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	IL6011571	A. BUILDING: _____ B. WING _____	01/16/2025

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ACCOLADE HC OF PAXTON ON PELLS	1001 EAST PELLS STREET PAXTON, IL 60957

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S 000	Initial Comments Annual Licensure and Certification	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 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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S9999	Continued From page 1 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: 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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Section 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. The plan shall be reviewed at least every three months.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to develop and implement pressure relieving interventions, complete pressure ulcer and skin assessments, and notify the physician of new pressure ulcers to obtain treatment orders for one of four residents (R70) reviewed for pressure ulcers in the sample list of 38. These failures resulted in R70 developing two stage two and one stage three pressure ulcers.

Findings include:

On 1/13/25 at 9:15AM, 12:38 PM, 1:46 PM and 2:05 PM R70 was sitting in a wheelchair in R70's room. R70 was in her wheelchair in the assisted dining room from 11:50 AM until 12:23PM. At

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2:08 PM V12 and V13 Certified Nursing Assistants (CNA) entered R70's room with a full mechanical lift and transferred R70 into bed. R70 was wearing pressure relieving boots. V12 and V13 stated R70 was not laid down after breakfast today due to having a shower and being in activities, but R70 is supposed to lay down between meals. V13 stated we try to offload pressure when R70 is in the wheelchair by shifting her weight with a rolled bath blanket that was used today. V12 and V13 stated R70 did not start using pressure relieving boots until after R70's heel wound developed.

On 1/14/25 between 12:10 PM and 12:52 PM V9 Wound Nurse, V18 Wound Nurse Practitioner, and V40 CNA entered R70's room to assess R70's wounds and administer wound treatments. V18 removed an undated dressing from R70's right heel which contained a moderate amount of tan colored drainage. There was a circular open wound to R70's right heel. V18 stated the wound was a stage three pressure ulcer. As V18 cleansed the wound, R70 said "oh" and tried to pull her foot away. This wound measured 1.76 centimeters (cm) long by 2.31 cm wide by 0.2 cm deep. There was a superficial open area to R70's left buttock, which V18 stated was a stage two pressure ulcer. This wound measured 1.66 cm by 2.83 cm by 0.1 cm. V40 and V9 turned R70 in bed and there was an undated dressing that was partially dislodged on R70's right ischium. V40 stated V40 was unsure how long the wound had been there and V9 stated V9 was not aware of the wound. V18 stated the wound was a stage two pressure ulcer and to apply calcium alginate with a bordered dressing. This wound measured 1.66 cm by 2.83 cm by 0.1 cm. V9 cleansed each wound and administered the wound treatments as ordered but did not date any of the wound

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dressings. R70 yelled out "oh, oh, ow" and had facial grimacing as V9 cleansed and dressed R70's right heel wound. V9 and V40 told R70 "I'm sorry" when R70 cried out in pain. V9 stated the nurses are supposed to document weekly skin assessments under the assessments section of the resident's electronic medical record (EMR). V9 confirmed R70's dressings were not labeled with a date. V9 stated staff have been using a pillow to shift R70's weight in the wheelchair, but R70 should be laid down between meals to offload pressure and repositioned from side to side in bed, and R70 can't tolerate being up as much as R70 used to. V9 stated R70 has scheduled Tylenol but was unsure when the last dose was given. V9 confirmed V9 did not coordinate pain medication administration prior to R70's treatments.

On 1/15/25 at 10:30 AM V2 Director of Nursing (DON) entered R70's room to observe R70's buttock wounds. V2 confirmed the left buttock wound observed on 1/14/25 was the left buttock wound that was previously healed as of 1/7/25, and not the gluteal cleft wound.

The facility's Wound Report dated 7/13/24-1/13/25 documents R70 had a stage two pressure ulcer of right buttock on 10/27/24 that healed on 11/12/24, a stage two pressure ulcer of the coccyx on 11/12/24 that healed on 11/22/24, a stage two pressure ulcer to the left buttock on 12/21/24 that healed on 1/7/25 and a stage three pressure ulcer to the right heel as of 1/7/25. R70's Wound Report dated 11/1/24-1/14/25 documents an abrasion/trauma wound of the gluteal cleft as of 1/7/25.

