Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009369	A. BUILDING: ______ B. WING ______	C 02/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORVILLE CARE CENTER	600 SOUTH HOUSTON TAYLORVILLE, IL 62568

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S 000	Initial Comments Complaint 2241424/IL143797	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident.

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.

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 observation, interview and record review the facility failed to timely identify/assess and initiate treatment and provide pressure relief to prevent the formation of/or worsening of pressure ulcers for 3 of 3 residents (R2, R3, R4) reviewed for pressure ulcers in the sample of 5. This failure resulted in R2 developing a facility acquired Stage 3 pressure ulcer to his sacrum which progressed to an unstageable pressure ulcer and R4 developing a facility acquired unstageable pressure ulcer to his right heel.

Findings include:

1.R2's Electronic Medical Record (EMR) dated 2/2022 documents R2 was admitted to the facility

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S9999	Continued From page 2 on 1/26/22 with diagnoses to include Pneumonia due to SARS-Associated Coronavirus, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease, Benign Prostatic Hyperplasia. R2's Care Plan dated 2/2/22 documents "I am at risk for pressure ulcers or skin breakdown related to decreased mobility and weakness, recent COVID positive with pneumonia, COPD, legally blind, Peripheral Vascular Disease (PVD), Diabetes Mellitus (DM)." R2's Care Plan Interventions document "Please monitor my skin for redness, irritation, and report to my nurse, Keep skin clean and moisturized. Date Initiated: 2/7/22. Please remind/assist me to turn and reposition every 2 hours and as needed (PRN). Date Initiated 2/7/22." R2's Shower Sheet dated 1/28/22 documents R2 has an old dark spot on his left great toe and has a circle around the coccyx area which documents "may be open". R2's Skin Assessment dated 1/28/22 documents, "Weekly skin check. Skin intact. Groin red, cream applied. No open areas noted. medical doctor (MD) faxed for treatment (Tx)." R2's Skin Assessment dated 2/4/22 documents Stage 3 pressure ulcer to sacrum with measurements 7.0 X 2.5 X 0.25 centimeters (cm). There was no documentation in R2's medical record from 1/28 to 2/4/22 regarding this pressure ulcer. R2's Minimum Data Set (MDS) dated 2/10/22 documents R2 requires extensive assist of two for bed mobility.	S9999		

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S9999	Continued From page 3 R2's Transfer Form to hospital, dated 2/10/22 documents unstageable coccyx ulcer. The National Pressure Injury Advisory Panel website documents an unstageable pressure ulcer as "Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed." R2's local Emergency Room documentation dated 2/10/22 includes, "Clinical Impression: Benign Prostatic Hyperplasia (BPH) with urinary retention, Acute Cystitis with Hematuria, Low Magnesium, Chronic Anemia, Low Potassium, Elevated Glucose with DM2, Acute Renal Injury, obstructive, Sacral Decubitus with Fibrous exudate, 2 scrotal wounds, stage 2, bilateral pedal edema. Noted 3-centimeter (cm) X 2 cm open area on left side of scrotum, area cleansed, dried and covered with Mepilex. Also has a 1 cm X 1 cm open area on anterior lower scrotum, area cleansed a Mepilex applied. Patient turned to left side, has dried stool on buttocks and a large dressing on upper to mid buttocks. Dressing removed has a large irregular shaped wound to both sides of buttocks. Wound has minimal redness around outer edges, some yellow discoloration and some black areas noted. Large amount of yellowish tan foul-smelling drainage present. Wound rinsed with normal saline and packed with normal saline soaked gauze and covered with abdominal dressing (ABD)." On 2/23/22 at 11:00 AM, V2, Director of Nurses (DON), stated, "I would expect a residents pressure ulcer to be identified prior to it being a Stage 3."	S9999		

