STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000103	A. BUILDING: _____ B. WING _____	C 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DEBES REHAB & HCC	550 SOUTH MULFORD AVENUE 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 #2112937/IL133420 #2113050/IL133556	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210d)5) 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. 300.1210 General Requirements for Nursing and Personal Care d) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 These Regulations are not met as evidenced by: Based on interview and record review the facility failed to fully assess, document and treat a pressure ulcer on a resident's sacrum. This failure resulted in R1 leaving the facility with a large, unstageable, infected pressure ulcer requiring hospital evaluation and treatment with antibiotics upon discharge. This applies to 1 of 3 (R1) residents reviewed for pressure ulcers in a sample of 3. The findings include: R1's EMR (Electronic Medical Record) shows that R1 was admitted to the facility on 4/6/21 and discharged on 4/29/21. R1's Progress Notes dated 4/23/21 state, "Has skin alteration. Sacrum wound red wound bed. Scant serosanguineous drainage. Optifoam applied". There is no documentation of wound size, depth, tissue type or stage. R1's Physician's Orders dated 4/23/21 states, "Document weekly on skin condition: sacrum wound." On 5/4/21 at 12:00PM V1 (Administrator) stated, "We want the wound to be assessed by the nurse practitioner and (R1) discharged before the nurse practitioner could do that. For consistency sake we want the wounds assessed by the same person." On 5/4/21 at 10:30AM V3 (Assistant Director of Nursing) stated, "V5 (Wound Nurse) is off on	S9999		

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S9999	Continued From page 2	S9999		

FMLA so I have been one of the people helping to cover for her. (R1) came in with a surgical wound. She developed a pressure sore here and I was not able to assess her before she discharged (6 days). There is no assessment of the wound- I didn't get a chance to do it. (V4- RN) saw the wound initially and she is off on vacation now."

On 5/5/21 at 9:50AM V4 (RN) stated, " I usually measure the wound when I find them- I don't know why I didn't that day. I don't know what was happening that I didn't do it. We usually just write it in our progress notes and then the wound care nurse fills out the WASA (Weekly Assessment of Skin Alteration) form."

On 5/4/21 at 3:00PM V1 stated, "I spoke to (V4) and she stated that the wound was about 0.5 cm x 0.5 cm, circular and red." V3 then concurred with that assessment.

On 5/6/21 at 11:50AM V11 (Nurse Practitioner) stated, "I never saw (R1's) sacrum. She left before I got a chance to see it. I know she always refused to turn and didn't ever want to get up so she was definitely high risk- as I said she was very frail."

On 5/6/21 at 12:00PM, V15 (Home Health Case Manager) stated, "When the (Home Care Nurse) saw (R1) on 4/30/21 her sacral wound was unstageable. He documented the measurements as : 9cm x 7.5cm .We had no description of the pressure ulcer (upon discharge). We called the doctor and she said to send her to the hospital E.R. for further evaluation."

The Hospital documents dated 4/30/21(1 day after discharge) state, "86 year old female that

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S9999	Continued From page 3 presents to the ER with a sacral wound and bilateral skin tears to her shins after being discharged from a local extended care facility yesterday post rehab for hip replacement surgery. She was discharged to home and today while home health was there for evaluation it was noted a sacral wound and they were referred to the ER due to the extensive wound." Sacral Wound approximately 7cm across, redness, tenderness, black base of the wound, foul odor noted." "Multiple diagnoses considered during this visit but not exclusive to sepsis, infection. " Pressure Ulcer of the sacral region, unstageable." Amoxicillin (Antibiotic) twice a day for 10 days ordered for infection. R1's Braden Scale (Skin Risk Assessment) form dated 4/20/21 shows that R1 scored a 14 (13-14= Moderate Risk). R1's Braden Scale form dated 4/27/21 shows that R1 scored a 16 (15-18= Mild Risk) R1's Care Plan initiated 4/6/21 does not address R1's pressure ulcer. The facility policy entitled Weekly Assessment of Skin Alteration (WASA) Form dated 3/2021 states, " 3. The WASA should be completed weekly and PRN. 5. Based on the findings of the completed WASA form: a. Determine appropriate interventions/ changes and implement as needed on the care plan. " (B)	S9999		