STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002869	A. BUILDING: _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH & REHAB CTR	ONE PERRYMAN STREET LEBANON, IL 62254

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S 000	Initial Comments Complaint Investigation: 2146711/IL138120	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)2) 300.1210 d)3) 300.1210 d)5) 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 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. 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, interview and record review, the facility failed to initiate a treatment and reevaluate the treatment when the pressure ulcer deteriorated for 1 of 4 residents (R2) reviewed for pressure ulcers in the sample of 8. This failure resulted in R2 not receiving a change in treatment for 6 weeks as R2's pressure ulcer deteriorated and R2's pressure ulcer progressing from shear to a Stage 3 pressure ulcer.	S9999		

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S9999	Continued From page 2 Findings include: On 9/16/21 at 2:13 PM, R2 was observed lying in her bed on her left side. She responded to conversation, but her speech was unintelligible. V8 Certified Nursing Assistant (CNA), and V9 CNA assisted R2 to roll further onto her left side and a dressing was noted to her sacrum. The dressing was loose at the bottom and V8 raised the dressing to expose a deep pressure ulcer about the size of a golf ball on R2's sacrum. There was a moderate amount of brownish-yellow drainage on the dressing which was dated 9/16/21. The wound base was covered in dark brown necrotic tissue. On 9/16/21 at 2:25 PM, V18 Wound Nurse stated she monitors the residents' wounds, but V19 Registered Nurse (RN)/Treatment Nurse does the treatments. V18 stated R2's wound on her sacrum was present on her admission to the facility. R2's Face Sheet documents she was admitted to the facility on 6/28/21 with the diagnoses to include Cerebral Infarction (CVA), Type 2 Diabetes Mellitus, Morbid Obesity, Alzheimer's Disease, Hemiplegia affecting the left dominant side, and Venous Insufficiency (Chronic) (Peripheral). R2's Minimum Data Set (MDS), dated 7/3/21 documents she is cognitively impaired and is dependent on staff for bed mobility and transfers. The MDS also documents R2 had no pressure ulcers, venous or arterial ulcers and no other ulcers, wounds or skin problems. R2's Care Plan, undated documents, "Focus: Actual Pressure Ulcer Site: Left Buttock/Coccyx.	S9999		

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S9999	Continued From page 3 Requires turning and repositioning: Increased skin moisture, General Health Status. Present on Admit 6/28/21. R2's Admission Nursing Assessment dated 6/28/21 at 8:09 PM documents, under "Skin Assessed and Condition on Admission": Site: other: left buttocks; open area with measurements recorded as 2 centimeters (cm) in length and 1 cm in width. No treatment was ordered or documented on this assessment. On 9/17/21 V2 Director of Nursing (DON) presented an unsigned, untitled handwritten document dated 7/5/21 which she stated were the measurements of residents' wounds for those residents not followed by the wound specialist. On the bottom right corner of the document V2 had circled a note that listed R2's last name and documented, "coccyx/buttock 2 X 0.5 X (unknown). No treatment was documented for this wound. R2's Wound Assessment Report dated 7/12/21 documents, "Location: Coccyx/Sacrum Area; Admitted with; Type: Shear; epithelial and granulation tissue present; small amount of serous drainage; wound measurements: 2cm X 0.5 cm X 0.1 cm. The peri-wound tissue was macerated. Treatment: XXXX Paste. Evaluation: "First observation, no reference. " R2's Wound Assessment Report dated 7/19/21 documents: Location: Coccyx/Sacrum Area; Admitted with; Type: shear; epithelial and granulation tissue present; small amount of serous drainage; measurements: 2.5 cm X 1 cm X 0.2 cm; peri-wound tissue is intact. Treatment: topical medical- grade honey dressing. "Evaluation: worsening. " Treatment: topical	S9999		

