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| S 000 | Initial Comments<br><br>Annual Licensure | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>1 of 2<br><br>300.610a)<br>300.1210b)<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.

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 requirements are not met as evidenced by:

Based on Observation, Interview, and Record Review the facility failed to implement preventative measures to reduce the development of and worsening of pressure injuries in 2 of 7(R55, R39) residents in the sample of 31. This failure resulted in R55's skin documented on 1/7/25 as mid buttocks maceration, then developing into a sacrum pressure ulcer stage 3 documented on 1/16/25. R39 also developed several in house pressure inuries.

Findings include:

1. R55's Face sheet documents an admission date of 1/7/2025. Diagnosis include Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Dysphagia, Type 2

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Diabetes, Congestive Heart Failure.

R55's Minimum Data Set, MDS, dated 2/4/2025 documents R55 is moderately cognitively impaired. R55 is dependent for rolling left to right and chair to bed transfers. R55 is at risk for pressure injuries and has unhealed pressure injuries.

R55's care plan updated 3/4/2025 documents Actual Pressure Ulcer; Site(s): unstageable of sacrum. Requires assist with turning and positioning, present on admission. Provide off loading for ulcer site. R55 has an arterial ulcer of the right lateral ankle, arterial of right lateral foot. Heels up device as tolerated in bed.

R55's Admission Nursing Assessment dated 1/7/2025 documents mid buttocks maceration.

R55's Braden Scale for predicting pressure sore risk documents R55 is at moderate risk of developing pressure ulcers.

R55's progress notes dated 1/7/2025 at 6:25PM documents "Skin is unremarkable but there is maceration to buttocks, zinc is ordered for this."

R55's wound notes dated 1/16/2025 documents sacrum pressure ulcer stage 3. Measurements 6.5 cm x 1.5 cm x .10cm.

R55's wound notes dated 1/23/2025 documents Sacrum unstageable pressure wound. Measurements 5.5 cm x 1.2 cm x .20 cm. New in-house facility acquired right lateral ankle wound. Measurements 2cm x 1.5cm x .10cm.

R55's wound notes dated 2/13/2025 documents Sacrum pressure wound stage 3. Measurements

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2 cm x .8 cm x .2 cm. Right lateral ankle arterial ulcer full thickness 2.5 cm x 2.5 cm x .10cm. New facility acquired right lateral foot. Measurements .70 cm x .50cm.

R55's wound notes dated 3/20/2025 documents sacrum pressure wound stage 3. Measurements 1.5 cm x .7 cm x .7 cm. Right lateral foot new facility acquired. Measurements 1.5cm x 1cm x .10cm. Right lateral ankle arterial ulcer full thickness 3.5 cm x 3.3 cm x .3cm.

R55's Skin and Wound note dated 2/27/2025 documents stage 3 pressure injury to the sacrum and an arterial wound to his right lateral ankle and right lateral foot. Patient was placed on PO Augmentin by PCP for his right lateral ankle, he had a wound culture after he finished this antibiotic, and it was positive for MRSA. He was placed on doxycycline and finished this antibiotic 1-2 days ago per wound nurse. Preventative Measures: R55 has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Float heels while in bed with use of heel boots.

On 3/27/2025 at 10:45AM R55 lying flat in bed. No heel protectors on in bed. Heels to the mattress.

On 3/27/2025 at 12:15PM R55 up in geriatric chair sitting straight up with feet directly on bottom of chair. Heels not floated.

On 3/27/2025 at 3:15PM R55 remains up in geriatric chair with feet to bottom of chair. Heels not floated.

