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	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2022

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LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments Complaint 2247892/IL151853	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.3220f) 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. 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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. 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All	S9999		

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S9999	Continued From page 2 new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. These Regulations are not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents who admitted with no pressure ulcers, did not develop pressure related injury for 1 of 3 residents (R3) reviewed. This deficient practice resulted in R3 developing an unstageable (full thickness tissue loss with base covered by eschar (black, tan, brown dead tissue) pressure injury to the coccyx, left buttock and right buttock. This deficient practice also resulted in R3 being hospitalized for septic shock and surgical debridement including bone. R3's Care Plan, initiated date 8/30/2022, The resident has the potential for pressure injury development r/t, (related to), weakness and impaired mobility. It continues Goal: The resident will have intact skin, free of redness, blisters or discoloration through review date. Educate the resident/family/caregiver as to causes of skin breakdown including transfer/positioning requirements, the importance of taking care during ambulating/mobility and good nutrition. R3's Minimum Data Set, dated 9/4/2022, documents that R3 requires extensive assist of 2 staff for bed mobility and totally dependent with transfers and toilet use. It also documents that R3 is always incontinent of bowel and bladder. R3's MDS also documents that R3 had 3 unstageable pressure ulcers upon admission.	S9999		

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S9999	Continued From page 3 R3's Admission/Readmission Screener, dated 8/29/2022, documents that R3's skin condition was normal and does not have any skin impairment "(includes MASD, (moisture associated skin damage), Pressure Injury, Surgical Incision, Bruises, Abrasions, Arterial/Vascular, etc..)" R3's Braden Scale for Predicting Pressure Sore Risk, dated 8/29/22, documents that R3 is at moderate risk for pressure sores. It also documents that R3 has a problem with "Friction & Shearing". It continues "1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction." It also documents that R3's ability to change and control body position was very limited. It continues "Mobility 2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently." R3's Continence Evaluation, dated 9/1/22, documents that R3 is always incontinent of urine and frequently incontinent of bowel. R3's Skilled Notes, dated 9/4/2022 at 12:19 PM, documents "Note Text: (R3), a M, (male), resident, with a date of birth of (xxxxxxx) resides in (xxx). It continues "Skilled Services / Special Instructions: Resident admitted to facility after hospitalization for hematoma s/p, (status post), fall, hypoxemia & UTI, (urinary tract infection). PMH, (past medical history): mild chronic pulmonary fibrosis, bronchiectasis, asthma, AFIB, HTN, HLD, BPH & pacemaker exchange during	S9999		

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hospitalization. Skilled nursing to monitor surgical site, cardio/respiratory status & recurrent infection. PT/OT for strength, balance, fall recovery skills & activity tolerance." It also documents "Resident Assessment: patient is alert and oriented with confusion at times, he is able to make most needs known but is very quiet and doesn't ask for help. patient is unaware when he is incont, (incontinent). patient is up with x2 assist. no s/s (signs/symptoms) of infection at this time. Resident/Family Education and Teachback: push fluids."

R3's Skin Check, dated 9/5, documents that R3 had "No skin issues" to the right buttock, left buttock or coccyx.

R3's Skin and Wound Eval, dated 9/6/2022, documents an in house acquired unstageable pressure ulcer to R3's coccyx measuring 3.8cmx0.9cmx0.1cm. It also documents slough 100% wound filled with light serosanguineous exudate. It also documents 9/7/2022 as exact date of length of time present.

R3's Alert Note, dated 9/7/2022 at 7:31 PM, documents "Note Text: Skin condition observed during care - report to nurse Reported skin condition is not new."

R3's Physician Order Sheet, (POS), dated 9/8/2022, documents "Cleanse coccyx with generic wound cleanser, pat dry, skin prep peri wound, allow to dry, apply silver calcium alginate and cover with foam dressing daily and PRN (as needed). every night shift for wound" It also documents "9/8/2022 Cleanse right buttock with generic wound cleanser, pat dry, skin prep peri wound, allow to dry, apply hydrocolloid every 3 days and PRN (as needed)." It continues

