S9999 Final Observations

Statement of Licensure Violations:
2 of 2 Violations

300.610a)  
300.1010(g)(4)  
300.1210b)  
300.1210(d)(2)(3)  
300.3240a)  

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

g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following:
Continued From page 1

4) Orders from the physician regarding weighing of the resident, and the frequency of such weighing, if ordered.

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. Restorative measures shall include, at a minimum, the following procedures:

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.
Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based upon observations, interviews, and record review the facility failed to ensure that 3 meals were provided daily, failed to monitor weights, failed to follow dietary recommendations and failed to administer vitamins/supplements as ordered for one of four residents (R2) reviewed for change in condition. These failures resulted in R2’s significant weight loss of 12.32% (within 6 weeks), cachexia (muscle wasting), and failure to thrive.

Findings include;

R2 was admitted to the facility (5/26/20) with diagnoses which include but not limited to; end stage renal disease and dependence on renal dialysis.

R2’s weights (documented under vital signs) are as follows; (7/3/20) 118.8 lbs. This weight is noted to be documented 5.5 weeks after R2 was admitted. There are no additional weights.

On 8/3/20 at 3:55pm, surveyor inquired about the facility policy for monitoring weights. V4 (Nurse
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Consultant) stated "For new admissions we get the weight the same day they are admitted, weekly weights for 4 weeks, and then monthly." Surveyor inquired about R2's weights, V4 affirmed that he attempted to get additional weights from the dialysis center however was unable to obtain them.

Dietary Assessments for R2 include the following information; (5/28/20) per hospital, dry weight was 135.5 lbs. (pounds). Recommend discontinuing multivitamin and adding renal vitamin daily, Prostat AWC 30ml (milliliters) BID (twice daily) x 6 weeks for healing open areas. Talked with renal dietician, she told writer that resident is not getting breakfast before she leaves for dialysis. Recommend; house supplement 1.7 (4 ounces) TID (three times daily), and increasing vitamin D3 to 2,000 units daily. Per renal dietician, resident's dry weight is 124.3 lbs [8.27% loss within 2.5 weeks]. (7/9/20) Weight 118.8 pounds. BMI (Body Mass Index) 19.77. Recommend; Prostat AWC 30ml BID, house supplement 1.7 (4 ounces) TID due to low BMI/weight. [12.32% within 6 weeks].

On 8/4/20 at 1:39pm, surveyor inquired about R2, V10 (Registered Dietician) stated "They never got a weight on this person and I'm not sure why. The most recent weight we have on her is on 7/3/20, that's it. They should have weighed her from the get go. She's kinda thin, she's at the lower end of the BMI scale. I talked with the renal dietician and she told me she wasn't getting breakfast before she left for dialysis. She needs additional protein because she was on dialysis. I recommended Prostat and they didn't add it so I recommended it again."

R2's (June 2020) MAR (Medication)
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Administration Record) affirms Prostat, renal vitamin and house supplement were not prescribed and vitamin D3 dose was not increased as recommended. Vitamin D3 (1,000 unit) was not documented as administered on 6/5, 6/28, and 6/30.

R2's (July 2020) MAR affirms renal vitamin was prescribed daily on 7/13/20 however not documented as administered on 7/14, 7/16, 7/20, and 7/21. House supplement was prescribed TID on 7/13/20 however not documented as administered on 7/14 (all 3 entries), 7/16 (all 3 entries), 7/20 (all 3 entries), and 7/21 (1 entry). Nepro Carb Steady (Nutritional Supplement) was ordered T D on 7/20/20 however on 7/20, 7/21, and 7/22 all 3 entries are blank. Vitamin D3 (1,000 unit) was not documented as administered on 7/7, 7/10, 7/14, 7/16, and 7/20.

On 8/4/20 at 12:44pm, V11 (Nurse Practitioner) stated "For dietary recommendations they normally give me the forms to approve. It could be me or the PCP (Primary Care Physician) but I normally sign those. I don't recall if they gave one to me for (R2). We did some labs on her and I suggested putting her on supplementation Nepro." Surveyor inquired about potential harm to R2 if dietary recommendations are not followed and/or supplements are not administered as ordered V11 responded "I would imagine malnutrition or failure to thrive.

