STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014658	A. BUILDING: _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE REHAB & HEALTHCARE	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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 Survey #2017300/IL126814 #2017393/IL126908	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)2) 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: 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. Based on interview and record review, the facility failed to provide wound care to 2 of 3 residents (R3 and R5) reviewed for pressure wounds in the sample of 3. This failure resulted in wound deterioration, pain, and extensive wound debridement. The findings include:	S9999		

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S9999	Continued From page 2 On 9/15/2020 at 11:30 AM, V3, Wound Care Registered Nurse (RN) said she rounded with V18, Wound Care Physician, each Wednesday. V3 said dressing changes were being missed and the wounds deteriorated. V3 said she saw dressings that were not being changed every day as indicated by the date on the dressing. V3 said R5 and R3, specifically, did not get their wound dressings changed every day, as ordered. V3 said they just have not been consistent with the wound care. On 9/16/2020 at 11:04 AM, V18 said he was in the facility on 9/2/2020 to complete his wound rounds. V18 said R3's dressing was dated 8/26/20 and it was gray and soppy. V18 said the wound was macerated [Macerated skin looks lighter in color and wrinkly. It may feel soft, wet, or soggy to the touch. Skin maceration is often associated with improper wound care. (From Healthline.com)], and had increased in size. V18 said during his wound rounds on 9/9/2020, R5's wound dressing was dated 9/2/2020. The appearance of R5's wound was not largely increased, but R5 had increased pain. V18 said R3 and R5 both had daily dressing changes ordered and in each of those 1 week intervals between his wound rounds, approximately 21 shifts went by and no wound care was done. V18 said the lack of wound care resulted in deterioration to the wounds and made extensive debridement (Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Debridement methods may include a range of treatments such as the use of enzymatic dressings to surgical debridement in order to remove tissue or matter from a wound to promote healing) of R3 and R5's wounds necessary.	S9999		

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On 9/15/2020 at 1:28 PM, V1, Administrator, said V18 came to her with concerns regarding R5 last week because her dressing was not changed. V1 said V18 told her it was neglect and he was reporting it. V1 said she cannot explain why the wound care is not getting done.

On 9/15/2020 at 9:52 AM, V12, Director of Regulatory Compliance, said he was notified by regional that the wounds at the facility were "problematic." The wound care charting was all done on paper and it was hard to tell what was going on with the wounds. V12 said the goal for the Wound Care Program is to have the wound care nurse manage the wound care which means she would make sure dressings are being changed, complete weekly skin assessments, and do rounds with the wound care physician.

The Initial Wound Evaluation & Management Summary dated 8/26/20 shows R3 had an unstageable [due to necrosis (the death of most or all of the cells in an organ or tissue due to disease, injury, or failure of the blood supply)] wound of her right heel. The treatment plan included daily dressing changes with topical medication application. The goal for this wound is healing as evidenced by a decrease in the ...and/or percentage of necrotic tissue ... The percent of necrotic tissue was 100% with serous exudate (Serous drainage or exudate" is watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage).
The Wound Evaluation & Management Summary dated 9/2/20 shows "there was a tattered and soiled dressing in place which was clearly dated 8/26 (7 days prior) and the order is for daily dressing changes." The percent of necrotic tissue

