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S 000	Initial Comments Complaint Investigation 2573215/IL190115	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)2) 300.1210 d)3) 300.1210 d)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 300.1210 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	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:
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 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 complete a wound or skin event in risk management when a skin abnormality was found on a resident, failed to seek medical attention for a resident who developed rash-like skin redness, failed to monitor the skin rash/redness for improvement or worsening, failed to implement wound nurse

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practitioner's recommendations to keep the area clean and dry, and failed to implement wound nurse practitioner's recommendations for treatment of the rash.

These failures resulted in R1 developing a rash/reddened area under her breasts that went without assessment or treatment, experiencing a rash/redness on her groin and buttocks that did not improve, and R1 expressing she experienced extreme pain and discomfort for many months due to the rash/redness.

This applies to 1 of 3 residents (R1) reviewed for skin rashes in the sample of 3.

The findings include:

On April 16, 2025 at 9:18 AM, R1 was lying in bed. R1 had a tracheostomy in place and was unable to speak out loud, but was able to mouth intelligible words and make hand gestures. R1 said she was experiencing pain, and pointed to her perineal area and buttocks when asked where her pain was located. R1 was wearing an incontinence brief. The brief was closed at each side of R1's hip with the adhesive closures from the incontinence brief. R1 had an indwelling urinary catheter in place draining cloudy, yellow urine.

On April 16, 2025 at 10:38 AM, R1 continued to be lying in bed. V10 (Mother of R1) was sitting at R1's bedside. V4 (CNA-Certified Nursing Assistant) and V5 (CNA) came to R1's room to provide incontinence care. V5 said she arrived at the facility at 6:00 AM and was assigned to care for R1. V5 continued to say she had not had time to check R1's incontinence brief or provide incontinence care since she started her shift over

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four hours earlier. V5 said R1 was wearing the incontinence brief from a previous shift. V4 and V5 unfastened R1's incontinence brief. V4 and V5 said they had not been instructed to leave R1's incontinence brief open. As V5 pulled back R1's incontinence brief, the brief had a strong odor and appeared wet, despite R1 having an indwelling urinary catheter. V5 said the catheter "must have leaked." R1's front perineal area had a rash over R1's entire pubic area, along both groin areas, and extending to her inner left and right thigh, approximately six inches in diameter. The rash appeared as solid, bright red areas. As R1 was turned to her right side, R1's buttocks were exposed. The red rash encompassed R1's entire buttocks, approximately 12 inches in diameter and extended up her back, approximately six inches, on R1's right side. The rash on R1's buttocks was bright red and appeared as one solid red area. As the rash extended up R1's back, the rash appeared to be a spottier, red pattern. R1 flinched when V5 tried to use a disposable wipe to clean R1's buttocks. V4 and V5 said they did not have barrier cream to apply to R1's buttocks or groin area because they were not allowed to keep the cream in the resident's rooms, and they would have to ask V7 (LPN-Licensed Practical Nurse) to obtain the cream. V4 and V5 applied a clean incontinence brief to R1 and did not apply barrier cream and prepared to leave the room. V5 (CNA) said she has been assigned to care for R1 many times, and the rash on R1's perineal area and buttocks had been present since at least February 2025. V4 and V5 lifted R1's gown. R1 was not wearing a bra. V5 lifted R1's right and left breast. R1's skin appeared bright red under R1's right and left breasts, approximately one to two inches wide, and approximately 4 inches long. A white, pilled substance was under each breast and V5

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speculated it was "old powder." V5 used a disposable wipe to clean the white substance from under R1's breasts, and R1 flinched when V5 cleaned the area and indicated the area was painful by mouthing the words "that hurts." As V4 and V5 were ready to leave R1's room, V7 (LPN) entered the room with a small medication cup filled with a white cream and a wood tongue depressor. V7 said the white cream was zinc oxide. V4 and V5 opened R1's incontinence brief and again turned her to her right side. V7 (LPN) used her gloved hand to smear the zinc oxide on R1's buttocks. V7 did not cover the rash on R1's upper back with the zinc oxide. R1 was turned to her back by V4 and V5. With approximately one teaspoon of zinc oxide left in the medicine cup, V7 (LPN) used the wood tongue depressor to smear the remaining zinc oxide to R1's front perineal area in a swiping motion. The remaining zinc oxide ointment did not cover all red areas of R1's front perineal area, or R1's inner thighs. V7 (LPN) said she would have to return with more zinc oxide ointment to cover the reddened areas.