R2's (7/23/20) hospital history & physical states; presenting with failure to thrive, cachectic appearing. Diagnosis: Failure to thrive in adult.

The Nutirton/Unplanned Weight Loss Protocol (revised August 2008) states; monitor and document the weight and nutritional status of...
Continued From page 5

residents in a format which permits readily available month-to-month comparisons. The Physician and staff will monitor the nutritional status, response to interventions and possible complications of such interventions of individuals with impaired nutritional status. The Physician will document relevant medical observations and conclusions regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations where multiple active causes may coexist.

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<td>3) Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly known as bed sores), with grade, size and location specified, and orders for treatment, if present. (A photograph of incipient or manifest decubitus ulcers is recommended on admission.)</td>
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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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based upon record review and interview the facility failed to document daily and/or weekly wound assessments as ordered, failed to obtain treatment orders for all wounds, failed to clarify treatment orders (re: affected area), failed to prescribe antibiotic medication for infected wounds, and failed to administer treatments as ordered for one of four residents (R2) reviewed.
Continued From page 8

for pressure ulcer. These failures resulted in R2 requiring surgical debridement of devitalized and necrotic tissue on the sacrum and foot. R2 subsequently developed sepsis, dry gangrene of the left foot, and tunneling sacral wound.

Findings include;

Progress notes affirm that R2 was admitted to the facility on 5/26/20 with an "open area to left heel with discoloration and open area to sacrum" however stage, size, exudate and/or description of the wound beds were not documented.

On 7/30/20 at 1:51 pm, surveyor inquired about R2's wounds V5 (Wound Care Nurse) stated "I admitted her to the facility. She had a necrotic foot and an open area on her sacrum. At that time I was not the wound care nurse I called the doctor and verified the meds. He said continue the hospital orders." Surveyor inquired if R2's hospital orders included treatments, V5 responded "No, but the wound care nurse is supposed to follow-up within 24 hours and implement treatments."

R2's POS (Physician Order Sheets) include the following; (5/27/20) Skin assessment daily. Skin assessments weekly. Venelex ointment to affected area once daily.

R2's (May 2020) TAR (Treatment Administration Record) affirms Venelex and weekly skin assessments from 5/27 through 5/31 were not documented. [Daily skin assessments are not inclusive].

R2's (June 2020) TAR affirms Venelex was not documented on 6/3, 6/5, 6/11, 6/19, 6/25, 6/26, 6/27, and 6/30. [Daily skin assessments are not
On 7/30/20 at 2:31 pm, surveyor inquired about concerns regarding R2's (5/27/20) Venelex order V4 (Nurse Consultant) responded "The order says apply to their affected area but the location is not exact." Surveyor inquired what the blank spaces indicate on R2's (May/June 2020) TAR for daily Venelex and weekly skin assessments V4 stated "Possibly it wasn't done."

R2's (6/17/20) progress notes state in part; assessed patient and found open wound with red wound base on Right buttock, Stage II wound noted to site (1.5 x 1.0). Medical Doctor notified, new treatment order entered into EMAR (Electronic Medication Administration Record).

R2's (July 2020) MAR and TAR affirm that there were no (right buttock) treatment orders entered on or about 6/17/20.

On 8/3/20 at approximately 11:00 am, V4 stated "Generally if there's a wound they'll call the Physician to get orders and have the Wound Care Physician see the patient."

