STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009922	A. BUILDING: _____ B. WING _____	02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE	2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701

(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	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care 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. This requirement is not met as evidenced by: Based on observation, record review and interview the facility failed to implement pressure ulcer treatment protocol for one of one resident (R102) reviewed for pressure ulcers on the sample of three in the Licensure disinct part. Findings include: On 2/5/15 E14, Licensed Practical Nurse (LPN) sent a facsimile (FAX) dated 2/5/15 to Z3 (R102's Physician) documenting that R102 has a "pressure ulcer coccyx." Nurses Notes dated 2/5/15 document "aide reported open area to (R102's) coccyx which measured 0.3 (centimeters, cm) by 0.2	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 (cm)...applied (barrier) cream to area..." R102's Treatment Administration Record dated 2/5/15 documents "every shift for wound healing wash area with normal saline, pat dry, apply inzo barrier cream." On 2/10/15 at 12:10 pm E2, Director of Nursing, stated, "I didn't know that she (R102) had a pressure area on her coccyx." On 2/10/15 at 1:40 pm E16, LPN stated that she did not know that R102 had an open pressure area on her coccyx. E16 stated that she thought barrier cream was being applied to the area on R102's coccyx every shift. E16 stated that she had not applied any treatment to R102's coccyx. On 2/10/15 at 1:00 pm E15, Certified Nursing Assistant stated that R102 was last toileted at 11:00 am then was taken to the shower. E15 confirmed that R102 had an "open area on her bottom" that did not have a dressing on it. E15 stated that she thought she saw cream on the area. On 2/10/15 at 1:30 pm E15 assisted R102 to a standing position as she prepared to toilet R102. E15 pulled down R102's brief and pants revealing an open wound on R102's coccyx. There was no dressing covering the wound on R102's coccyx. On 2/10/15 at 1:45 pm E16 stated that E15 should have notified her of R102's wound when she did her incontinence care. E16 examined the wound on R102's coccyx and stated that the wound is an acquired Stage II pressure ulcer. E16 stated that the pressure ulcer measures 1.5 cm by 1.0 cm with pink tissue and no slough. E16 then applied barrier cream to R102's	S9999		

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S9999	Continued From page 2	S9999		

pressure ulcer. E16 did not cleanse the pressure ulcer with Normal Saline and did not apply a dressing.

A facsimile dated 2/10/15 to Z3 (R102's Physician) documents that R102 has an open wound to her coccyx area measuring 1.3 centimeters (cm) by 1.3 cm. The facsimile documents "cleansed with normal saline, calcium alginate cut to size of wound and border form dressing daily prn (as needed) till healed per (facility) protocol."

On 2/11/15 at 10:00 am E2, confirmed that E14 and E16 did not follow the pressure ulcer protocol for R102's Stage II pressure ulcer. E2 stated that E14 and E16 should have implemented proper treatment per protocol for R102's pressure ulcer, which is cleansing the area with Normal Saline and applying alginate or border foam dressing to cover the pressure ulcer. E2 stated, "To my knowledge" (R102's) pressure ulcer had not been covered with a dressing since it was identified on 2/5/15. E2 stated that when a pressure area is identified on a resident "I receive a skin tear alert." E2 stated that she had not received a skin tear alert on R102's pressure ulcer. E2 stated that E14 had identified R102's pressure ulcer on 2/5/15 on the night shift and "I should have had the alert the next morning."

The Stage II Partial Thickness Skin Loss protocol dated 8/14/14 documents "Cleanse with Normal Saline, apply Hydrogel dressing, cover with gauze and wrap with stretch gauze and secure with tape."

(B)