R70's Minimum Data Set (MDS) dated 12/10/24 documents R70 has severe cognitive impairment,

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is dependent on staff assistance for toileting, hygiene, transfers, and bed mobility, and has no pressure ulcers. R70's Braden Assessments dated 10/28/24 and 12/22/24 document R70 is at moderate risk for developing pressure ulcers. R70's current Care Plan documents R70 is at risk for skin impairment and has not been updated to include R70's pressure ulcers or any new pressure relieving interventions since 2022. There are no pressure relieving interventions documented on R70's EMR profile or in the section for CNA charting.

R70's ongoing weight log documents R70's weight (pounds) as follows: 120 on 4/4/24, 107.5 on 8/6/24, 102.5 on 9/4/24, 103 on 10/6/24 (14.17% loss in six months), 97.5 on 11/12/24 (5.34% in one month), 98 on 12/1/24, and 95 on 1/5/25 (15.93% loss in six months).

R70's Skin Assessments dated 12/6/24 and 1/10/25 document no new wounds but does not identify if there were any existing wounds found on the head-to-toe assessment as instructed. R70's Skin Assessment dated 12/22/24 documents R70's stage two pressure ulcer to the left buttock measured 1.0 centimeter (cm) x 0.5 cm x less than 0.1 cm deep. These skin assessments document a turn schedule as the only pressure relieving interventions, the sections for specialized mattress, heels floated, and heel protectors are not marked. There are no other documented skin assessments in R70's EMR between 12/1/24 and 1/14/25.

R70's Nursing Note dated 1/6/2025 at 12:51 PM documents V9 Wound Nurse was notified that R70 had an open area to the right heel that was previously scabbed over, and a treatment order was implemented. R70's Nursing Note dated

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1/10/2025 at 12:52 PM documents an air mattress was applied to R70's bed and R70's wheelchair cushion was changed. There is no documentation that R70's right ischium wound was reported to a physician and treatment orders were implemented prior to 1/14/25.

R70's December 2024 Treatment Administration Record (TAR) documents a treatment order to cleanse left buttock wound, apply skin protectant to the periwound, apply calcium alginate, and cover with a hydrocolloid dressing three times per week initiated on 12/21/24. R70's January 2025 TAR documents R70's left buttock wound treatment was discontinued on 1/7/25 when this wound resolved and there are no treatments for this wound after. There are no documented treatments for R70's right heel wound prior to 1/7/25. These TARs document R70's skin assessments were completed on 12/13/24, 12/20/24, 12/27/24 and 1/3/25, but there are no corresponding skin assessments documented to indicate if R70's skin was intact or impaired.

There are no documented assessments in R70's EMR of R70's left buttock wound until 12/22/24, R70's right heel wound prior to 1/7/25, R70's left buttock wound between 1/8/25 and 1/13/25, or R70's right ischium wound prior to 1/14/25. R70's Multi Wound Chart Details documents on 1/7/25 R70's right heel stage three pressure ulcer measured 1.8 cm by 1.8 cm by 0.3 cm and this wound was debrided (removal of dead tissue), and R70's gluteal cleft wound measured 1.9 cm by 0.2 cm by no measurable depth. This report documents to elevate R70's heels off bed at all times, turn/reposition frequently per facility protocol and avoid direct pressure to wound site.

R70's January 2025 Medication Administration

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Record documents Tylenol Extra Strength Tablet 500 milligrams three times daily as of 8/28/23 and the noon dose was not administered as of 12:46 PM on 1/14/25. There are no other pain medication orders.

On 1/14/25 at 12:53 PM V18 Wound Nurse Practitioner stated R70 should be repositioned side to side in bed every two hours using cushions to relieve pressure and R70 should not be up in the wheelchair for more than two hours. V18 stated V18's office was not aware of R70's right ischium wound prior to today. On 1/14/25 at 1:37 PM V18 stated R70 should have pressure relieving boots or heels floated with a pillow when in bed. V18 confirmed weight loss is a risk factor that can contribute to the development of pressure ulcers and pressure relieving interventions should be implemented to prevent skin breakdown. V18 stated R70's skin is thin and wounds can develop overnight.

