STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003081	A. BUILDING: _____ B. WING _____	07/27/2022

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S 000	Initial Comments Annual Licensure Complaint Investigation 2265639/IL149187	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3)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. Section 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 plan	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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S9999	Continued From page 2 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 requirements were not met as evidenced by: Based on record review, observation and interview the facility failed to perform timely incontinence care to prevent shearing over R28's bilateral Ischium (pressure ulcers), continued to implement nursing order while waiting for physician to be notified for a pressure ulcer treatment for two newly, facility acquired, Stage II pressure ulcers (shearing over bony prominence) 7/2/22-7/27/22 (25 days) and failed to measure the new, worsening pressure ulcers in accordance with facility policy for R28. These failures affected R28 and resulted in avoidable Stage II pressure ulcers with deterioration of the pressure ulcer as evidence by an increase in size. R28 is one of three residents reviewed for pressure ulcers on the sample list of 21. Findings include: 1. R28's "Physician Order Sheet (POS)" dated 7/1/22- 7/31/22 documents the following diagnoses: "Dementia, CVA (Cerebrovascular Accident/ Stroke), Cellulitis, and HX (history) DVT (deep vein thrombosis/blood clot). The same POS does not have a treatment order documented until 7/27/22. (Pressure ulcer were identified 7/1/22 as documented below).	S9999		

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S9999	Continued From page 3 R28's Minimum Data Set (MDS) dated 7/1/22 (same day pressure ulcers discovered) documents the following: R28's Brief Interview of Mental status score was 10 out of a possible 15 indicating moderate cognitive impairment. The same MDS documents R28 had a history of pressure ulcers with no pressure ulcers at the time of the MDS assessment. The same MDS documents R28 is always incontinent of bladder and frequently incontinent of bowel and has had no behaviors of rejecting care. The same MDS documents R28 is dependent on total physical assistant of two staff for hygiene needs and requires extensive assistance of one staff with toileting and transfers. R28"s Care Plan dated 5/12/22 documents the following: "P (Problem) High Risk for Pressure Ulcers per (Formal) Risk Assessment. (Formal) Risk score of 13 on 5/12/22. Risk factors Include bladder incontinence, history of pressure ulcers to left fourth toe, healed January 2015. Resident Specific Information: Requires assistance with toileting, bathing, dressing, needing reminders and physical assistance. G. (Goal) Will have no open areas caused by pressure or friction for the next review." A (action to be implemented) Apply house stock (Brand name) to peri-area with every (sic)after incontinent episode and as needed. Toilet/change brief when wet and upon rising, hs (bedtime) and after meals." The same Care Plan documents the following: P (Problem) Alteration in bladder elimination as related to incontinence. G (Goal) Skin will remain intact thru (through) next review.	S9999		

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S9999	Continued From page 4 A (action to be implemented) Toilet and/or change padding and give proper hygiene before/after meals, upon rising, upon request, before retiring for the evening, after napping, and prn (as needed) for incontinence." R28's (Formal) scale for predicting pressure ulcer risk date 7/1/22 (the same date as the MDS look back assessment) documents R28 is at high risk for level for developing pressure ulcers. 07/24/22 at 10:05 am R28 stated "I (R28) have sores on my (R28's) bottom from not getting changed often enough." R28 also stated "The night staff got me (R28) up (out of bed) and dressed between 5:00 am - 6:00 am. I (R28) have not been changed (provided incontinence care) since." R28 also stated R28 incontinence brief is very wet at this time and has soaked through R28's pants. On 7/24/22 at 10:12 am V11, Certified Nursing Assistant (CNA) stated R28 was already up and dressed when V11, CNA came in to work at 6:00 am. V11, CNA stated "(R28) usually gets up around 4:00 am, but I (V11, CNA) am not sure what time night shift (staff) changed (provided incontinence care) (R28). (R28) has not been changed since I (V11, CNA) came in at 6:00 am. I have been very busy." On 7/24/22 at 10:25 pm R28 had wheeled R28's wheelchair to the hall bathroom door. V11, CNA assisted R28 assisted to a standing position. R28's sweat pants were visibly saturated across the full seat of R28's pants. R28's incontinence brief was totally saturated, hanging down between her legs to mid-thigh, and dripped with urine onto R28's bilateral legs and the floor. V11, CNA removed R28's saturated incontinence brief.	S9999		

