STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001457	A. BUILDING: _____ B. WING _____	C 04/20/2021

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CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

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S 000	Initial Comments Complaint Investigaion: 2162434/IL132620 2162482/IL132692	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)3)5) 300.1220)b)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional	S9999		

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S9999	Continued From page 2 status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These requirements were not met evidencded by: Based on observation, interview, and record review, the facility failed to implement pressure reducing interventions, keep skin free of moisture to prevent pressure ulcer development, assess for and implement additional nutritional interventions, monitor the pressure ulcer weekly, complete pressure ulcer treatment as ordered, and prevent cross contamination of the pressure ulcer for two of three residents (R5, R10) reviewed for pressure ulcers on the sample list of 12. This failure resulted in R10 developing an unstageable sacral pressure ulcer. Findings Include: 1.) R10's MDS (Minimum Data Set) dated 01/25/21 documents R10 has moderately impaired cognition, requires extensive assistance with bed mobility, transfers, and toileting, is always incontinent of bowel and bladder and is at risk for pressure ulcers. R10's Care Plan dated 01/15/21 documents R10 has the "potential for skin alteration due to deficits in sensory, presence of moisture, decrease activity and mobility, deficits in nutritional intake, potential for friction and shear, due to resident's current medical condition" with interventions of assisting with toileting and/or incontinence care and providing a pressure reducing mattress to the bed.	S9999		

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R10's 03/18/21 Wound Evaluation and Management Summary dated 03/18/21 by V19 Wound Physician documents R10 has an unstageable pressure ulcer to the right sacrum, which R10 has had for more than one day that is 100% covered by thick adherent devitalized necrotic tissue measuring 1.8 cm (centimeters) by 2.5 cm by 0.2 cm. V19 debrided the pressure ulcer and post debridement, the pressure ulcer presents as a stage four. V19 recommendations are to turn R10 side to side, and front to back in bed, everyone two hours if able and apply a foam or gel cushion to R10's chair.

R10's 03/31/21 Wound Evaluation and Management Summary dated 03/31/21 by V19 documents R10's sacral pressure ulcer as a stage four pressure ulcer of more than 14 days duration measuring 2 cm by 1.8 cm by 0.2 cm with 100% muscle showing. This Summary continues to recommend R10 be turned side to side and front to back in bed everyone two hours if able and apply a foam or gel cushion to R10's chair.

R10's medical record does not contain any Wound Evaluation and Management Summaries or wound measurements or assessments after 03/31/21.

R10's dietary assessment dated 02/14/21 by V16 RD (Registered Dietician) documents R10 has a low BMI (Body Mass Index) at 17.5, R10's weight has been stable for the past month. R10 eats the ordered magic cup well and would benefit from increasing it to three times daily. R10's recent wound has healed, will continue to monitor.

There is no dietary assessment in R10's medical record since R10 developed the unstageable

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sacral pressure ulcer in March 2021.

R10's April 2021 Physician Order Sheet documents an order for R10's Right sacral pressure ulcer: Cleanse with Normal Saline or Wound Cleanser, Pat dry, Apply Calcium Alginate, and cover with foam daily and PRN (as needed).

On 04/15/21 at 11:30 am, 12:02 pm, 12:30 pm and 1:09 pm, R10 was lying in a low bed, with a regular scoop mattress, on R10's back. There was a very strong odor of urine coming from R10.

On 04/15/21 at 1:18 pm, V3 Scheduler/CNA (Certified Nursing Assistant) stated "there wasn't any staff assigned to R10's hall due to their only being three CNA's on the floor today" V3 stated V3 "had not personally provided any care to R10 today".

On 04/15/21 at 1:20 pm, V3 and V7 LPN (Licensed Practical Nurse) entered R10's room to provide R10's pressure ulcer treatment. R10's brief was saturated with dark yellow urine. V7 removed R10's soiled dressing, that was also saturated with urine, to reveal a sacral pressure ulcer that V7 measured as 1.5 cm by 2.5 cm not measurable due to the wound bed being covered in a white/yellow slough. V7 proceeded to cleanse the pressure ulcer with a gauze soaked in wound cleanser, then applied the ordered dressing, all without changing gloves or performing hand hygiene.

On 04/15/21 at 1:38 pm, V14 CNA stated V14 was assigned to R10's floor but not the hall and V14 had not provided any cares to R10.

On 04/15/21 at 1:39 pm, V15 CNA stated V15

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was assigned to R10's floor and had been at work since 6:00 am, but that V15 had not provided any cares to R10.

