Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005490	A. BUILDING: _____ B. WING _____	C 02/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT LINCOLN	2202 NORTH KICKAPOO STREET LINCOLN, IL 62656

(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
S 000	Initial Comments Complaint Investigation #1920903/IL 109333	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.1210b) 300.1210d)5) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. (Section 2-107 of the Act) These requirements were not met evidenced by: Based on interview and record review the facility failed to develop a program for offloading while in the wheelchair, and implement a turning and repositioning program for one of three residents (R1) reviewed for pressure ulcers in a sample of three. These failures resulted in R1, a resident with new onset of paralysis, developing an unstageable pressure ulcer to the sacrum which required debridement and hospitalization.	S9999		

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Findings include:

A Skin Assessment Policy and Procedure dated 5/2017 states, "Intact healthy skin is the body's first line of defense. It is the policy of this facility to monitor skin integrity for signs of injury and irritation. In addition to ongoing assessment of the skin, the facility will implement measures to protect the resident's skin integrity and to prevent skin breakdown.

A Pressure Ulcer Prevention Protocol dated 5/2018 states, "Interventions necessary to maintain skin integrity or to promote healing will be incorporated into the plan of care based on each resident's individual needs and risks, which may include: A. Daily skin checks conducted either by the CNA or Licensed Nurse to ensure identification of potential problem areas. B. Plan of Care to address mobility status and ability to reposition self." This same protocol documents, "The resident's care plan will indicate the resident's risk factor(s) and include individualized interventions as needed for a comprehensive pressure ulcer prevention program."

R1's list of current diagnoses includes Pervasive Developmental Disorder, Stable burst fracture of T11-T12, and Paraplegia."

R1's Minimum Data Set (MDS) assessment dated 1/23/19 documents R1 is totally dependent on staff for bed mobility, transfers, and locomotion on and off the unit. This same MDS documents R1 had functional limitation in range of motion to both upper and lower extremities. This MDS further documents that R1 was at risk of developing pressure ulcers and at the time of the assessment had a stage one pressure ulcer

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with intact skin but with non-blanchable redness of a localized area. R1's MDS also documents that R1 was on a turning and repositioning program.

R1's new admission Skin Integrity Observation sheet dated 1/17/19 documents R1 had "redness to the buttocks with barrier cream ordered."

R1's physician's orders (POS) dated 1/16/19 documents that R1 was to have new admission skin checks once daily starting 1/16/19 but those orders were discontinued on 1/21/19. This same POS does not include an order for any type of cream, or wound treatment until 1/27/19.

R1's care plan dated 1/21/19 states that R1 is at risk for developing pressure ulcers related to paraplegia. This same care plan instructs staff to, "Turn and reposition as resident (Resident) tolerates." R1's care plan does not address R1's lack of mobility related to R1's paralysis, and does not include a program to turn and reposition R1 every two hours, or a plan to off load R1 while R1 is up in the wheelchair.

R1's Braden Scale assessment for pressure ulcer risk dated 1/17/19 documents that is able to R1 respond to verbal commands but can't always communicate discomfort or need to be turned or has some sensory impairment that limits R1's ability to feel pain or discomfort in one or two extremities. This same assessment documents R1 is chair fast with R1's ability to walk severely limited or nonexistent, is able to make occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently, and requires moderate to maximum assist in moving as well as frequent repositioning with maximum assist. R1's Braden

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Scale score indicates R1 is at moderate risk for the development of a pressure ulcer, however, this same Braden Scale assessment further instructs that if other major risk factors are present to consider the resident as the next higher risk category.

R1's CNA (Certified Nurse Aide) Monitoring Form dated 1/24/19 documents R1 had redness to the buttocks and sacral area.

R1's Tissue Tolerance Assessment dated 1/25/19 documents that R1 had redness to the buttocks on that date and required an every two hour repositioning schedule.

R1's New Site Wound documentation dated 1/27/19 documents that a 5cm (centimeters) long x 3.5cm wide wound was found on R1's buttocks which had a black-brown wound bed.

R1's Initial Wound Evaluation & (and) Management Summary dated 1/30/19 and signed by V5 (wound Physician) documents R1 developed an unstageable pressure ulcer due to necrosis to the sacrum, a boney area in the center of the back just above the buttocks which measured 5cm long x 3.5cm wide with a depth not measurable. This Summary further document that R1's wound bed was 100% (percent) devitalized necrotic tissue which required surgical excisional debridement of the wound. This same summary documents that after the debridement R1's wound was considered a stage three pressure ulcer for R1's MDS assessment.