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S9999	Continued From page 4 medical- grade honey dressing. R2's Wound Assessment Report dated 7/27/21 documents: Location: Coccyx/sacrum area; admitted with; Type: shear; epithelial and granulation tissue present; 50% necrotic tissue; small amount of serous drainage; measurements: 2.5 cm X 1.5 cm (no depth recorded). peri-wound tissue intact. Treatment: topical medical- grade honey dressing. Evaluation: Worsening." R2's Wound Assessment Report dated 8/3/21 documents: Location: Coccyx/sacrum area; acquired on 7/12/21; Type: shear; epithelial and granulation tissue present; 50 % necrotic/slough tissue present; small amount of serous drainage present; measurements: 3 cm X 2 cm (no depth recorded); peri-wound tissue intact; Treatment: topical medical- grade honey dressing." Evaluation: Worsening." R2's Wound Assessment Report dated 8/9/21 documents: Location: Coccyx/Sacrum area; acquired; Type: shear; epithelial and granulation tissue present; 50 % necrotic/slough tissue present; small amount of serous drainage; measurements: 3 cm X 2 cm X 1cm; peri-wound tissue intact; treatment: topical medical- grade honey dressing. Evaluation: Improving." The measurements and wound description did not support evidence of improvement. R2's Wound Assessment Report dated 8/19/21 documents: Location: Coccyx/sacrum area. Admitted; pressure (no stage marked); epithelial and granulation tissue present; 50% necrotic/slough present; small amount of serous drainage; measurements: 3.5 cm X 1.5 cm X 0.5 cm. peri-wound tissue intact; Treatment: topical medical- grade honey dressing." Evaluation:	S9999		

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S9999	Continued From page 5 Improving." R2's Wound Assessment Report dated 8/25/21 documents: Location: Coccyx/Sacrum area; admitted with; pressure (no stage marked); epithelial and granulation tissue present; slough present; measurements: 2.5 cm X 1.5 cm X 1.5 cm; peri-wound tissue intact; Treatment: topical medical- grade honey dressing" Evaluation: Improved." According to this assessment, the wound increased in depth. R2's Wound Assessment Report dated 9/2/21 documents: Location: Coccyx/sacrum area; admitted with; pressure (no stage documented); epithelial and granulation tissue present; slough present; small amount of serous drainage; measurements: 3 cm X 1.5 cm X 1 cm; peri-wound tissue intact; Treatment: Silvadene/Calcium Alginate." Evaluation: unchanged." R2's Wound Assessment Report dated 9/9/21 documents: Location: Coccyx/sacrum area; admitted with; pressure (no stage documented); epithelial and granulation tissue present; 20% necrotic/ slough present; small amount of serous drainage; Measurements: 3.5 cm X 2.5 cm X 1.5 cm; peri-wound tissue intact; Treatment: Silvadene/Calcium Alginate; Evaluation: worsening." R2's Order Review Report dated 9/16/21 documents the following current, discontinued and completed orders (all orders for R2 since her admission to the facility): 7/13/21: XXXX Hydrophilic Wound Dress Paste-apply to bilateral buttocks, coccyx topically every shift for preventative skin care. Cleanse bilateral buttocks, sacrum and coccyx with soap and water. Apply	S9999		

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S9999	Continued From page 6 XXX Paste every shift. 7/30/21: Silver Sulfadiazine 1%- Apply to coccyx topically as needed for soilage or dislodgement. Cleanse coccyx area with soap and water, normal saline (ns) or wound cleanser. Apply Silvadene cream, cover with calcium alginate and bordered gauze dressing. Change daily and as needed (prn). There was no order for topical medical- grade honey dressing treatment found in R2's Order Review Report. Review of R2's Wound Assessments and Order Review Report from 7/30/21 until 9/17/21 when R2 was transferred to the emergency room document her pressure ulcer worsened, but no new treatment orders were added even though there was no evident improvement in the wound after 6 weeks with the same treatment. R2's Medication Administration Record (MAR) dated 6/1 to 6/30/21 does not document any treatment for the open area to R2's left buttock identified on her admission assessment. R2's MAR dated 7/1/21 to 7/31/21 documents an order for XXXX Hydrophilic Wound Dress Paste to be applied every shift starting 7/13/21 and an order for Silver Sulfadiazine Cream 1%, cover with Calcium Alginate and bordered gauze, change daily and as needed. No treatments were documented before 7/13/21. R2's MAR dated 8/1/21 to 8/31/21 document the same treatment orders of XXXX Hydrophilic Wound Dress Paste every shift and Silver Sulfadiazine Cream 1% covered with Calcium Alginate and bordered gauze change daily and as needed.	S9999		