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| S9999 | Continued From page 4<br><br>On 3/27/2025 at 10:30AM V3, Wound Nurse, stated when R55 came to us the Nurse Practitioner called the redness to his sacrum maceration. The wound kind of deteriorated into a stage 3.<br><br>R39's Face sheet documents an admission date of 12/21/2024. Diagnosis includes Encephalopathy, Sepsis, Acute Cystitis, Paroxysmal Atrial Fib, Chronic Kidney Disease, Hyperlipidemia.<br><br>2. R39's MDS dated 2/28/2025 documents R39 is severely cognitively impaired and is dependent for bed mobility and transfers. R39 is at risk for pressure ulcers and has unhealed pressure ulcers.<br><br>R39's care plan dated 2/24/2025 documents Actual Pressure Ulcer; Site(s): unstageable sacrum unstageable Left heel stage 3. Requires assist with turning and repositioning. Interventions include Encourage to Float heels.<br><br>R39's Braden scale for pressure ulcer development dated 11/26/2024 documents R39 is at risk for pressure ulcer development.<br><br>R39's Admission Assessment dated 11/26/2024 documents wound to left buttock.<br><br>R39's Skin/Wound visit dated 1/16/2025 at 2:57 PM documents Wound # 1 left heel Pressure ulcer. The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. | S9999 | | |

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| S9999 | Continued From page 5<br><br>R39's wound notes dated 1/16/2025 documents new facility acquired wound to left heel. Measurements 3.5cm x 2cm.<br><br>R39's wound notes dated l/23/2025 document left heel. Measurements 2.5cm x 2.5cm.<br><br>R39's wound notes dated 1/30/2025 document left heel. Measurements 3.5cm x 3.0cm.<br><br>R39's wound notes dated 2/6/2025 document left heel. Measurements 2.5cm x 3.0cm.<br><br>R39's wound notes dated 2/20/2025 document sacrum new facility acquired. Measurements 6.5 cm x 7cm x .10 cm. Left heel 1.5cm x .75cm.<br><br>R39's wound notes dated 2/27/2025 document sacrum 7cm x 4.5cm. Left heel 1.5cm x .5cm.<br><br>R39's wound notes dated 3/20/2025 documents sacrum 5.5cm x 4.5cm.<br><br>R39's order sheet dated 3/17/2025 documents Heel protectors as tolerated two times a day.<br><br>On 3/26/2025 at 10:00AM R39 lying in bed with no float heels on. Heels on mattress.<br><br>On 3/27/2025 at 12:55PM V8, CNA, stated R39 is able to roll on side by himself.<br><br>On 3/27/2025 at 1:00PM V8, CNA, and V20, CNA, provided incontinent care to R39. R39 unable to roll self from left to right or right to left without max assist. Float heels not on. Heels on mattress.<br><br>On 3/27/2025 at 3:00PM V2, Director of Nursing, | S9999 | | |

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| S9999 | Continued From page 6<br><br>DON, stated her expectation is for residents to be turned and repositioned every 2 hours and heels floated as the resident will tolerate.<br><br>Facility policy with a revision date of 10/16/2023 states "Prevention program including Turning and Positioning, will be utilized for all residents who have been identified of being at risk for developing pressure ulcers. The facility will initiate an aggressive treatment program for those residents who have pressure ulcers. A pressure ulcer is defined as any lesion caused by unrelieved pressure those results in damage to underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed.<br><br>(B)<br><br>2 of 2<br><br>300.610a)<br>300.1210b)<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 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. | S9999 | | |

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| S9999 | Continued From page 7<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 resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br><br>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.<br><br>These requirements are not meet as evidenced by:<br><br>Based on interview, observation, and record review the facility failed to provide progressive interventions and to prevent multiple falls for 1 of 5 (R47) residents investigated for accidents in a sample of 31. The failure resulted in R47 sustaining a right hip fracture and then sustaining a right hip surgical incision dehiscence requiring a return to the hospital for sutures and antibiotics.<br><br>Findings include: | S9999 | | |

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R47's EMR (Electronic Medical Record) undated documents that the resident was readmitted to the facility after right hip surgery on 12/04/24.

R47's EMR dated 4/25/24 documents a diagnosis of unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified osteoarthritis, unspecified site; and age-related osteoporosis without current pathological fracture.

R47's MDS (Minimum Data Set) dated 3/11/25 documents a BIMS (Brief Interview for Mental Status) score of 4 out of 15. The MDS documents that the resident requires substantial/maximal assistance for roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer.

