, Document location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements weekly. Evaluate wound for: Size, depth margins, peri-wound skin, sinuses, undermining (a separation of the wound edges from the surrounding healthy tissue creating a pocket under the wound surface), exudates (fluid coming from wound), edema, granulation (new connective tissue that develops at the wound site in the process of healing), infection, necrosis (a pathological process where cells and tissues die prematurely due to injury or

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disease), eschar (dead tissue), and gangrene (dead tissue cause by an infection or lack of blood flow). The interventions also showed to document the progress in wound healing on an ongoing basis. Notify Physician as indicated. Monitor/document/report to doctor for signs and symptoms of infection: green drainage, foul odor, redness and swelling, red lines coming from wound, excessive pain, fever.

R1's 1/9/2025 care plan showed he had skin alteration related to vascular wounds to both lower extremities. Interventions listed were to monitor wounds for signs of infection, weekly wound assessments with wound rounds and wound care as prescribed.

R1's Weekly Skin Checks from 1/24/2025 through the present showed no new changes. The Weekly Skin Checks do not provide measurements, or wound characteristics. R1's Weekly Wound Evaluations from 1/20/2025 through 3/26/2025 were requested. The only Wound Weekly Evaluations-Non-Pressure that were provided were the evaluations from 1/20/2025, 3/20/2025, and 3/24/2025. The 3/20/2025 Wound Weekly Evaluations-Non-Pressure for R1's left lower extremity and right lower extremity both documented no odor was present (even though V19 said it smelled very bad).

R1's March 2025 TAR showed on 3/10/2025, 3/14/2025, and 3/17/2025 the dressing changes were not signed off as being completed. The TAR showed the dressing changes were scheduled to be done every Monday and Friday. The wound orders on the TAR also showed to call physician or go to ER (emergency room) with increased redness, pain, swelling, drainage, warmth, odor,

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or fever.

R1's progress notes from 1/20/2025 through 3/26/2025 were reviewed. The progress notes did not show R1 refusing to allow staff to change the wound dressings or do wound assessments.

The facility's 1/2025 policy and procedure titled Skin Identification, Evaluation, and Monitoring Policy showed "Licensed Nurse Weekly: A. Complete a Weekly Skin Check to evaluate for changes in skin integrity. B. Document in medical record the finding of weekly skin assessment. a. If wounds are present and previously identified: i. Document integumentary findings in weekly skin assessment. ii. Appearance of the wound, including measurements if the wound is due for a treatment change, if not, assess the dressing and document this in the assessment. iii. Complete weekly re-evaluation of previously identified skin alterations/wounds. iv. Treatment applied/initiated per health care provider order in the medical record."

2. R5's face sheet printed on 3/26/25 showed diagnoses including but not limited to pressure-induced deep tissue damage of other site, diabetes mellitus, chronic kidney disease, spinal stenosis of lumbar region, and cervical disc disorder.

On 3/26/25 at 10:10 AM, R5 was lying in bed while V10 (Assistant Director of Nurses) performed wound care. V10 rolled R5 to his side and lifted his shirt. A deep, dime size open wound was observed in the middle of his back. There was no dressing covering the wound. V10 said it is a chronic wound from a surgical procedure. V10 stated she had no idea why the dressing was off and did not receive any reports from floor staff

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that a new one was needed. V10 said the dressing is important to prevent infection and to help the wound heal. V10 removed R5's left sock and a dark purple wound was noted on the second toe. V10 said she was doing a facility wide sweep on wounds and just found it yesterday. V10 said it is a DTI (deep tissue injury). V10 stated skin checks should be done during all CNA daily cares. Floor nurses should be doing weekly skin checks from head to toe. R5's toe wound "absolutely should have been found" prior to becoming an advanced stage. Infection and slow healing is a big problem. V10 said R5 had just been seen by the wound physician for the weekly rounds yesterday and assessed the toe as a DTI and measured it at 0.4 x 0.4 x unknown centimeters.

R5's March 2025 physician order summary report showed an order start dated 3/18/25 for daily wound care to his back including cleansing, calcium alginate, and cover with a dressing.

The most recent wound assessment dated 3/18/25 showed a non-pressure chronic ulcer of the back measuring 1.3 x 0.7 x 0.5 centimeters.

R5's March 2025 physician order summary report showed an order start dated 3/25/25 for pressure injury to left second toe and betadine ointment every evening shift.

R5's most recent wound assessment dated 3/25/25 showed a deep tissue injury to the left second toe.

On 3/26/25 at 1:14 PM, V12 (Wound Physician) stated R5 should always have a dressing on the back wound. Drainage needs to be contained. The wound ointment needs to stay in place.

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S9999	Continued From page 11 Without any dressing the ointment can run down his back and irritate normal skin. V12 stated R5's toe wound is vascular in nature and denied any assessment of a DTI. V12 stated he had no control over how facility staff are charting the stage of wounds or wound care orders. V12 stated he was just notified of the open toe area at his visit yesterday. V12 said early treatment is important to lower the risk of infection and reduce the risk of further complications. The facility was unable to supply any documentation of the 3/25/25 visit by the wound physician during the survey. The facility Skin Identification, Evaluation, and Monitoring Policy dated January 2025 states: "A licensed nurse will evaluate skin integrity through a physical skin evaluation upon admission, weekly, and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse." (A)	S9999		