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S9999	Continued From page 4 was 100% with purulent exudate (Purulent exudate is any product of inflammation that contains pus, Exudate is any fluid that has been forced out of the tissue or its capillaries because of inflammation or injury). R3's current Care Plan shows "Wound care as ordered by physician" as one of the interventions related to the pressure ulcer of her right heel. R3's Physician Order Sheet (POS) shows an order dated 8/26/20 as follows: Unstageable (due to necrosis) of the right heel- clean with normal saline, pat dry, apply Santyl (a debriding medication) and Mupirosin (an antibiotic for the skin) to affected area daily with foam border for 30 days. At 10:47 AM on 9/16/2020, V3 verified the order dated 8/26/20 for R3 was the current order for R3's dressing changes. The Wound Evaluation & Management Summary dated 9/2/2020 shows R5 has a stage 3 pressure wound of the right, lateral foot which measured Length (L) 0.3 cm (centimeters) x Width (W) 0.3 cm x Depth (D) Not measurable cm with moderate serous exudate and Wound Progress was Improved. The dressing treatment plan was Alginate calcium apply once daily for 9 days and a foam silicone border and faced secondary dressing apply once daily for 9 days. The Wound Evaluation & Management Summary dated 9/9/2020 shows R5's stage 3 pressure wound of the right, lateral foot increased to L 0.4 cm x W 0.4 cm x not measurable cm. Additional wound detail shows the following: On exam, there was a soiled dressing in place that was clearly dated 9/2 (one week prior) and the orders are clearly for daily dressing changes. Wound is larger and with some foul odor and patient complaining of increased pain at the wound site. Wound Progress: Deteriorated. R5's current Care Plan shows "Wound care as	S9999		

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S9999	Continued From page 5 ordered by physician" as one of the interventions related to her pressure ulcer. R5's POS shows an order dated 8/12/20 as follows: Stage 3 pressure injury to the right lateral foot- clean with normal saline, pat dry, apply Alginate Calcium with foam border dressing daily and as needed. At 10:47 AM on 9/16/2020, V3 verified that the order dated 8/12/20 was the current order for R5's dressing changes. The facility's Standards and Guidelines Wound Care revised 11/1/2016 says wound care procedures and treatments should be performed according to physician orders. (B) 2 of 2 300.690b) 300.1210b) 300.1210d)6) 300.3240a) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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	S9999		

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S9999	Continued From page 6 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview and record review, the facility failed to ensure the safety of a resident during care. This failure resulted in R1 sustaining a traumatic open distal fracture on R1's left leg. This applies to 1 of 3 resident reviewed for safety in the sample of 3. The findings include: R1's facility assessment dated 9/2020 shows R1 has diagnoses of Alzheimer's and Dementia. R1's facility assessment dated 7/1/2020 shows R1 is moderately cognitively impaired and R1 is total care on bed mobility, transfers, toileting and feeding. A progress notes by V8 (License Practical	S9999		

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Nurse-LPN) dated 9/13/2020 timed at 4:30 PM, shows, "This writer called to room by CNA, this writer observed large lump approximately sized of a silver dollar to left outer knee. No redness no bruising no discoloration, denies pain. Resident moving left extremity. NP notified and stated to monitor site and NP will see her in the facility tomorrow. 4:50 PM,-This writer rechecked resident's knee, left knee purple in color, called (NP) and x-ray orders were received. Then the CNA came and told me the left knee is bleeding. 5:15 PM, notified NP that red blood moderate in amount coming from the left knee received order to resident to ER."

The local hospital emergency room document dated 9/13/2020 shows "89 year old female with baseline dementia. Presents from the nursing home with open femur fracture. The injury happened this afternoon when it was noted that her left knee was swollen ....Around dinner it was noted that there was bleeding and exposed bone was noted. "

The emergency room radiology report of R1's left leg dated 9/14/2020 shows, "Comminuted and displaced fracture of the distal femur"

On September 15, 2020 at 8:45 AM, R1 was in bed being fed breakfast. R1's left leg was propped with a pillow. R1's left leg was wrapped with an ace wrap from the upper thigh to the foot. An additional dressing with ace wrap was wrapped around R1's left knee. A visible splint was noted at R1's left foot. R1's bed had side rails on both sides on the middle part of the bed. There were floor mats around R1's bed. V6 (Certified Nursing Assistant-CNA) said she was told that R1 fractured her left leg and that R1 will be staying in bed today. At 10 AM, R1 was in

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bed facing her window. R1 was awake and alert. When R1 was asked what happened to her left leg, R1 responded, "I wish she knew. " R1 said she does not have any pain at this time.