R47's Care Plan dated 7/25/24 documents "(R47) is at potential risk for falls and injuries r/t (related to) use of hypoglycemic medications and diagnosis of Type II DM (Diabetes Mellitus), PVD (Peripheral Vascular Disease), Dementia, Chronic Ischemic Heart Disease, and HTN (Hypertension)."

R47's Health Status note dated 10/09/24 at 6:58 PM documents "Resident had a witnessed noninjury fall at approx. 0830- did not hit head. Vitals 110/62, 69 pulse, 16 resp, 97.4T 96% RA (room air). Resident had c/o (complaint of) of dizziness and pain to LUQ (left upper quadrant) prior to fall. (V17), Medical Director's office notified and POA (Power of Attorney) aware. NNOR (no new order) at this time."

No intervention noted for fall on 10/09/24.

R47's Health Status Note dated 10/10/24 at 4:08

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PM documents "Writer called to resident's room by CNA (Certified Nursing Assistant) staff. Resident was observed laying on the floor on the right side of the bed near the door. Floor was dry and free of debris. Resident's legs extended outward. CNA at bedside sitting on floor with resident. CNA (V8) stated "I seen (sic) her just roll out of the bed and on to the floor. She didn't hit her head. I just couldn't get to her quick enough to stop her from rolling out of the bed." Resident assessed by writer and assisted to standing position without difficulty. Nursing staff assisted resident back into bed per her request and call light placed in reach. Resident bed was placed in the lowest position and turned towards the wall."

Intervention for fall on 10/10/24 is bed to be against the wall.

R47's Health Status note dated 10/17/24 at 2:11 AM documents "This writer was sitting at the nurse's station when a hospice CNA stated that someone had fell on the floor. Upon entering room resident was noted to be on right side with left hand on the floor in front of her. The second drawer to her nightstand was open. On the floor by her head was a yellow bead. Resident had proper fitting shoes on bilateral feet. Resident was assisted up to her bed. Resident has complaints of her left wrist hurting. Resident stated her bracelet had broken, she was trying to find a string, and that she slipped on the bead. This writer cleaned the floor of all objects and took all beads out of room. POA, DON (Director of Nursing), and (V17) notified. New orders received for x-ray to left wrist."

No intervention noted for fall on 10/17/24.

R47's Health Status Note dated 10/26/24 at 3:55

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PM documents "Resident inside therapy room and fell, complaints of pain to right hip. Called (V18) NP (Nurse Practitioner) to report fall. Pain level keeps increasing, NP states to send to ER (Emergency Room) for eval. 911 called for non-emergency transfer to (local hospital), (V19) POA called to report fall and orders from NP. No rotation or shortening noted, resident is able to put weight on Right hip but has pain with pressure. EMT (Emergency Medical Technician) arrived x 2 to transport, report called into (local hospital) ER, will update with results."

R47's Health Status Note dated 10/29/24 at 11:33 PM documents "Called (local hospital) and spoke with (hospital staff) RN, transferring resident to Metropolitan hospital) for fractured right hip.

Resident did not have an intervention for the fall prior to this fall with an injury.

Intervention for fall on 10/26/24 is for PT/OT (Physical Therapy/Occupational Therapy) to eval and treat, as needed.

R47's Health Status Note dated 11/20/24 at 5:26 PM documents "Resident fell at approx. 1645, unwitnessed. Surgical wound to R hip dehiscence. Resident found laying (sic) on her left hip in the doorway/hallway with pants to knees. Puddle of blood next to bed. Staff applied pressure to site. 911 called, paperwork gathered. Returned with ABD (Abdominal) pads. Ambulance arrived-- applied pressure dressing. Transferred to stretcher without complications. V17(Medical Director), DON and POA notified."

R47's Health Status Note dated 11/20/24 at 10:40 PM documents "(V18), NP for (R47), notified of resident's return and of sutures and of ABT

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(antibiotic) order."

No intervention noted for fall on 11/20/24.