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S9999	Continued From page 7 R2's MAR dated 9/1/21 to 9/30/21 documents the same above orders through 9/17/21 when R2 was transferred to the emergency room. There were no treatment orders for topical medical- grade honey dressing documented on R2's MARs since she was admitted. R2's Progress Notes by her physician and nurse practitioner dated 7/2/21, 7/6/21, 7/9/21, 7/12/21, 7/15/21, 7/19/21, 7/22/21, 7/28/21, 8/3/21, 8/4/21, 8/6/21, 8/10/21, and 8/13/21 do not include assessment of or plan for her pressure ulcer on her buttocks or coccyx. R2's Physician Progress Note dated 9/16/21 documents, "Nursing also notes a worsening sacral decubitus ulcer. Integumentary: Venous stasis changes. (Wound Specialist) ordered, please see wound assessments for treatments and plans, dark yellow tissue noted, no odor or drainage." On 9/17/21 at 12:20 PM, V2 DON, stated this was V18's Wound Nurse notes when she measured the wound on R2's coccyx/sacral area. V2 reviewed the timeline of the wound, along with measurements, and stated as the slough cleared, they could see the wound better and determined it was a stage 3 pressure ulcer. She stated during the time the wound was being treated, R2 was also treated for a UTI and the antibiotic would have helped the wound also. (No culture of the wound was ordered until 9/16/21.) R2 was transferred to the emergency room and expired the next morning on 9/17/21. V2 stated R2's wound was initially treated with XXXX Paste, which has topical medical- grade honey dressing in it, and then just topical medical- grade honey	S9999		

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S9999	Continued From page 8	S9999		

dressing and then Silvadene and calcium alginate to clean off the slough. She stated the topical medical- grade honey dressing is not documented because the wound nurse forgot to write the order. V2 stated they tried to get in touch with R2's family to get consent for the wound specialist to evaluate and treat R2's wound but they didn't answer the phone calls. She stated there were nurses on duty when family came to visit that could have gotten consent from family while they were there for the wound specialist to treat R2's wounds.

On 9/21/21 at 11:20 AM, V20 R2's physician returned call. She reviewed R2's orders for wound treatment and her progress notes. V20 stated she did not have any additional information regarding R2's wound. She stated R2's wound was discussed in wound meetings and did show some improvement on some of the wound assessments, but stated she relies on the wound nurse's reports to keep her updated. V20 stated if a wound does not show improvement after a few weeks, she would probably change the treatment. V20 stated she was reviewing the orders and did not see where the order had been changed after the treatment for Silvadene cream and calcium alginate dressing was ordered on 7/30/21.

The facility's policy, "Skin Integrity," dated August 2014, documents, "Purpose: Residents identified to be at risk for skin breakdown (pressure ulcers) will have a routine assessment and interdisciplinary (IDT) care plan process implemented to maintain and/or improve skin integrity. The objective is to create an on-going process to identify and actively manage risk and/or skin integrity issues, and determine appropriate referrals or interventions to achieve positive clinical outcomes." It continues,

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S9999	Continued From page 9 Procedure: "15. If skin integrity issues are identified post-admission to the facility the following documented information is required: Wound specifics: location of wound-as specifically as possible, size of wound including length, width and depth in centimeters. For superficial wound depth state the smallest measure on the measuring guide (for example, "0.1 cm) or "less than 0.1cm; amount of drainage, and description of wound bed; presence of necrotic tissue, eschar or slough, color, moist or dry, odor, signs and symptoms of infection, description of surrounding tissue, stage of wound, notification of physician, notification of responsible party." It further documents, "19. If wound has shown no signs of improvement in 2-4 weeks reevaluate interventions and plan of care." "B"	S9999		