

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2021
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NAME OF PROVIDER OR SUPPLIER OAK HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298
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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to timely identify, assess, and monitor the formation of a pressure ulcer for 1 resident (R114) reviewed for pressure ulcers. This failure resulted in R114 developing an unstageable pressure ulcer on her elbow.</p> <p>Findings Include:</p> <p>R114's Minimum Data Set (MDS) dated 07/01/21 documents R114 has moderate cognitive impairment.</p> <p>R114's Electronic Health Record (EHR) Progress Note dated 6/24/21 documents, "report was received from a regional hospital. We were informed that a 94 year old Caucasian female who fell on 6/19/21, and was admitted with a diagnosis of right hip and humerous fracture. She (R114) has shearing and a red spot to her bottom."</p> <p>R114's Baseline Care Plan Observation/Admission Note dated 6/24/21 documents R114 has bruises to her arms, hands, and right hip. She has a surgical incision to her right hip and leg. R114 has a bruise to her left and was an intravenous site. R114's buttocks and coccyx were red. R114's Baseline Care Plan Observation/Admission Note dated 6/24/21 does not document a pressure ulcer to R114's right elbow.</p> <p>R114's Physician Order Sheet (POS) dated 6/24/21 documents weekly skin checks, and</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>weekly skin checks by nurse.</p> <p>R114's EHR Progress Note dated 6/25/21 documents R114 has a sling to her right arm.</p> <p>R114's EHR Progress Note dated 6/27/21 documents R114's skin color is pink right arm sling in place. Heel protectors are in place.</p> <p>R114's Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower review form dated 6/27/21 documents R114 skin is clear and nothing is new.</p> <p>R114's EHR Progress Note dated 7/7/21 documents, "guest c/o (complained of) right elbow pain. Sling removed and noted a pressure ulcer 1.5 cm (centimeters) x 2.0 cm. Area around open area red. (V12's, Medical Doctor (MD)) office notified for TX (treatment) orders. Was notified by PT (Physical Therapy) and they stated 'she is keeping her elbow drawn back on to bed.' Need to make sure sling is tighter and arm across abdomen." It also documents that R114 is friendly and cooperative.</p> <p>R114's Wound and Skin Care Management Documentation Form dated 7/7/21 documents the right elbow wound was not present upon admission. The right elbow wound measures 1.5 cm x 2.0 cm is an unstageable pressure injury: obscured full-thickness skin and tissue loss with slough.. R114's dressing is Medihoney.</p> <p>R114's Wound and Skin Care management Documentation Form dated 7/14/21 documents R114's right elbow wound measures 2.0 cm x 2.0 cm is an unstageable pressure injury: obscured full-thickness skin and tissue loss with slough. Her dressing is Medihoney.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R114's Weekly Pressure Injury Log dated 7/18/21 through 7/24/21 documents her right elbow pressure ulcer is unstageable, and it measures 2.0 cm x 2.0 cm, and has a scant serous drainage. R114's treatment is Medihoney twice daily.</p> <p>R114's Wound and Skin Care Management Documentation Form dated 7/28/21 documents R114's right elbow wound measures 2.0 cm x 2.0 cm is an unstageable pressure injury: obscured full-thickness skin and tissue loss with slough.</p> <p>On 7/29/21 at 10:30 AM, V4, Licensed Practical Nurse (LPN), entered R114's room and informed R114 that she was going to change her dressing. V4 removed the old dressing dated 7/28/21. V4 placed Medihoney and a new dressing on R114's elbow. V4 stated, "She complained of elbow pain and we removed the Sling, and found the pressure ulcer." R114's elbow pressure ulcer was red around the perimeter measuring about 1.5 inches by 1.5 inches.</p> <p>On 07/29/21 at 12:25 PM, V5, Care Plan Nurse, stated, "She (R114) had a sling on her arm from the hospital. When it was taken off, it (the right elbow pressure ulcer) was there. It was found on 7/7/21, and she was admitted on 6/26/21. We looked at her arm on admission and she didn't have a pressure ulcer. She (R114) was supposed to wear the sling for 4 weeks, and then it can come off. That's why the sling is not on this week."</p> <p>On 7/29/21 at 3:56 PM, V12, Medical Doctor, stated, "She (R114) was refusing to move; she is refusing therapy. She was resistant to care, it was challenging. She was refusing to get out of</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>bed. It doesn't surprise me she got a pressure area. If she was allowing care, we may have seen the redness before the pressure area."</p> <p>The facility's Wound Care and Management policy and procedure, dated 7/16/18, documents, Policy Statement "Residents who enter the facility without pressure ulcers do not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable."</p> <p>The NPUAP (National Pressure Ulcer Advisory Panel) at https://cdn.ymaws.com/npuap.site-ym.com/resourcel/resmgr/npuap_pressure_injury_stages.pdf documents the definition, "Unstageable Pressure Injury: Obscured full- thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed."</p> <p>(B)</p>	S9999		