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S9999	Continued From page 5 R28 stated "Oh my sores hurt so bad." R28 did not have a treatment dressing on either of two Stage II pressure ulcers at the back of her thigh/buttock fold. R28 had two nickel sized open areas of shearing over the bony prominence, (Stage II pressure ulcers), one on each upper inner thigh crease, ischial region. Both areas were red and raw in appearance. R28's buttocks and thigh skin were deeply indented and red. V11, CNA stated "Usually (in general) those open areas have a wound dressing on them." R28 asked V11, CNA if V11, CNA would put some cream on the areas because they 'hurt so bad.' V11, CNA could not find a barrier cream to apply to R28's open wounds. V11, CNA stated to R28 "All I can do is get you washed up. You don't have any cream (barrier). I will make sure you are clean and dry and that will fill better (relieve pressure ulcer pain)." R28's "A.I.M for Wellness" nursing note dated 7/1/22 documented by V7, Licensed Practical Nurse (LPN) documents the following: "Assess; This change in condition, symptoms, or signs observed and evaluated are MASD (Moisture-Associated Skin Damage) to bilat (bilateral) back thighs. This started on 7/1/22. This condition, symptom, or sign has occurred before (blank checked) Yes. Other relevant information: Is at risk for skin breakdown per (formal skin evaluation)." The same AIM for Wellness nursing note documents the following: ' (Number) 7. Skin Evaluation, Contusion (bruise) check marked, Other MASD to back bilat (bilateral) thighs. (Number) 8. Pain Evaluation; Does the resident have pain? (checked) Yes. Is the pain new (checked) Yes. Description /location of pain; While performing peri-care (incontinence care). Intensity of pain (rate on scale of 1-10, with 10 being the worst): 5 (moderate)." The same	S9999		

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S9999	Continued From page 6 "AIM for Wellness" nursing note documents the following: "Manage; Physician recommendations and /or nursing interventions, Assist c (with) toileting q (every) 2 (two) hours and prn (as needed) and toileting hygiene. Assist c (with) T and P (turning and repositioning) while in bed and wheelchair q two hours and prn. Implement physician ordered treatment." V7, LPN also provided a hand written pressure ulcer plan of care for additional interventions dated 7/1/22. The hand written plan documents: "P (problem).) Resident (R19) has 2 (two), Stage 2 (two) pressure injuries on posterior thighs. G (goal). Residents wounds will heal and no new skin issues by next review. (first bullet) Start 7/1/22 nsg (nursing) A (action to be implemented).) Apply ordered TX (treatment)- see POS (Physician Order Sheet) for current TX (treatment) orders. (bullet number 10) Start 7/1/22 nsg A. Daily skin (check mark) c (with) documentation and prn with any new skin issues." On 7/26/22 at 9:30 am V7, Licensed Practical Nurse (LPN) reviewed a quality assurance document and stated she can give me the information from the document but is not allowed by the corporation to give a copy to the surveyors. V7, LPN stated "I can tell you what happened, I was the nurse that found (R28's) shear wounds from (R28's) excessive incontinence on 7/1/22. (R28's) skin breakdown was obvious (obviously) from being so wet. I was helping (not sure which it was) CNA's with resident care. I cleansed (R28) peri-area. (R28) had two areas, very irritated and open. (R28's) Left, back inner thigh open area (identified below on plan of care as Stage II) measured 1.2 centimeter (cm) long by 0.2 cm wide, and superficial so depth could not be measured. (R28's) second open area (identified below on plan of care as Stage II) to her right,	S9999		

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inner back thigh open wound measured 1.3 cm long by 0.4 cm long and the depth was superficial and could not be measured. I (V7, LPN) cleaned them with Theraworx (wound cleaner), applied skin prep around the outside of the wounds and put hydrocolloid dressings on them to prevent further destruction of the tissue. I did this as a nursing judgment and faxed (facsimile) the doctor for actual orders (physician). I notified the family and (V1, Administrator in Training), we don't have a DON (Director of Nursing who is required to be notified of new pressure ulcers). I faxed the orders to (V23, Physician) and reported off to the next shift nurse. I can't remember which one (nurse). I thought they (nurses) would follow-up and get an order (physician, pressure ulcer treatment order). I didn't put (document) the treatment (V7, LPN implemented as a nursing judgement) on (R28's) POS (Physician Order Sheet) because the next nurse had to confirm that is what the doctor wanted. (R28) has a history of skin breakdown, MASD (Moisture-Associated Skin Damage) the cause. I (V7, LPN) educated the CNA's (unidentified) on turning and repositioning resident (R28), and proper timely incontinence care."