On 9/15/2020 at 2:00 PM, V8 (LPN) said she was the nurse working on 9/13/2020 on PM shift. V8 said V7 (R1'S CNA) reported to her that something was wrong with R1's left leg. V8 said she went to R1's room and assessed R1's left leg. V8 said R1's left outer knee had a raised lump but no discoloration and R1 was moving her left knee without any pain. V8 said she told V7 that R1 needs to get up for supper. V8 said she helped V7 transfer R1 with the mechanical lift. V8 said while R1 was in the dining room, R1's left leg started bleeding. V8 said she called the Nurse Practitioner. R1 was sent to the ER. V8 said the hospital informed her R1 had a fracture in her left leg. V8 said she did not know what happened to R1's left leg. V8 said she was also the nurse yesterday (9/12/2020) and she did not notice anything wrong with R1's left leg.

On 9/15/2020 at 11:23 AM, V7 (Certified Nursing Assistant-CNA) said she was R1's CNA last Saturday 9/13/2020 when the incident happened. V7 said she worked a double shift, from 6am to 8pm that day. V7 said during the morning shift, she got R1 up using a mechanical lift with V9's assistance. V7 said after breakfast, R1 was put to bed with V9 for toileting. She got R1 back up using a mechanical lift with the help of V9 for lunch. V7 said she went to her lunch after all the resident were done with lunch around 1 PM. V7 said when she got back from her lunch break, R1 was already in bed. V7 said she did not know who put R1 back to bed. V7 said at 4:00 PM, she went to ready R1 for evening meal. V7 said she noticed R1's left leg was a little bit swollen. V7

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S9999	Continued From page 9 said she went and got the nurse. V7 said the nurse said to get R1 up for supper. V7 said V8 (LPN) helped her get up R1 using the mechanical lift. V7 said she then wheeled R1 to the dining room for supper. V7 said later during dinner, it was noticed that R1's left leg was bruised and bleeding. V7 said V8 called the doctor and R1 was sent to the hospital. V7 said she ended her shift at 8: 00 PM. V7 said the next day she heard R1 had fractured her left leg. V7 said she had no idea what happened to R1. V7 said R1 was fine until later that afternoon before dinner time and she reported what she noticed to her nurse. V7 said R1 did not fall or bumped her knee while R1 was under her care. V7 said she was suspended per V1 (administrator). On 9/16/2020 at 9:20 AM, V9 (CNA) said she worked this past weekend Saturday and Sunday. V9 said last Sunday (9/13/2020) before 6:30 AM, she was walking in the 100 hallway and noticed that R1 was sitting at the edge of her bed. V9 said she entered R1's room and told V7 (CNA) that R1 was a mechanical lift transfer. V9 said she then went to get the mechanical lift and assisted V7 to transfer R1 to her wheelchair. V9 said once R1 was in her wheelchair, she left R1's room. V9 said after breakfast, she saw R1 in the common area, with no leg rest and no footboard. V9 said R1's leg needed to be supported and she thought V7 knew that. V9 said she went to get R1's leg rests and footboard and applied them to R1. V9 said after lunch, she assisted V7 to put R1 back to bed using the mechanical lift. V9 said both times that she helped V7 transfer R1, V9 did not see R1's lower legs. R1 was wearing pants. V9 said R1 was not showing any kind of pain or discomfort during the time she assisted V7 to transfer R1. V9 said she assisted V7 twice during the morning shift on 9/13/2020, before	S9999		

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breakfast to get up R1 and after lunch, to put R1 back to bed. V9 said she did not assist V7 after breakfast to put R1 to bed. When the surveyor clarified with V9 what V7 said, that V9 assisted V7 between breakfast and lunch for R1 to be changed, V9 said no, she did not help V7. When the surveyor informed V9 that V7 said she did not know who put R1 back to bed. V9 said she assisted V7 after lunch between 1:30 and 2 PM to put R1 back to bed. V9 said she also worked last Saturday (9/12/2020) and R1's CNA was V20. V9 said last Saturday, she assisted V20 with the mechanical lift- getting R1 up, putting back R1 to bed after breakfast to be changed, then assisted again to get up R1 for lunch then after lunch when R1 needed to go back to bed. V9 again reiterated that last Sunday, V9 only assisted V7 twice with R1, before breakfast and after lunch.