On 04/19/21 at 10:24 am, V10 NP (Nurse Practitioner) stated residents who are at risk for skin breakdown need to be on a routine turning/repositioning schedule with cushions in their chair and repositioning devices in the bed, be on a toileting/changing schedule. If they develop a wound, they need to be seen by the RD for recommendations. Even if the resident is on supplements, if the wound progresses to an unstageable wound, the RD would need to see again for additional recommendations. V10 stated extra protein like super foods, double proteins at meals, vitamin c, and zinc, could be implemented but those recommendations would come from the RD. V10 stated in R10's case, there are multiple factors that could contribute to acquiring an unstageable wound but "being wet for a long period of time could have contributed and it definitely won't improve the wound", R10 should also be on a specialty mattress, to prevent pressure.

On 04/19/21 at 11:22 am, R10 was sitting up in a reclining wheeled chair in R10's room, without any pressure relieving devices under R10.

On 04/19/21 at 12:10 pm, R10 remained up in the reclining wheeled chair being fed lunch by an unidentified nursing student. R10 had eaten 100% of the served pasta, potatoes, carrots, and fruit.

On 04/19/21 at 1:00 pm, V16 RD confirmed the last note in R10's medical record was dated 02/14/21, that was when R10 was reviewed for weight loss and R10's wound had healed. V16

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stated V16 "would assume I {V16} would have made a note if I {V16} reviewed (R10) after that" but can't say for sure if staff told V16 of R10's wound or not. V16 stated R10 had remained on R10's supplements even after R10's wound was resolved. V16 stated V16 does recommend fortified foods or double protein at times but with someone like R10 that doesn't eat well, the liquid supplements are the way to go.

On 04/19/21 at 1:10 pm, V2 DON (Director of Nursing) stated V19 Wound Physician is at the facility weekly but that R10 has not been seen by V19 since 03/31/21. V2 stated there was some confusion and R10 got removed from V19's wound list. V2 confirmed R10's wounds have not been measured/assessed since 03/31/21 due to V22 Former Wound Nurse no longer working at the facility. V2 stated V2 was not aware that R10 even had a wound until this past weekend when V2 worked the floor. V2 stated V2 does not personally stage wounds, as V2 is not certified in that area. At this time, V1 Administrator stated, "if you can't see the wound bed, it's an unstageable." V2 stated V19's recommendations of a chair cushion should have been implemented.

2.) R5's MDS (Minimum Data Set) dated 02/12/21 documents R5 requires extensive assistance with bed mobility and toileting, is totally dependent on staff for transfers, is frequently incontinent of bowel and bladder and at risk for pressure ulcers.

R5's Progress Notes dated 04/12/21 by V11 RN (Registered Nurse) documents R5 has an "open area on resident {R5's} sacrum approx. (approximately) measures 0.5 {cm} (Centimeters) x (by) 0.5 cm", barrier cream applied, NP (Nurse Practitioner) notified.

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S9999	Continued From page 7 R5's April 2021 Physician Orders documents a treatment order obtained on 04/13/21 for a hydrocolloid dressing to the sacrum/coccyx every 3 days as needed. R5's April 2021 TAR (Treatment Administration Record) does not document the ordered hydrocolloid dressing was applied on 04/13/21. On 04/14/21 at 10:15 am, R5 was sitting up in R5's wheelchair and stated, R5 used to have a "sore spot on my {R5's} butt, but nothing now." On 04/14/21 at 10:28 am, V4 CNA (Certified Nursing Assistant) and V5 CNA entered R5's room to provide cares. V4 and V5 removed R5's brief to reveal a 0.5 cm by 0.5 cm red, superficial open area to the left buttocks/sacral area, without a dressing. V4 and V5 confirmed there was no dressing. At this time, R5 stated, R5 has not had a dressing on the open area since it developed on 04/12/21. The facility Physician Orders-Medications and Treatments dated November 2017 documents each medication or treatment order shall be administered to the resident as ordered by the physician. The facility Prevention of Pressure Ulcers Policy dated December 2015 documents "The purpose of this procedure is to provide information regarding identification of pressure ulcers risk factors and interventions for specific risk factors." For a person in bed, change position at least every two hours or more frequently if needed; if the resident has a wound on the sacral/buttocks area, determine if resident needs a special	S9999		

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S9999	Continued From page 8 mattress. For a person in a chair, change position at least every two hours or more frequently if needed, and use foam, gel or air cushion as indicated to relieve pressure. Risk Factors for pressure ulcers include moisture, friction and shear, immobility, bowel/bladder incontinence, poor nutrition, and lowered mental awareness. Residents shall be checked and changed at least every two hours and PRN (as needed), use pillows or wedges to keep bony prominence's from touching each other, and the dietician shall assess nutrition and hydration and make recommendations based on the individual resident's assessment. " B "	S9999		