On April 16, 2025 at 11:11 AM, V10 (Mother of R1) remained at R1's bedside, and said V7 (LPN) had not returned to R1's room to apply zinc oxide ointment to R1's front perineal area. V7 also said no other facility staff had come to the room to apply the ointment.

On April 16, 2025 at 11:45 AM, V10 (Mother of R1) remained at R1's bedside, and said V7 (LPN) had not returned to R1's room to apply zinc oxide ointment to R1's front perineal area. V7 also said no other facility staff had come to the room to apply the ointment.

On April 16, 2025 at 11:50 AM, V7 (LPN) came to R1's room and applied zinc oxide ointment to

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R1's front perineal area, and said she was unable to do it sooner due to caring for other residents. V7 did not assess the skin under R1's breasts or apply the zinc oxide ointment. As V7 was ready to leave R1's room, V7 was asked what the treatment would be for R1's skin redness under her bilateral breasts, and V7 turned around and applied the remaining zinc oxide ointment to the area under R1's bilateral breasts.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on August 16, 2024 with multiple diagnoses including metabolic encephalopathy, pneumonia, UTI (Urinary Tract Infection), acute and chronic respiratory failure, COPD (Chronic Obstructive Pulmonary Disease), acute pulmonary edema, myotonic muscular dystrophy, ascites, dependence on ventilator, gastrostomy tube, tracheostomy, and intestinal obstruction.

R1's MDS (Minimum Data Set), dated February 6, 2025, shows R1 is cognitively intact, requires partial/moderate assistance with oral hygiene, substantial/maximal assistance with bed mobility, and dependent on facility staff for all other ADLs (Activities of Daily Living). R1 has an indwelling urinary catheter and is always incontinent of stool. The MDS continues to show R1 receives 51 percent or more of her total calories from tube feeding. R1 had no unhealed pressure ulcers, rashes or MASD (Moisture-Associated Skin Damage) at the time of this MDS assessment.

R1's care plan for potential/actual impairment to skin integrity, created on January 31, 2025, shows multiple interventions initiated on January 31, 2025 including, keep skin clean and dry. Identify/document potential causative factors and eliminate/resolve where possible.

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S9999	Continued From page 6 On January 31, 2025 at 6:46 AM, V6 (LPN) documented, "[R1] buttock dry, redness, and flaky to touch ...." V6's (LPN) Admission/Readmission Evaluation, dated January 31, 2025, shows R1 was readmitted to the facility with groin redness, redness on her inner thighs, and perineal area. The evaluation also shows R1 was high risk for skin breakdown. The EMR shows the following order, dated January 31, 2025: Zinc oxide external ointment 20 percent to groin, peri, and buttock topically every 12 hours for redness. The facility's Skin Monitoring/CNA Shower and Grooming sheets show the following for R1: January 21, 2025: Redness on R1's bilateral groin areas and redness on R1's buttocks. March 18, 2025: Redness under R1's right breast, and redness in R1's perineal area. April 1, 2025: Redness under R1's right and left breasts, and redness in R1's perineal area. The facility does not have documentation to show R1's physician was notified about the redness/rash on R1's skin, or that the redness/rash was assessed by nursing staff between January 31, 2025 and April 9, 2025. The facility does not have documentation to show the nurse assessed the reddened areas or completed a wound or skin event within risk management. The facility does not have documentation to show the wound care nurse checked risk management and proceeded with an assessment or investigation.	S9999		

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On January 7, 2025, V9 (Wound Care NP-Nurse Practitioner) documented, "Wound #2 groin is a partial thickness moisture associated skin damage and has received a status of not healed. Initial wound encounter measurements are 20 cm. (centimeters) length by 15 cm. width x 0.1 cm. depth, with an area of 300 square cm, and a volume of 30 cubic cm. There is a scant amount of serous drainage noted which has a mild odor. The patient reports a wound pain of level 3/10 (0/10 equals no pain, 10/10 most pain). The wound margin is undefined. Active problems, irritant contact dermatitis due to friction or contact with body fluids, erythema intertrigo (inflammatory skin condition caused by skin-to-skin friction). Wound orders groin: cleanse wound with wound cleanser, topical treatment: apply house stock antifungal cream twice a day. Follow-up: re-evaluation in 1 week. Incontinence/moisture management: barrier cream/ointment 3 x (times) per day and after incontinent episodes, recommend antifungal, keep area clean and dry, reduce briefs whenever possible."