On 1/14/25 at 12:57 PM V12 CNA stated R70 has had a dressing to the right buttock for at least three or four days.

On 1/14/25 at 1:00 PM V10 Licensed Practical Nurse stated V10 had not yet given R70's scheduled noon dose of Tylenol today. V10 stated V10 reported R70's right ischium wound to V9 yesterday, but V9 thought V10 was referring to R70's left buttock wound. V10 stated yesterday V10 covered the wound with a dressing but did not do anything else besides notify V9. V10 stated the wound was not there on Friday (1/10/25) when V10 last cared for R70.

On 1/14/25 at 1:28 PM V40 CNA stated pressure relieving interventions are listed as part of the CNA charting or on the resident's dashboard

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profile in the EMR. On 1/14/25 at 1:30 PM V12 CNA stated prior to the pressure relieving boots, V12 used pillows to float R70's heels in bed. V12 stated depending on who works night shift depends on if R70's pressure relieving interventions are implemented as V12 has come on duty and found that R70's heels weren't floated or boots weren't in place.

On 1/14/25 at 1:35 PM V9 stated R70's pressure relieving boots weren't implemented until last week. V9 stated pressure relieving interventions should be listed on the bottom of the skin assessments and was unsure where this information is documented for the CNAs to see.

On 1/14/25 between 4:15PM and 4:28PM V2 DON stated skin assessments should be done weekly and documented in the assessment section of the resident's EMR and confirmed R70's missing skin assessments in December 2024 and January 2025. V2 stated that is something V2 was going to work on, V9 was recently hired within the last two weeks and V2 planned to have V9 follow up on skin assessments to ensure they were being completed and follow up to ensure pressure relieving interventions are implemented. V2 stated pressure relieving boots and an air mattress were initiated last week for R70. V2 stated V2 is working on having the pressure relieving interventions on the resident's profile and on the kardex, which is pulled from the resident's care plan. V2 confirmed R70's profile does not document pressure relieving interventions. V2 stated V2 has been having a hard time keeping up with wounds and updating the care plans. V2 stated V2 was not aware that R70's left buttock wound had reopened and that it had healed on 1/7/25. V2 stated V20 was not

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aware of R70's right ischium wound, and the nurse should have notified V9. V2 confirmed there were no documented assessments for this wound prior to today. V2 confirmed staff should coordinate pain medication prior to wound treatments and stated it is hard since the facility doesn't always know what time V18 will be rounding. On 1/15/25 at 8:50 AM V2 stated wound dressings are not dated, per facility policy, and the TAR is used as the documentation for when dressings are changed. At 12:35 PM V2 confirmed all of R70's December 2024 and January 2025 wound assessments were provided.

On 1/15/25 at 10:50 AM V28 Nurse Practitioner stated V28 was not consulted regarding R70's pain during wound treatments and the nurses should be coordinating pain medication to be given prior to wound treatments.

On 1/15/25 at 11:30 AM V15 MDS Coordinator confirmed R70's care plan had not been updated with R70's pressure ulcers and pressure relieving interventions.

The facility's Wound Treatments policy dated April 2023 documents to implement prevention protocol according to resident needs, turn at least every two hours, reposition in chair, and provide appropriate redistribution and pressure reducing devices.

The facility's Treatment Administration policy dated April 2023 documents treatment orders are documented on the Treatment Administration Record, ensure pain medication is offered and given as needed prior to treatments, and document all significant observations in the resident's electronic medical record.

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S9999	Continued From page 10 The facility's Skin and Wound Management Guidelines dated April 2023 documents to notify the wound care nurse of new alterations in skin, if the wound nurse is not in the facility, then the staff nurse must notify the physician and obtain a treatment order. This guide documents to ensure immediate pressure relieving interventions are implemented. This guide documents the wound care nurse will assess, measure, photograph, and document; and update the resident's plan of care with identified site and new interventions. This guide documents the nurse management or wound care nurse will review shower documentation and weekly skin checks to ensure compliance and identify new wounds at an early stage and will round to ensure residents are positioned correctly and heels are off loaded. (B)	S9999		