R28's Treatment Administration Record (TAR) dated 7/1/22-7/31/22 documents R28 was not provided weekly skin assessments 7/11/22, and 7/25/22. R28's same TAR documents on 7/4/22, R28's had redness to buttocks and groin, on 7/8/22, R28 had irritation at an unidentified location, and on 7/18/22, R28 had redness and/or irritation in the groin area. On the same TAR there are no measurements documented of R28's bilateral, posterior thigh pressure ulcers (identified 7/1/22) until 7/27/22.

The same TAR does not document the following

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S9999	Continued From page 8 treatment was completed until 7/27/22. The treatment order documents: R28's "Bilateral thigh had shearing related to Moisture-associated Skin Damage, clean area with (name brand wound cleaner) and apply hydrocolloid dressing, every three days and as needed. The back of the same TAR documents measurements were obtained on 7/27/22 as follows: "Left, posterior med (medial) thigh, shearing (Stage II, shearing over bony prominence) related to MASD, measured 1.4 cm long, by 0.2 cm wide, by 0 cm, (increased from 7/1/22 Stage II measurement of left, posterior thigh 1.2 cm long by 0.2 cm wide by 0 cm depth). Right, posterior med (medial) thigh, shearing (Stage II, shearing over bony prominence) related to MASD, measured 3.0 cm long, by 0.4 cm wide, by 0 cm, (increased from 7/1/22 Stage II measurement of right, posterior thigh 1.3 cm long by 0.4 cm long by 0 cm depth). In comparison to the only measurements obtained prior to 7/27/22, from the quality assurance document 7/1/22 mentioned above, and reviewed by V7, LPN, R28's left thigh pressure ulcer increased by .2 cm in length, and R28's right thigh pressure ulcer increased by 1.7 cm in length. On 7/26/22 at 1:55 pm V17, Medical Director/Physician (MD) stated V17, MD expects all incontinent resident to receive timely incontinence care. MASD (Moisture-associated skin damage) causes skin breakdown. V17 also stated V17, MD was not informed (R28) had open areas caused by MASD. V17, MD stated V17, MD should have been informed. A treatment order would have been given. V17, MD also stated the Hydrocolloid dressing applied by the V7, LPN that	S9999		

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S9999	Continued From page 9 found the open areas was appropriate and should have been continued to prevent further breakdown. V17, MD also stated R2's incontinence saturation observed, and no dressings on the open wounds after R28 complained of being wet for hours, "Absolutely, caused the added pain, pressure ulcers and possibly further skin impairment." (B) Statement of Licensure Violations (2 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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	S9999		

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S9999	Continued From page 10 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to lower R19's bed after providing cares and left R19 unattended in an elevated bed by resulting in a fall with serious injury and failed to complete neurological assessments for R19's fall. This failure resulted in R19 sustaining a fracture of the left wrist. R19 is one of three residents reviewed for falls on the sample list of 21. Findings include:	S9999		

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S9999	Continued From page 11 R19's "Face Sheet" dated 6/30/17 documents the following diagnoses: "Guillain-Barre syndrome, Paraneoplastic Neuromyopathy and Neuropathy, Muscle Weakness Generalized, and Unsteadiness on Feet. R19's "Physician Order Sheet" (POS) dated July 1-31, 2022 documents the following: "Continue to wear splint, make appointment with (Private Hospital) 7/9/22. R19's Minimum Data Set (MDS) dated 6/10/22 documents the following: "Brief Interview of Mental Status" score of 15 out of a possible 15, (no cognitive impairment). The same MDS documents R19 has limited range of motion in one upper extremity, and bilateral lower extremities. The same MDS documents R19 is totally dependent on two staff for transfers and bed mobility. R19's Care Plan dated 6/26/22 documents the following: "(R19) will use bed rail for repositioning at every opportunity thru (through) next review. Bed in lowest position." The same Care Plan documents: "(R19) rolled out of bed, alleged fall. Fall mat placed, ed (education) given to (R19) and staff (unidentified) on bed in the lowest position." On 07/24/22 at 10:48 am, R19 was seated in R19's wheel chair next to R19's bed. R19 had a splint on the left wrist. R19 stated the following: "All is good here except, I fell out of my bed about a month ago (6/26/22) and fractured my (left) wrist. I had to wait several days before the facility would get an X-ray (second X-ray). I don't think I would have broke my wrist if the bed was in a lower position. It was high like it is now. (R19 points to the elevated bed. R19's bed was three	S9999		

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and a half feet above the floor). I (R19) Fell far and hard. They were worried about my head. I am hard headed. It (R19's head) didn't hurt but I kept telling them my left wrist hurt and I wanted an X-ray (completed 6/27/22 and 7/8/22). I should have put on my call light and waited for staff to turn me. I thought I could adjust my position in bed on my own. Obviously, I won't do that again."