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S9999	Continued From page 5 "9/8/2022 Cleanse left buttock with generic wound cleanser, pat dry, skin prep peri-wound, allow to dry, apply hydrocolloid every 3 days and PRN." R3's Skin and Wound Eval, dated 9/12/2022, documents an in house acquired unstageable pressure ulcer to R3's left buttock measuring 5.1cmx1.2cmx0.1cm with a total surface area of 4.4cm2. It documents that the exact date of area as 9/7/2022. It also documents the wound bed filled with 100% eschar. It continues to document that the wound has moderate serosanguineous exudate and a faint odor noted after cleansing. It also documents the progress of the wound as deteriorating. R3's Skin and Wound Eval, dated 9/13/2022, documents an in house acquired unstageable pressure ulcer to R3's coccyx measuring 1.8cmx0.5cmx0.1cm. It also documents slough 100% wound filled with eschar. It documented the presence light serosanguineous exudate with faint odor after cleansing. It also documents the progress of the wound as deteriorating. R3's Wound Documentation from wound physician, dated 9/14/22, documents a necrotic pressure ulcer to R3's left buttock measuring 5.1cmx1.2cm. Depth not measurable due to the necrosis to the wound bed. It continues to document Necrotic pressure ulcer to R3's Right buttock 5cmx2.3cm. Depth unmeasurable due to necrosis of wound bed with moderate drainage. It also documents a necrotic pressure ulcer to R3's Coccyx measuring 1.8cmx0.5cm. Depth unmeasurable due 100% slough to the wound bed. It continues to document that the pressure ulcers to the coccyx and left and right buttock were debrided at the bedside. Recommends:	S9999		

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S9999	Continued From page 6 Off-load wound; Reposition per facility protocol; Turn side to side and front to back in bed every 1-2 hours if able; Low air loss mattress R3's Skin and Wound Eval, dated 9/19/2022, documents an in house acquired unstageable pressure ulcer to R3's coccyx measuring 4.6cmx0.5cmx0.1cm. It also documents the wound is filled 100% with eschar. It documents the presence moderate serosanguineous exudate with faint odor after cleansing. It also documents the progress of the wound as deteriorating. R3's Wound Documentation from wound physician, dated 9/21 documents the right and left buttock wound Resolved. "Wound present. See Focused Wound Exam below. The pressure ulcer to R3's coccyx measures "(L x W x D): 10 x 8 x Not Measurable cm, Surface Area: 80.00 cm², Odor Exudate: Heavy Purulent Thick adherent devitalized necrotic tissue: 100 % Wound progress: Deteriorate" It also documents Recommendations Off-load wound; Reposition per facility protocol; Turn side to side and front to back in bed every 1-2 hours if able; Low air loss mattress; Roho cushion R3's Skin/Wound Note, dated 9/21/2022 5:43 PM, documents "Data: patient was seen by (V6) today for Wound Care, new orders were obtained for Tetracycline 500mg BID x 14 days, Probiotics daily x 30 days, Dakins wet to dry dressing to Coccyx wound that is being treated for Cellulitis, Right Buttock and Left Buttock wounds have merged with Coccyx wound," R3's Skin and Wound Eval, dated 9/26/2022, documents an in house acquired unstageable pressure ulcer to R3's coccyx measuring 9.7cmx7.0cmx0.1cm. It also documents the	S9999		

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S9999	Continued From page 7 wound is filled 100% with eschar. It documents the presence of heavy amount of purulent exudate with a strong odor after cleansing. It also documents the progress of the wound as deteriorating. R3's Wound Documentation from wound physician, dated 9/28/22 documents The pressure ulcer to R3's coccyx measures "(L x W x D): 14x 11.5 x Not Measurable cm, Surface Area: 161.00 cm² , Odor Exudate: Heavy Purulent Thick adherent devitalized necrotic tissue: 100 % Wound progress: Deteriorate" It also documents Recommendations Off-load wound; Reposition per facility protocol; Turn side to side and front to back in bed every 1-2 hours if able; Low air loss mattress; Roho cushion R3's Skin and Wound Eval, dated 9/27/2022, documents an in house acquired unstageable pressure ulcer to R3's coccyx measuring 11.7cmx7.9cm. It also documents the wound is filled 100% with eschar. It documents the presence of a moderate amount of purulent exudate with moderate odor after cleansing. It also documents the progress of the wound as deteriorating. R3's Nursing Note, dated 9/29/2022 at 3:16 PM, documents "Note Text: Patient being sent out to (local Hospital) per wound MD for possible sepsis R/T, (related to), wound infection." R3's Interact SBAR Summary for Providers, dated 9/29/2022 at 3:56 PM, documents "Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Other change in condition At the time of evaluation resident/patient vital signs,	S9999		