R2 was not assessed by the wound care physician until one month after the (6/17/20) stage II (right buttock) wound was identified.
R2's (7/17/20) initial (Physician) wound evaluation includes 3 wounds;
1) Sacrum: unstageable wound 2 x 2cm (sentimeters) x not measurable. Thick adherent devitalized necrotic tissue 100%. Moderate purulent exudate, odor. Etiology: pressure. Surgical excisional debridement performed. Treatment plan: dakins solution (1/4 strength) apply once daily for 30 days. Cover with gauze.
2) Right Foot: arterial wound 10 x 10cm x not measurable. Thick adherent necrotic tissue
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| S9999 | Continued From page 10 | 100%. Treatment plan: betadine apply once daily for 30 days.  
3) Right heel arterial wound 4 x 4 x 0.5cm. Moderate purulent exudate. Thick adherent devitalized necrotic tissue 50%. Surgical excisional debridement performed. Treatment Plan: dakins solution (1/4 strength) apply once daily for 30 days. Cover with gauze. Recommend Augmentin (Antibiotic) 875/125 BID (twice daily) x 10 days.  
R2’s (July 2020) POS affirms the following orders were entered on (7/20/20) Left foot: cleanse with NS (Normal Saline), apply betadine gauze, cover with dry dressing every other day and PRN (as needed). Sacrum: cleanse with NS, skin prep peri wound, apply Dakin's soaked gauze, cover with dry dressing daily and PRN (as needed). [Augmentin, right foot and/or right heel treatment orders are not inclusive].  
On 7/30/20 at 2:35pm, surveyor inquired about treatment orders for R2's right foot and right heel as recommended on 7/17/20 by the Wound Care Physician V4 reviewed her (July 2020) TAR and stated “All they have is the left foot.” R2’s (July 2020) treatment administration documentation was requested V4 stated "We do not have wound care documentation for July.”  
R2’s (July 2020) TAR affirms daily skin assessments, left foot treatments and sacrum treatments are not documented (all entries are blank).  
R2’s (7/22/20) weekly skin assessment includes only the sacrum. The following was documented; Sacrum: moderate drainage (25-75% of dressing). Exudate: purulent. Indicate what referrals may be appropriate: no referrals necessary. | S9999 | | | |
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On 8/3/20 at 9:58am, surveyor inquired about R2's (7/22/20) wound assessment documented by V6 (Licensed Practical Nurse). V8 stated "The wound nurse enters the wound assessments but I was designated that day to do it. When I assessed the wound there was dark, it was pink, and there was no drainage." Surveyor inquired if R2 had any other wounds V6 replied "I think it was one on her foot."

On 8/3/20 at 11:29am, surveyor requested R2's weekly wound assessments from 5/26/20 through 7/22/20. V4 presented only one assessment (dated 7/22/20) and stated "There was a process but it was not in place so we don't have them."

On 8/3/20 at 3:53pm, surveyor relayed concerns regarding care and services provided to R2 wounds V4 (Nurse Consultant) stated "For change in condition we notify the physician to obtain orders and notify the appropriate members like wound care."

R2's medical records affirm she incurred significant weight loss of 12.32% (within 6 weeks) while residing at the facility.

On 8/4/20 at 12:44pm, surveyor inquired if V11 (Nurse Practitioner) was aware that R2 had wounds V11 responded "I was not." Surveyor inquired about the potential harm to R2 if she had wounds and significant weight loss V11 stated "It depends on how vigilant they are with the wound care but it would be slow wound healing I would imagine."

On 8/5/20 at 2:02pm, V12 (Medical Director) stated "They have to notify the attending physician or nurse practitioner for change in
Continued From page 12

condition. When they don't find them they call me and I give orders what to do." For wound care recommendations they send them (in writing) to the attending physician to approve or disapprove. When the wound is purulent you're supposed to get an order to culture it and treat it." Surveyor inquired about potential harm to R2 if antibiotic and/or treatment orders were not received and/or carried out V12 responded "The wound just continues to deteriorate." Surveyor inquired if he was aware of R2's significant weight loss, declining wounds and/or Augmentin recommendations for an infected wound V12 responded "The attending is in charge of the patient. The DON (Director of Nursing) did not tell me about this patient, I did not get any calls."

R2's 7/23/20 hospital history and physical states; presenting with failure to thrive, left foot with dry gangrene, and tunneling sacral wound.

Presentation of sepsis. Initial labs notable for leukocytosis (increased white blood cells) 23.1.

Given the extent of the gangrene, non-salvageable left foot.

The (January 2017) prevention of pressure wounds policy states; routinely assess and document the condition of resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.