On 2/11/19 at 11:23a.m. and 2:15p.m. and on 2/13/19 at 1:30p.m. V3 (Wound Nurse) stated that staff reported that R1 developed an

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unstagable pressure ulcer to the sacrum on 1/30/19. V3 stated that V3 documented the assessment on R1's new admission Skin Integrity Observation sheet dated 1/17/19, R1's Braden Scale assessment for pressure ulcer risk dated 1/17/19 and R1's Tissue Tolerance Assessment dated 1/25/19. V3 also stated that V3 also serves as the facility's Care Plan Coordinator and developed R1's care plan for pressure ulcer prevention. V3 verified that R1 had a reddened area to the buttocks at the time of admission and a non-blanchable area which was documented as a stage one pressure ulcer during the seven day look back period of the MDS assessment dated 1/23/19. V3 stated that she did not document any additional assessments of R1's reddened area or non-blanchable stage one pressure ulcer to the sacrum following her initial assessments. V3 stated that R1 was not on a scheduled every two hours turn and reposition program stating, " I don't like to put a specific schedule on the care plan for turning because the resident may not follow that schedule and so I care planned to turn him as he tolerates." V3 stated that there was no specific plan to off load R1 while he was in the wheelchair but instead he was to be off loaded "as tolerated."

On 2/11/19 at 3:58p.m. V6 (Registered Nurse) stated that on 1/27/19 V6 was R1's nurse until 6:00a.m. that morning at which time V7 (Licensed Practical Nurse) took over as R1's day shift nurse. V6 stated that on the morning of 1/27/19 she was just about to leave the facility at approximately 6:30a.m. to 6:45a.m. when a CNA (Certified Nurse Aide) approached her stating that R1 had a new wound to the sacral area. V6 stated that she decided to look at R1's wound then reported what she observed to V7. V6 stated R1's wound was a large blackened area on

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the sacrum with a stripe-like pattern down each side of the wound. V6 stated that when she cared for R1, "He was cooperative with care and didn't like to lie down and he would negotiate to stay up longer. We knew he would be on the call light if he layed down because he liked a lot of attention." V6 stated that every time V6 was R1's nurse, R1 would lie down and turn to his side when asked.

On 2/13/19 at 3:20p.m. V1 (Administrator) stated that V1 did an investigation into why R1 developed an unstageable pressure ulcer on 1/27/19. V1 stated that staff reported R1 spent a great deal of his time in the wheelchair. V1 stated that whenever staff asked R1 to lay down R1 would cry so staff would leave R1 in his wheelchair.

On 2/13/19 at 10:30a.m. V2 (Director of Nurses) verified that R1's Braden Scale Assessment dated 1/17/19 documents that if a resident has other major risk factors then that resident should be moved up to the next level of risk. V2 stated that R1 did not fall into the category of having additional risk factors that would increase his risk of developing a pressure ulcer, despite being paraplegic and totally dependent on staff for turning and repositioning. V2 stated that R1's paraplegia, and dependence on staff for positioning was built into the Braden score which showed R1 was only at a moderate risk for developing pressure ulcers. V2 stated that even though R1 had a stage one pressure ulcer documented on his MDS on 1/23/19 and redness to the buttock at the time of admission on 1/16/19, R1 still would not have been at a higher risk to develop an open pressure ulcer. V2 also stated that R1 was not nutritionally compromised at 225 lbs (pounds) and 74 inches tall. V1 also

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stated she thought that R1's pressure ulcer was unavoidable because he was a paraplegic and had Autism. V2 stated that the facility does not have a policy for how often to offload a resident who spends a lot of time in the wheelchair.

On 2/11/19 at 2:55p.m. V5 (Wound Physician) stated that he considered R1 a moderately high risk for the development of a pressure ulcer. V5 stated he examined and treated R1 for an unstageable pressure ulcer to the sacrum on 1/30/19. V5 stated that R1's sacral wound was very large and required debridement. V5 stated that if V5 had been able to completely debride R1's wound it would have been considered, "At least a stage three if not a stage four pressure ulcer." V5 stated that R1's wound was the result of unrelieved pressure of at least two to four hours of duration. V5 stated that the only way R1's pressure ulcer would have been unavoidable was if the facility had put every possible preventive measure in place and R1 developed a pressure ulcer despite those preventive measures.

R1's emergency physician progress notes dated 2/4/19 documents that when R1 was admitted to the emergency room from the facility on that date with a fever of 101.8F (Degrees Fahrenheit). This progress note further states, "Patient does have foul-smelling stage IV (four) sacral decubitus (pressure) ulcer present." which required antibiotic treatment.

(B)