On 9/16/2020 at 9:40 AM, V21 said she was the nurse on 9/13/2020 from 6AM to 2:30 PM. V21 said she has 2 CNAs working with her in the 100 wing, V7 and V9. V21 said R1 is total care in everything, getting up, transfers, toileting and feeding. V21 said the staff use the mechanical lift when they transfer R1. V21 said she did not notice any abnormality with R1's lower legs. V21 said R1's left leg tends to go towards the right leg. V21 said the staff is careful when putting the mechanical pad in between her legs and her legs need to be supported with leg rest and foot board for safety and support. V21 said R1 needs to be up for meals. V21 said R1 is incontinent of bladder and bowel and needs to be toileted in between meals. V21 said R1 needs to be in bed to be changed. V21 said none of the staff asked her help to transfer any resident this past weekend. V21 said she was also the nurse last Saturday (9/12/2020) and she did not notice anything wrong on R1. V21 said at the end of her

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shift for both Saturday and Sunday, she made her rounds and both days, R1 was in bed sound asleep.

On 9/16/2020 at 10:20 AM, this surveyor spoke to V7 again to clarify her statement with regards to R1. This surveyor informed V7 that V9 said she did not assist her after breakfast when R1 was put to bed to be changed. V7 insisted that V9 assisted her using the mechanical lift to put R1 to bed after breakfast. When this surveyor also informed V7 that V9 said they both put R1 to bed after lunch. V7 said she did not put R1 back to bed after lunch, someone else did.

On 9/16/2020 at 9:30 AM, V20 (CNA) said he was R1's CNA day shift last Saturday 9/12/2020. V20 said he did not notice anything wrong with R1. V20 said V9 was the other CNA on 100 wing. V20 said V9 assisted him when he got R1 up for meals and when R1 needed to be changed in bed. V20 said R1 is total care on everything. V20 said R1 did not fall and did not bump any part of R1's body. V20 said if he noticed anything wrong with any resident he would report to the nurse immediately.

On 9/16/2020 at 7:30 AM, V22 (CNA) said she was R1's regular CNA on PM's and night shift. V22 said last Saturday (9/12/2020) she worked a double shift PM's and night shift. V22 said she did not get R1 up last Saturday on the evening shift because they were short and she knew R1 was 2 assist using the mechanical lift. V22 said she kept R1 in bed, fed her in bed and kept R1 clean and dry. V22 said she did not notice anything wrong with regards to R1's leg. On night shift, V22 said R1 slept well. V22 said she again worked PM and night shift the next day (Sunday) but she did not have R1. V22 said she

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CARRIAGE REHAB & HEALTHCARE	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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
S9999	Continued From page 12 was told that V7 was working a double shift and already had R1 this morning and V7 would like to keep her assignment. V22 said during dinner time, she was the one that noticed a puddle of blood beneath R1's wheelchair. V22 said she reported this to V8 (LPN) who was already on the phone talking to the nurse practitioner. V22 said she is upset this happened to R1 as she was R1's regular CNA and she knows how to take care of R1. V22 said she saw R1's left knee and it was bruised "like a strong force went against her knee". On 9/16/2020 at 11:45 AM, V1 (Administrator) stated "I know something happened to (R1's) leg but staff is not telling me what really happened." V1 said there were no cameras in the facility that would have helped in the investigation. On 9/15/2020 at 1: 15 PM, V17 (Orthopedic Surgeon) stated "This kind of fractures is NOT related to spontaneous fracture, it is not a stress fracture or a pathological fracture. This lady's fracture (R1) is related to trauma from a fall, or a forceful trauma to her left knee. Something happened to this lady that had caused this kind of break in her bone. After the bone was fractured, the shaft (long part of the bone) was sharp like a spike, so when she was being moved in bed, the bone worked its way out to the skin and became an open fracture. V17 said R1's fracture is fairly new. V17 said (R1's) family elected to not have surgery so a splint was placed on R1's left leg. (A)	S9999		