STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005938	A. BUILDING: _____ B. WING _____	C 10/11/2022

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LOFT REHAB OF DECATUR	500 WEST MCKINLEY AVENUE DECATUR, IL 62526

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S 000	Initial Comments Complaint #2267986/IL151967	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)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 care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. These requiremnts are not met as evidenced by: Based on interview and record review the facility failed to provide interventions and monitoring for a resident identified as high risk for skin breakdown for one of three (R1) residents reviewed for pressure ulcers on the sample of three residents. These failures resulted in R1 developing an Unstageable Pressure Ulcer to the right heel three weeks after admission. Findings include: The facility's policy, with a revision date of 9/5/22, titled "Pressure Injury Prevention and Management, documents, "Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure	S9999		

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S9999	Continued From page 2 ulcers/injuries. Definition: "Avoidable- mean that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with residents needs, resident goals and professional standards of practice, monitor and evaluate the impact of the interventions, or revise the interventions as appropriate. Policy explanation and compliance guidance: 2- the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment, interventions to stabilize, reduce or remove underlying risk factors, monitoring the risk factors; monitoring the impact of interventions; and modifying the interventions as appropriate. 3- Assessment of Pressure Injury Risk, a- licensed nurses will conduct a pressure injury risk assessment on admission and weekly for four weeks. b- This tool will be used in conjunction with other risk factors not captured by the risk assessment. c- licensed nurses will conduct a full body skin assessment on all residents upon admission, weekly and after any newly identified pressure injury. d- assessments of pressure injuries will be performed by a licensed nurse and documented, the staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. e- nursing assistants will inspect skin during bath and will report any concerns to the nurse immediately after the task. 4- Interventions for prevention and promote healing. 1- after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries. c- evidence based interventions for prevention will be implemented for all residents who are	S9999		

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S9999	Continued From page 3 assessed at risk or who have a pressure injury (ie: Redistribute pressure (such as repositioning protecting and/or offloading heels, etc.). f-interventions will be documented in the care plan and communicated to all relevant staff." R1's medical record documents an admission date of 8/19/22 to the facility. R1's admission diagnosis include: Trochanteric Fracture of the right femur, Right joint replacement surgery, Acute Embolism and thrombosis of deep veins right lower extremity, Ischemic Heart disease, Type 2 Diabetes Mellitus, Chronic Kidney Disease stage 3, Hypertension. R1's Braden Assessments (skin risk assessment) dated 8/19/22 and 9/3/22 document a score of 12 indicating R1 was at "high risk" for skin breakdown. No Braden assessment was completed for R1 the week of 8/26/22. R1's skin integrity assessment dated 8/19/22 (admission) does not document R1 had any pressure ulcers present on admission. R1's progress notes dated 8/19/2022 document, "Resident received in bed alert, oriented, able to make her needs known, admitted to the facility for Physical Therapy/Occupational Therapy strengthening post fall at home, had (surgery) on Right hip on 08/10/22. Weight Bearing As Tolerated to right leg. Upon body assessment, has no open areas on body, has two surgical sites with sutures. Scattered bruising on both arms from venipuncture/IV needle sticks. Old incision scar from left knee replacement. Also has some old healed scars/marks on right lower shin from old injuries. Heels are clear, pedal	S9999		

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S9999	Continued From page 4 pulses palpable, no edema noted. Toe nails are hard, has scab on 3rd left toe. (Physician) visited and assessed the resident." R1's physician progress notes dated 8/19/22 document, "Right femur fracture, status post fall, has developed weakness in legs after being laid up, therapy seeing patient." R1's Physical Therapy Evaluation and Plan of Treatment documents, start of care: 8/20/22. Reason for referral: recently admitted to the hospital due to fall at home resulting in right hip intertrochanteric fracture with displacement and angulation status post cephalomedullary nailing. Patient referred to physical therapy due to exacerbation of decrease in functional mobility, decrease range of motion, decrease postural alignment, falls/fall risk, fracture, functional limitation with ambulation, increased need for assistance from others, pain, reduced dynamic balance, reduced static balance and reduced ADL (Activities of Daily Living) participation. Functional Mobility Assessment: roll left to right- Substantial/maximal assistance, sit to lying- substantial/maximal assistance, lying to sitting on side of bed- substantial/maximal assistance. R1's baseline careplan dated 8/19/22 documents, "Skin risk:" Current skin integrity issues is not checked and History of skin integrity issues is not checked. There are no interventions documented on R1's baseline care plan for skin breakdown prevention. R1's Comprehensive Care plan with initiation dates of 8/19/22, 8/26/22 and 9/1/22 do not document R1 being at risk for skin breakdown, prevention measures in place or a plan for pressure ulcer treatment after the development of wounds on 9/6/22.	S9999		

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S9999	Continued From page 5 R1's Minimum Data Set Assessment dated 8-26-22 documents, section M: R1 is at risk for pressure ulcers, pressure relieving device to bed and chair "yes" is checked, and turning and repositioning program: "no" is checked. Section G: Bed Mobility, requires extensive assistance of two staff members, dressing total dependence on staff members, and bathing total dependence on staff members. R1's Occupational Therapy Encounter notes document on 9/5/22 by V8 Certified Occupational Therapist Assistant: "bed mobility training with task breakdown for sequencing, patient benefits from increased time to perform rolling side to side at contact guard assist. Patient reports sore heels, and notes redness on bilateral heels, reported to nurse and nurse to perform skin assessment." R1's electronic medical record does not document skin monitoring for R1 after 8/19/22 through 9/6/22. R1 had 2 paper skin monitoring forms completed, one dated 9/5/22 and one dated 9/8/22. A Skin monitoring form dated 9/5/22 signed by V11 Certified Nursing Assistant with R1's first name and incorrect last name, documents on the body assessment: posterior right heel circled and "black" is documented beside it, posterior left heel is circled and "redness" is documented, this form is also signed and dated 9/5/22 by V6 Licensed Practical Nurse. V11 CNA confirmed the skin monitoring form completed on 9/5/22 was for R1, V11 confirmed documenting the wrong last name on the form. R1's skin monitoring form dated 9/8/22 documents, "went home" no skin assessment completed.	S9999		