R19's A.I.M. (Assess, Intercommunicate, Manage) for Wellness (nurses note) dated 6/26/22 (Sunday), signed by V6, Regional Director of Clinical Operations, documents the following: "Alleged fall." The same AIMS for Wellness note documents the following; "Manage, Physician recommendations and/or nursing interventions. X-Ray to L (left) wrist, may wait till Monday d/t (due to) patient (R19) request of not wanting to leave the facility and wait till Monday (6/27/22). Fall mat placed, and resident and staff educated on bed in lowest position." There was no documentation of neurological assessments noted on the AIM note or in the Nurse Notes after R19's unwitnessed fall.

R19's X-ray report dated 7/8/22 was ordered by V17, Medical Director documents the following: "Reason: Swelling, pain with movement post fall (6/26/22)." The same report documents "Left wrist, two views. Findings; see impressions. Impression: Acute distal ulnar fracture."

R19's Illinois Department of Public Health (IDPH), Final report (initial report 7/8/22 after second X-ray) dated 7/14/22 documents the following: "(R19) Rolled out of bed and landed on her arm. It was not fractured at the time of the incident but was later determined that her wrist was fractured." The same IDPH report documents: "Staff Interview: (V20, Certified Nursing Assistant)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003081	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DECATUR REHAB & HEALTH CARE CT	136 SOUTH DIPPER LANE DECATUR, IL 62522

(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 13 CNA, "I had laid resident (R19) down to use the bathroom, when I went back a few minutes later she (R19) was on the floor. I put a pillow under her head and the other CNA (V22) went to get the nurse (unidentified). On 7/26/22 at 9:55 am V7, Licensed Practical Nurse (LPN)/ Minimum Data Set Coordinator stated V7, LPN was the nurse that cared for R19 the day of R19's fall on 6/26/22. V7, LPN stated the fall was not witnessed. V7, LPN also stated "I should have initiated neurological assessment according to the policy, but I did not." V7, LPN stated "(V20, Certified Nursing Assistant/CNA) was the CNA that worked that day. "I re-educated (V20, CNA) to lower the resident beds after providing resident care so, this kind of thing doesn't happen to anybody else. I had noticed (R19's) bed was too high, immediately when I did her assessment (6/26/22)." V7, LPN also stated "When (R19) fell, (R19) complained of serious left arm pain. I can't remember if I gave her Tylenol, but I think I gave it (Tylenol)." V7, LPN also stated "(V17, MD) gave and order that day for x-ray that showed no fracture. It was about six days later that (R19) continued to complain of wrist pain and another X-ray was done. The second (X-ray) did show a fracture (left wrist). (R19) only had a skin tear the day of the fall from her bed. There was no swelling. I wanted to send (R19) to the hospital but (R19) refused. (R19) said she was ok and did not hit her head. I am pretty sure I gave Tylenol for the pain." On 7/26/22 at 2:10 pm V17, Medical Director stated the height of R19's bed should have been in the lowest position. The elevated height of the bed would increase the impact during the fall and was the likely the cause of R19's wrist fracture. V17, Medical Director also stated R19's fall was	S9999		

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S9999	Continued From page 14 unwitnessed, therefore neurological assessments should have been ongoing as our policy documents. The facility policy "Fall Prevention" dated December 2009 documents the following:" Policy: To provide for resident safety and minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: All staff. Procedure: (Number 5). Immediately after any resident fall the unit nurse will assess the resident and provide any care and treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions." Number 6. " The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new interventions deemed appropriate at the time. The unit nurse will also place any new interventions on the CNA assignment worksheet." The same Fall Prevention policy documents the following: "Fall Prevention Interventions: (Number 10.) Bed in lowest position-wheels locked." The facility policy "Head Injury:" dated reviewed 12/22/17 documents the following: "It is the policy of (Private Corporation) to evaluate head injuries for a minimum period of 72 hours, to determine any negative effects, and to allow for immediate treatment to minimize permanent damage." (B)	S9999		