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S9999	Continued From page 8 weight and blood sugar were: - Blood Pressure: BP 80/44 - 9/29/2022 15:18 Position: Pulse: P 71 - 9/29/2022 15:18 Pulse Type: Regular RR: R 20.0 - 9/29/2022 15:18, Temp: T 98.4 - 9/29/2022 15:18 Route: Forehead (non-contact) R3's Nursing Note, dated 9/29/2022 at 7:02 PM, documents "Note Text: Patient is being admitted to ICU for sepsis." R3's Hospital Infectious disease progress note, dated 10/5/2022, documents 94-year-old male with PMH, HTN, HLD, pacemaker placement, AFIB, who was admitted to (Local Hospital) on 9/29/2022 for septic shock. Has large decubitus ulcer that a significant amount of wet gangrene on exam. Went to the OR (operating room) on 9/30 for excision debridement including bone. There was a significant amount of purulence extending down adjacent to the bone. On 10/6/2022 at 2:30 PM requested documentation of education provided to R3 and wife regarding pressure ulcer prevention and or management and documentation of R3's refusal of care. As of 10/12/2022 at 2:05 PM the facility had not provided information. On 10/11/2022 at 3:30 PM requested the Pressure ulcer Prevention Policy. As of 10/13/2022 the facility had not provided the pressure ulcer prevention policy. On 10/5/2022 at 2:15 PM, V5 Licensed Practical Nurse, (LPN), stated that she admitted R3 to the facility. V5 stated, that R2 was quiet. V5 stated, that he was alert. V5 stated, that R3 was cooperative with care. V5 stated, that she is not aware of R3 refusing to turn and reposition. V5 stated, that R3 was weak and like to be in bed.	S9999		

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S9999	Continued From page 9 V5 stated, that the staff would get R3 up in the chair for meals and then lay R3 back down in the bed. V5 stated, that she performed a skin assessment of R3 upon admission and stated that the pressure ulcers to R3's buttocks and coccyx were not there. V5 stated, that the area started as a slit and progressed into the necrotic wound. On 10/5/2022 at 11:01 AM V4, Wound Nurse, stated, that she became aware of the area on 9/6/2022. V4 stated, at that time R3 had red discoloration to both right and left buttocks and a necrotic slight on his coccyx. V4 stated, that the areas to R3's buttocks were deep tissue injury. V4 stated, that she notified the physician and received orders. V4 stated, that R3 was to be seen by the wound doctor the following day but was out of the facility. V4 stated, that R3 was seen the following week and the wound doctored began to follow. V4 stated, that she was not sure how R3 obtained the area but thought they were present on admission. V4 stated, that she requested an air loss mattress on 9/6/2022 when first becoming aware of the area. On 10/5/2022 and 11:32 AM V6, Wound Physician, stated, that she seen R3 for the first time on 9/15/2022. V6 stated, at that time he had multiple unstageable necrotic wounds to his buttocks and to his coccyx. V6 stated, that she performed debridement at the bedside on the areas. V6 stated, that the wounds continued to deteriorate. V6 stated, that she requested an albumin and R3's albumin was low and requested protein supplements. V6 stated, that during a debridement of the wound the wound had a large amount of puss and V6 was sure there was an infection. V6 stated, that at that time she orders Tetracycline and a culture. V6 stated, that when	S9999		

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the culture came back the tetracycline was not the appropriate drug and then changed the order to Levaquin. When asked how R3 would have obtained the area. V6 stated, it's a pressure ulcer and unrelieved pressure is what caused it. When asked why did the area continue to deteriorate? V6 stated that looking at the logistics. V6 stated, that to have a pressure ulcer you have to have pressure. V6 stated, that I can order all the supplements and medications I want but if the offloading is not occurring the pressure ulcer will not improve and it will continue to deteriorate as in this case.