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S9999	Continued From page 6 On 10/6/22 at 12:50 PM V11 Certified Nursing Assistant stated, when I gave (R1) a shower on 9/5/22 (R1) had one heel that was black and the other one was red. I told the nurse about it, I don't remember who the nurse was, the nurse told me to get (R1) some heel protectors, when I came in the next day (R1) still had the heel protectors on. When (R1) first got to the facility (R1) didn't want to get out of bed much because of the pain from the hip fracture but then (R1) started working with therapy and was getting stronger. R1's medical record does not document an assessment was completed for R1's skin conditions to bilateral heels on 9/5/22 after V11 reported them to the nurse nor after V8 COTA reported them on 9/5/22 to nursing staff. R1's progress notes dated 9/6/2022 at 11:27 AM, document, "Resident noted having a blister to right heel, and resident left heel is red and mushy. (V14 Physician) notified, new orders received, encouraged to keep heels floated." R1's skin observation tool dated 9-6-22 documents right heel type: blister 4 centimeter length by 5 cm width, no depth is documented, stage is blank. Location: Left heel, type: red and mushy, measurement columns are blank, stage is blank. R1's physician order summary documents, start date: 9/6/22 Skin prep to left heel every shift for red mushy and Skin prep right heel every shift for blister. On 10/6/22 at 10:40 AM V9 Licensed Practical Nurse stated, "I believe V8 came to me and said that (R1) was complaining of heels hurting. I did an assessment on (R1's) heels. (R1) had a fluid	S9999		

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S9999	Continued From page 7	S9999		

filled blister on one of the heels and the other heel was red and mushy (boggy skin), I encouraged (R1) to keep her heels up. (R1) had no heel protectors in place prior to to this."

On 10/6/22 at 10:15 AM V2 Acting Director of Nursing (DON) stated, "a full body assessment is done on admission, braden (skin risk assessment) is completed on admission. If a resident admits with or develops any type of skin condition I have the wound physician see them, the nursing staff do not stage wounds, I let the wound doctor do that. Skin observations should be done weekly, using the skin observation tool in the electronic medical record. Skin observations are also done with showers, they are documented on paper forms. I never saw (R1's) heels, the wound doctor was supposed to see (R1) the day of (R1's) discharge but since (R1) was going home that day I had the nurse practitioner see (R1) for orders."

On 10/6/22 at 9:30 AM V4 Nurse Practitioner stated, "I saw (R1) the day (R1) was discharging to home. (R1's) insurance ran out and (R1) could not afford to stay in a long term care facility so (R1) was discharging home with family. (R1) stated (R1) was having increased pain in the right lower extremity. (R1) had a recent fracture to the right hip and a blood clot in the right extremity while in the hospital and (R1) said (R1) thought it was related to all of that. I looked at (R1's) heels, (R1) had a blister to one heel and the other heel was unblanchable and boggy. I was specifically concerned about the pain to the right leg due to (R1's) history. (R1) did have one plus generalized edema to both lower extremities, I spoke with (R1's) daughter and encourage her to have (R1) seen soon due to the complaints of pain and (R1's) history. (R1's) daughter was

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S9999	Continued From page 8 going to take (R1) to the Emergency room when they left the facility. Because of the location of the blister area to (R1's) heel and the mushy area to the other heel, the areas were caused by friction or rubbing of the heels, could have been on the mattress or on something when up in the wheelchair, (R1) wore diabetic shoes. All residents should have frequent monitoring of the skin, especially if they are high risk. Heels are at risk for pressure ulcers, especially if a patient has history of hip fractures or blood clots and decreased sensation. If (R1) would have had heels floated in bed (R1) would have benefited." R1's Hospital History and Physical dated 9/8/22 documents, "Assessment-plan: Right heel ulcer unstageable." R1's hospital records document, "date: 9/8/22, Emergency Provider notes, patient presents to the emergency room from extended care facility for right foot ulcer, patient recently had a right hip fracture and has been at extended care facility for rehab for the past three weeks. States past 3 or 4 days has noted pain in right heel, is diabetic and states blood sugars have been from 200 to 400, was due to be discharged from extended care facility today. Skin- Right heel with large pressure ulcer noted." R1's MRI (Magnetic Resonance Imaging) of the right foot without contrast documents, "exam: 9/9/22, Findings: There is soft tissue ulceration/blister over the posterior aspect of the calcaneus." On 10/11/22 at 10:15 AM V2 Acting DON stated, "I was not able to find any other skin monitoring for (R1) besides the paper ones dated 9/5/22 and 9/8/22. R1 had a baseline care plan, (R1's) comprehensive care plan was being developed when R1 discharged. I am not certain what skin	S9999		

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S9999	Continued From page 9 prevention measures (R1) had in place off the top of my head." (B)	S9999		