The facility does not have documentation to show R1 received the antifungal cream or barrier cream as ordered by V9 (Wound Care NP) on January 7, 2025. The facility does not have documentation to show R1 was re-evaluated in one week. The facility does not have documentation to show measurements were obtained after January 7, 2025 to determine if the rash area was improving or deteriorating.

On April 9, 2025, V9 (Wound Care NP-Nurse Practitioner) documented, "Patient being evaluated for skin assessment due to at risk conditions/Braden score for skin breakdown of 12." V9's documentation continues to show R1 had irritant contact dermatitis due to friction or

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contact with body fluids, and erythema intertrigo. V9's documentation continues to show, "Incontinence/Moisture Management: Barrier cream/ointment 3 x (times) per day and after incontinent episodes, maintain prompt cleansing and moisture management to support skin health, use breathable alternatives to briefs when appropriate to promote skin integrity."

The facility does not have documentation to show R1 received the barrier cream as ordered by V9 (Wound Care NP) on April 9, 2025.

On April 16, 2025 at 1:16 PM, V9 (Wound Care Nurse Practitioner/NP) said he assessed R1 on April 9, 2025. V9 said the skin redness on R1's buttocks is due to MASD (Moisture Associated Skin Damage), and if there is moisture involved, R1 may also have a fungal rash. "I was asked to see the resident because the rash was not improving and was getting worse. This skin condition can be handled by the nurses, and they can call me anytime, if the need arises. Last week when I saw her, she had dermatitis and the area had not spread up her back. I told them to apply barrier cream three times a day and after every incontinent episode. I was not notified by the facility before today that the rash looked worse. If they left her in feces or urine overnight or for a long period of time, it could go from zero to 100. It needs to be addressed immediately and appropriately."

On April 17, 2025 at 11:11 AM, V9 (Wound Care NP) said, "I saw [R1] on January 7, 2025. She had MASD in the groin area. We recommended house stock antifungal to the bilateral groin area twice a day and barrier cream three times a day. We did not specify a stop date. They should have put the antifungal cream and barrier cream

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order in place when I saw her on January 7, 2025. It is my expectation that they institute my recommendations. The skin issue will deteriorate if they do not do it. If it is a recommendation and it was never done, then I would say that is why the rash got worse."

On April 17, 2025 at 2:55 PM, V11 (Physician) said, "Based on (V9's, Wound Care NP) documentation dated April 9, 2025, there has been an acute change in (R1's) skin since last week, possibly caused by the antibiotic medication (R1) was taking." V11 said it would be his expectation that facility staff follow provider recommendations for wound care, and they should follow the facility's policy for nursing assessment of abnormal skin conditions and completing wound or skin events in risk management.

The facility's policy entitled Wound Prevention Program, dated March 2025, shows, "Purpose: The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as non-pressure related wounds. Process: 1. Upon admission and in conjunction with the Resident Assessment Instrument, and when a significant change in the resident status occurs, the resident's skin will be evaluated head-to-toe by licensed nurse. 2. Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's EMR. 3. Daily, during routine care, the CNA will observe the resident's skin. When abnormalities are noted, this will be communicated to the licensed nurse and the licensed nurse will proceed as mentioned in step 2 and complete a wound or skin event within risk management. The wound care nurse will check

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S9999	Continued From page 10 risk management daily for any new wound/skin event and proceed with an assessment/investigation." The facility's policy entitled Wound Prevention and Healing, reviewed 06/01/2024, shows, "Policy Statement: To provide wound care treatments/services using a multidisciplinary approach based on evidence-based standards of care under the direction of a physician. 1. Risk Assessment and Prevention: a. Braden Scale will be completed upon admission, readmission, quarterly, and when there is a change in condition by a licensed or registered professional nurse. ...c. Skin will be inspected during showers, following orders for daily and/or weekly skin checks as scheduled, and PRN (as needed)." (B)	S9999		