On 10/5/2022 at 12:00 PM V8, Physical Therapist, stated, that she had performed treatment with R3. V8 stated, that R3 was weak and required staff assistance with turning and repositioning. V8 stated, that R3 did refuse therapy at times because he was weak. V8 stated, that during her assessment and treatment she noticed a disconnect with R3. V8 stated, that when giving R3 specific directions R3 could not perform or would perform them different. V8 stated, that an example of this was she requested R3 to kick his feet out of the bed and R3 lifted his feet with his hands and moved his feet. V8 stated, that she put in a request for R3 to be screened by the speech therapist at that time for cognition. V8 stated, that shortly after that R3 went to the hospital and had not returned.

On 10/5/2022 at 1:00 PM V7, LPN, stated, that she works at the facility 2x week. V7 stated, that when she works it is on R3's unit and that she did provide care for R3. V7 stated, that R3 was pleasant and cooperative with care. V7 stated, that she is not aware of R3 refusing to reposition. V7 stated, that he did stay in the bed a lot. V7 stated, that R3 was shy but was alert and

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oriented to 4. V7 stated, that the pressure ulcers to R3's coccyx were necrotic. V7 stated, that when the areas continued to decline R3 was only out of bed for meals and then placed back in bed.

On 10/5/2022 at 1:37 PM V3, Assistant Director of Nursing, stated, that he was familiar with R3. V3 stated, that R3 came to the facility from the hospital due to a fall and surgical wounds related to pacemaker placement. V3 stated, that R3 initially presented with a red area and then the area progressed. When asked how R3 got the area, V3 stated, that it is a bedsore and if the pressure is not relieved it, (unrelieved pressure), caused it. When asked if R3 was being turned and repositioned? V3 stated, that he believes so. V3 stated, that R3 did have some problems with therapy, but this was all he was aware of. When asked if R3 could move about the bed independently? V3 stated, that he was not sure. V3 stated, that therapy would be able to answer more accurately.

On 10/11/2022 at 12:50 PM V12, CNA, stated, that R3 was quiet. V12 state that R3 rarely used his call light. V12 stated that occasionally R3 would refuse care. V12 stated, that she charted this in the behavior tracking. V12 stated, that R3 wanted to stay in the bed. V12 stated, that R3 was incontinent. V12 stated, that R3 allowed staff to clean him and turn him. V12 stated, that R3 didn't want to get out of bed.

On 10/11/1011 at 2:30 PM V2, Director of Nursing, (DON), stated, that R3's pressure ulcers to the coccyx and right and left buttocks occurred at the facility. When asked about the MDS charting areas were there upon admission and staff stating that the areas were there upon admission. V2 stated, that the areas were

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(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
S9999	Continued From page 12	S9999		

acquired at the facility. When does it mean when a resident is at moderate risk for pressure injury? V2 stated, that this means the resident is at more risk for obtaining a pressure sore than the normal resident. When asked what interventions would this require? V2 stated, that it depends on the resident and their history and comorbidities. V2 stated, that the turning and repositioning would be more frequent. V2 stated, that skin checks would be performed weekly, boots on feet, dietician review. V2 stated, that the facility obtained on 9/12/2022. V2 stated, that she had reviewed R3's chart. V2 stated, that the multiple necrotic pressure injuries occur at the facility. V2 stated, that she felt that R3 obtained the areas not from lack of care. V2 stated, that she does not have the documentation to prove that. V2 stated, that the facility had a pressure ulcer prevention policy.

On 10/12/2022 at 11:53 AM V13, CNA, stated, that she worked with R3 prior to going to the hospital. V13 stated, that R3 was nice and quiet. V13 stated, that R3 refused care occasionally like getting out of the bed. V13 stated, that R3 was in pain and didn't like to move a lot. V13 stated, that this was after R3 got the pressure ulcer to his buttocks. V13 stated, that R3 was alert and confuse. V13 stated, that it would vary. V13 stated, that he was dependent on staff for repositioning and could not turn himself.

The facility's Wound Management policy dated January 14, 2014, documents "It is the policy of this facility to facilitate residents' independence, promote resident comfort, and preserve resident dignity through an effective wound management program. It also documents A. Pressure Ulcers A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue damage. Treatment of the ulcer, dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 10/13/2022

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S9999	Continued From page 13 management, management of tissue loads and interventions to improve tissue tolerance to pressure, friction, and shearing forces are critical components. 4. Managing Tissue Load: Tissue load will be managed and tissue tolerance to pressure, friction, and shearing forces will be improved. This will be accomplished through the use of appropriate positioning practices, positioning devices, and support surfaces. (A)	S9999		