STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to follow interventions to prevent a pressure ulcer after a decline in mobility and identify an open wound as a pressure ulcer for two residents (R63, R19) reviewed for pressure ulcers. These failures resulted in R63 and R19 developing a Stage IV pressure ulcer.	S9999		

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S9999	Continued From page 2 Findings include: 1. The facility's Skin/Pressure Ulcer Risk Evaluation policy, dated 1/16/14, documents, "It is the policy of this facility to evaluate all residents for additional factors that place them at risk for developing pressure ulcers. To establish a consistent and objective method of evaluating the resident's risk for pressure ulcer development upon a reliable and valid evaluation of pressure ulcer risk." The facility's Wound Management policy, dated 1/14/14, documents, "An assessment will be used to provide a consistent means of wound evaluation. The skin care program will be utilized following the guidelines of the Agency for Healthcare Research and Quality, the National Pressure Ulcer Advisory Panel and current standards of Clinical Practice. Wounds will be treated based on the following etiology. A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Pressure ulcers are staged to determine the extent of tissue damage. Treatment of the ulcer, dietary management, management of tissue loads and interventions to improve tissue tolerance to pressure, friction, and shearing forces are critical components." R63's current care plan dated 9/3/21, documents, "(R63) has the potential for pressure injury development related to disease process, poor nutritional intake, decreased mobility, status post left femur fracture." This same care plan documents an intervention dated 6/24/21, "(Pressure reduction) boots on bilateral feet and float heels for skin protection." R63's Skin and Wound evaluation, dated 9/3/21	S9999		

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and signed by V2 (Director of Nursing), documents R63 developed an unstageable pressure ulcer to R63's left heel. This form also documents the wound was "Acquired in-house. Resident is status post left hip nailing. Staff was not ensuring heels were being floated at all times with boots on. Education: Floating heels properly".

R63's Initial Wound Evaluation and Management Summary, dated 9/13/21 and signed by V7 (Wound Physician), documents R63 has an unstageable pressure ulcer (due to necrosis) of the left posterior heel. This same form documents necrotic tissue was removed from R63's heel wound, and the wound was then staged at a stage four pressure ulcer.

On 11/30/21 at 11:08 AM, R63 was lying in her bed awake with an intact dressing to her left heel. At this time V9 (Licensed Practical Nurse, Wound Nurse) performed R63's pressure ulcer treatment and dressing change to her left heel. V9 stated R63 has had this wound a couple of months and that it is the result of pressure.

On 12/02/21 at 9:40 AM, V7 (Wound Physician) Confirmed that R63 has a pressure ulcer on her left heel that he is treating. V7 stated "I would not consider her pressure ulcer unavoidable. With proper skin care and positioning (R63) developing a pressure ulcer could've been avoided."

On 12/02/21 at 9:49 AM, V2 (Director of Nursing) confirmed filling out R63's wound evaluation after it was discovered. V2 confirmed the pressure ulcer developed as a result of R63's heels not being floated post surgical procedure. V2 stated, "I had to educate staff about keeping (R63's) heels floated. She was wearing boots but the

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heel was still getting placed on the bed which led to her developing a pressure ulcer on that left heel."

2. R19's current Electronic Medical Records document, R19 was admitted to the facility with the diagnoses of Paraplegia, Hemiplegia and Hemiparesis affecting the right side.

R19's MDS (Minimum Data Set) Assessment, dated 11/11/21, documents R19 requires extensive assistance of two for bed mobility and transfers.

R19's current care plan "undated", states, "(R19) has a risk for pressure ulcer development related to history of ulcers and immobility, Paraplegia, Hemiplegia right side, Malignant neoplasm of breast, Peripheral Vascular Disease, Anemia, Non-compliance with off loading, and limit sitting time to 60 minutes. Abrasion from 7/1/20 changed to a Stage IV pressure wound 2/1/21."

R19's Wound Care "TeleMedicine" Follow Up Evaluation, dated 1/13/21 and signed by V8 (R1's previous Wound Doctor), documents, "(R19) has an abrasion to her Right Ischium, 182 days Duration, Size (1.5 x 2 x 3 cm) (centimeters), with Undermining of 2 cm at 1 o'clock and 20 Percent Slough and 80 percent Granulated tissue." This same report documents, "Reason For No Debridement: Telemedicine, with treatment orders for Collagen Sheet apply once daily; calcium with silver apply daily for nine days."

R19's Wound Care Evaluation and Management Summary, dated 2/1/21 and signed by V7 (R19's current Wound Doctor), documents, "(R19) has a Pressure Ulcer of the Right Ischium, Stage four, Size (2.1 x 1.5 x 1 cm) with thick adherent

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devitalized necrotic tissue of 50 percent and undermining of 3 cm at 12 o'clock." This same report documents this wound was debrided on this date with 1.58 cm of devitalized tissue and necrotic muscle and surrounding fascial fibers removed at depth of 1.1 cm."

R19's current Wound Evaluation and Management Summary, dated 11/29/21 and signed by V7, documents, "(R19's) Stage IV pressure ulcer of the right ischium is 5 x 4.5 x 1.5 cm, and again debrided."

On 11/30/21 at 10:30 am., V9 (Wound Nurse) performed wound care to R19's right ischium. R19's wound was approximately a quarter size and approximately 1.5 cm in depth. V9 stated, "(R19's) wound was followed by V8 and classified as an abrasion. V8 moved and V7 took over the wound care stating the wound was then classified as a pressure ulcer. The wound had been working from the inside out. I was surprised when the wound was that big."

On 12/1/21 at 2:00 pm., V9 stated, "The previous wound doctor (V8) did some of (R19's) cares via TeleMedicine due to the COVID and did not come to the facility and actually assess the wound."

On 12/2/21 at 9:38 am., V7 stated, "When (I) started taking care of R19's area to her right ischium it was a pressure ulcer stage 4. (R19) has had this area for quite a few months before (I) took over. The area had necrotic tissue that (I) debrided at that time."

(B)