R47's Health Status Note dated 11/30/24 at 8:35 PM documents "called to resident's room. noted this resident sitting in doorway of room to hallway only wearing shirt. sitting on buttocks with knees bent. noted urine beside bed. alarm on bed on but not sounding. PROM (Passive Range of Motion) is wnl (within normal limits) for this resident. surgical site to right hip is intact. neuro checks started and are wnl. assist of 2 to get in chair. resident cleaned and put to bed per CNA. VS (vital signs) 97.8, 73, 18, 84/53. sp02 (oxygen saturation) 91% r/a.

No intervention noted for fall on 11/30/24.

R47's Health Status note dated 1/10/25 at 4:25 PM documents "resident had unwitnessed fall, resulting in a lump to the right side of the back of her head, range of motion completed, vitals WNL, resident responds appropriately per her baseline. MD (Medical Director) made aware, calls POA, no VM (voice mail) set up. poc (plan of care) ongoing."

Intervention for fall of 1/10/25 is pressure pad alarm placed.

R47's Health Status Note dated 2/18/25 at 11:15 PM documents "called to resident's room for resident sitting on floor at FOB (foot of bed) on buttocks pulling on catheter. ROM and PROM without resistance or c/o pain/discomfort. neuro checks initiated and are wnl. assist of 2 to get back in bed. Noted large purple bruise to right hip area, resident able to move hip joint without c/o or resistance. MD notified. son(V19), notified."

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| (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 |
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| S9999 | Continued From page 12 | S9999 | | |

No intervention noted for fall on 2/18/25.

R47's Health Status Note dated 2/24/25 at 7:40 PM documents "called to oakwood hall for resident on floor. noted resident sitting on floor on buttocks in oakwood DR (dining room) with back against corner. resident unable to say what she was doing d/t (due to) usual confusion. c/o some pain to right leg with PROM but no resistance noted. assist to w/c (wheelchair) with 2 assists. neuro checks initiated and are wnl. VS 98.4, 91, 20, 94/57. sp02 96% r/a."

Intervention for fall on 2/24/25 is anti-roll backs applied to w/c.

R47's Health Status Note dated 3/12/25 at 8:00 PM documents "Resident observed sitting on legs on floor in front of w/c. Barefoot (Removed socks per self). No c/o pain. Able to move extremities without difficulty. No noted injuries. Resident does not remember what was doing. VS: 124/71 97.7 69 20. SPO2 96% RA. Assisted to w/c. Alarm turned on and placed in w/c. Neuro-checks attempted. Resident refuses to participate. Closes eyes. Resident remains in area with staff."

Intervention for fall on 3/12/25 is dycem (anti slip cushion) to w/c, gripper socks as tolerated.

On 3/27/25 at 10:59 AM, V4, RN (Registered Nurse) stated that today is her second day working at this facility. She stated that she would add interventions to a resident's care plan after a resident has fallen.

On 3/27/25 at 11:01 AM, V8, CNA stated that (R47) has a pressure alarm on her bed and wheelchair. She stated that R47 likes to stay

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6000723 | A. BUILDING: _____ B. WING _____ | 03/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 13<br>busy, so they keep her busy to keep from falling.<br><br>On 3/27/25 at 11:02 AM, V9, LPN (Licensed Practical Nurse) stated that today is her second day working at the facility. She stated that she thinks that it's the MDS person's job to add interventions to the care plans.<br><br>On 3/27/25 at 11:03 AM, V5, LPN stated that it is the MDS, DON, and V3 the QA (Quality Assurance) nurse's job to add interventions to the care plans.<br><br>On 3/27/25 at 2:19 PM, V21, MDS Coordinator/LPN stated that she just started as the MDS coordinator in December. She stated that it is her job to add interventions to the care plans after a resident falls. She stated that when she took over the MDS, it was a mess and care plans were not up to date.<br><br>Facility's policy "Accidents & Incidents" dated 7/01/23 documents "All accidents/incidents involving a resident will be documented in Risk Management. The nursing team will complete an investigation with the root cause and new interventions."<br><br>Facility's policy "Fall Prevention Program/Protocol" dated 7/01/23 documents "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."<br><br>(A) | S9999 | | |