| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation 2563717/IL191493 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1210 b)<br>300.1210 d)2)<br>300.1210 d)5)<br>300.1220 b)3)<br><br>Section 300.610 Resident Care Policies<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>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. | S9999 | | |

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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.

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.

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 requirements are not met as evidenced by:

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Based on observation, interview, and record review, the facility failed to identify one (R4) resident's Sacral Deep Tissue Injury, failed to obtain and provide treatment orders, failed to update careplan timely, and failed to implement pressure reducing interventions out of three residents reviewed for pressure ulcers in a sample list of eight residents. As a result of these failures, R4 had pain from her Stage 3 Sacral pressure ulcer which was acquired and worsened under the care of the facility.

Findings include:

R4's undated Face Sheet documents R4 admitted to the facility on 3/29/25. This same face sheet documents R4 has medical diagnoses of Pressure Ulcers, Paraplegia, Urinary Tract Infection (UTI), and Osteomyelitis.

R4's Electronic Medical Record (EMR) documents R4 admitted to the facility with a Stage Four Pressure Ulcer to her Right Ischium and Stage Four Pressure Ulcer to her Left Knee.

R4's Minimum Data Set (MDS), dated 4/4/25, documents R4 as cognitively intact. This same MDS documents R4 is dependent on staff for bed mobility, toileting, dressing, and requires maximum assistance with bathing and personal hygiene.

R4's Physician Order Sheet (POS), dated May 2025, documents a physician order starting 4/11/25 and ending 5/7/25 to cleanse R4's Sacrum Pressure Ulcer, apply Calcium Alginate and cover with bordered foam daily. R4's POS does not include any orders for the treatment of R4's Sacral Stage Four Pressure Ulcer prior to

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4/11/25.

R4's Careplan, initiated 4/11/25, does not document R4's Stage Four Sacral Pressure Ulcer.

R4's Pressure Ulcer Risk Assessment, completed 4/21/25, documents R4 as being high risk for obtaining a pressure ulcer.

R4's initial facility Wound Summary report, dated 4/7/25, documents R4's Sacral Stage Two Pressure Ulcer as facility acquired, with dated identified as 4/7/25 measuring 5.0 centimeters (cm) long by 3.0 cm wide by undetermined depth.

R4's Initial Wound Evaluation and Management Summary dated:

-4/9/25 documents R4's Sacral Pressure Ulcer as an Unstageable pressure ulcer measuring 12.0 centimeters (cm) long by 6.0 cm wide with undetermined depth. This same summary documents R4 should have her Left Lateral Stage Four pressure ulcer off-loaded with two pillows above the wound. This same summary documents a physician order starting 4/9/25 for 30 days to apply Calcium Alginate and foam daily to R4's Sacral pressure ulcer.

-4/17/25 documents R4's Sacral pressure ulcer as an open Unstageable pressure ulcer due to necrosis, full thickness wound with moderate serous drainage.

-4/23/25 documents R4's Sacral pressure ulcer as a Stage Four with 80% thick adherent devitalized necrotic tissue measuring 9.0 cm long by 6.0 cm wide by undetermined depth. This same summary documents R4's Stage Four

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Pressure Ulcer is not at goal.

-4/30/25 documents R4's Sacral pressure ulcer as a Stage Four with 80% thick adherent devitalized necrotic tissue measuring 9.0 cm long by 6.0 cm wide by 1.5 cm deep. This same summary documents R4's Stage Four Pressure Ulcer is not at goal.

-5/5/25 documents R4's Sacral pressure ulcer as a Stage Four with 85% muscle, fascia and subcutaneous tissue measuring 9.0 cm long by 6.0 cm wide by 1.5 cm deep. This same summary documents R4's Stage Four Pressure Ulcer is not at goal.

On 5/7/25 at 11:30 AM-2:00 PM, R4 was laying on her back in her bed, with no pillows/blankets used for off loading pressure areas.

On 5/8/25 at 11:40 AM, V4, Licensed Practical Nurse (LPN)/Wound Nurse, completed wound care for R4's Left Knee Stage Four Pressure Ulcer. After V4 completed R4's Left Knee dressing change, R4 declined to have her Sacral pressure ulcer dressing changed, due to R4 having pain in her Sacral area. R4 was laying on her back in her bed with no pillow/blankets for support. There were two extra pillows sitting in the chair in the corner. V4 stated R4 should have the pillows placed under her back and knee to off -load the pressure to her current pressure areas. R4 was grimacing with her dressing change to her Left Knee. R4 stated after the dressing change, she is a Paraplegic and has little feeling in her legs. R4 stated, "I can feel my butt though. And it hurts a lot most of the time, especially when they (staff) change that dressing."

On 5/7/25 at 11:35 AM, V6, Agency Licensed

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Practical Nurse (LPN), stated residents are having to wait to be turned and positioned for more than the two hours, due staff being busy. V6, LPN, stated R4 requires the staff assistance for turning and positioning.

On 5/8/25 at 12:00 PM, V4, LPN/Wound Nurse, stated R4 should be propped on pillows to help alleviate pressure. V4, LPN, stated R4's Left Knee Stage Four Pressure Ulcer showed slough, Fascia, Tendon, and bone, with yellow serous drainage. V4, LPN/wound nurse, stated she did have to soak off the previous dressing because it had adhered to the wound due to the excess drainage. V4 stated R4's Stage Four Sacral Pressure Ulcer started at the facility. V4, LPN, stated she was made aware on 4/7/25, but forgot to obtain and implement the dressing orders. V4, LPN, stated V23, Wound Physician, saw R4's Sacral Stage Four Pressure Ulcer on 4/9/25, and documented it as an Unstageable pressure ulcer. V4, LPN, stated V23, Wound Physician, ordered Calcium Alginate with an absorbent pad and wrapped in gauze on 4/9/22, but those orders were not entered into the EMR until 4/11/25. V4, LPN/Wound Nurse, stated R4's Sacral wound deteriorated in that time, because no one was treating it, due to there were no updates to the careplan and no physician orders were entered. V4, LPN/Wound Nurse, stated the floor nurses were dressing R4's Right Ischium Stage Four Pressure Ulcer twice daily prior to 4/7/25, and should have known to tell V4, LPN/Wound Nurse, about R4's Sacral area. V4, LPN/Wound Nurse, stated the floor nurses failed to communicate to V4 that R4 had a new Sacral wound until 4/7/25. V4 stated the facility is unable to provide any documentation that R4's Sacral pressure ulcer was provided any kind of treatment prior to 4/11/25.

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| S9999 | Continued From page 6<br><br>The facility policy titled Pressure Ulcer Prevention, effective April 2025, documents dependent residents should be turned approximately every two hours or as needed. Position dependent residents with pillow or pads protecting bony prominences as needed. Use positioning devices or pillows, rolled blankets etc. to reduce pressure and/or friction/shearing as indicated.<br><br>(B) | S9999 | | |