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S9999	Continued From page 4 2. R4's Electronic Medical Record (EMR) dated 2/2022 documents R4 was admitted to the facility on 1/14/22 with diagnosis to include, Parkinson's, Dementia, Acute Cystitis with Hematuria, Urinary Tract Infection (UTI), Hyperosmolality, Hypernatremia, Anemia, Hypothyroidism, Acute Kidney Failure. R4's Shower Sheet dated 1/15/22, 1/22/22 does not document any skin issues. R4's Shower Sheet, dated 2/7/22, documents, Right heel diagram has a circle around it and documents, not new, came with a spot. R4's Shower Sheet, dated 2/13/22, buttock diagram has a circle around it and documents "old'. The Shower sheet did not have any documentation regarding R4's right heel. R4's Shower Sheet dated 2/16/22 documents no abnormalities. R4's Shower Sheet dated 2/22/22 documents no abnormalities and does not include any documentation regarding R4's right heel or his buttocks. R4's Skin Assessments dated 1/14/22, 1/24/22, 1/31/22 all document no skin issues, no open areas. R4's Skin Assessment on 2/4/22 documents laceration to face. R4's Skin Assessment dated 2/7/22 documents right inner buttock pressure ulcer stage 2. R4's Skin Assessment 2/15/22 documents skin	S9999		

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tear to right elbow and abrasion to vertebra. R4's Skin Assessment had no documentation regarding R4's right heel or buttocks.

R4's Skin Assessment dated 2/17/22 documents Unstageable Pressure Ulcer Right Heel, In House Acquired measurements 1.9 centimeters (cm) X 1.5 cm X 2.0 cm, Eschar (dead tissue) 100%.

R4's Initial Wound and Management Summary, dated 2/13/22, written by V9, Wound Doctor, documents, "Unstageable (Due to Necrosis) of the Right Heel Full Thickness. Wound Size 2 X 2.5 cm. Surface Area 5.00. Thick Adherent black necrotic tissue (eschar) 100%. Dressing Treatment Plan: Betadine apply twice daily for 30 days. Recommendations: Elevate legs; Float heels in bed; Off load wound; Reposition per facility protocol; Turn side to side and front to back in bed every 1-2 hours if able."

R4's Care Plan dated 1/27/22 documents "I am at risk for pressure ulcers or skin breakdown related to decreased mobility, bowel incontinence. 2/23/22 I have an unstageable pressure injury to my right heel and redness to my buttocks. Interventions: Do a daily skin check and notify my family and MD of any new areas. Date Initiated: 1/27/22. Please monitor my skin for redness, irritation and report to my nurse. Keep skin clean and moisturized. Date initiated 1/27/22. Please remind/assist me to turn and reposition every 2 hours and PRN. Treatment as ordered to my right heel. Date initiated 2/23/22."

R4's MDS dated 1/21/22 documents Basic Interview for Mental Status (BIMS) cognition intact. Functional Status: Needs extensive assist of two for bed mobility.

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S9999	Continued From page 6 On 2/22/22 at 2:10 PM, R4 was lying in his bed on his back, his right heel is resting on the mattress and was not off loaded. At 2:55 PM, R4 was in the same position, right heel is not off loaded. On 2/23/22 at 10:00 AM, R4 was laying in his bed on his back and his right heel was not off loaded. On 2/23/22 at 2:00 PM, V2 was asked if the first time R4's unstageable pressure ulcer was identified was when V9 wound doctor did his initial wound assessment on 2/13/22. V2 stated, "(V9) was not in the facility on 2/13/22 he was here on 2/10/22 and identified R4's right heel pressure ulcer then. His document is dated on 2/13/22 because that is when he documented it. "Yes, that is when the wound was first identified." On 2/24/22 at 10:25 AM, V11 Licensed Practical Nurse (LPN) looked in R4's EMR to see when R4's pressure ulcer was first identified and stated, "I would assume if (V9) came to the facility on 2/10/22 that is when it was first identified." On 2/24/22 at 12:15 PM, V2 was asked if R4's heel should be off loaded and she stated, "What do you mean?" V2 was asked again would you expect R4's heel to be floated so it is not resting on the bed, she stated, "Yes". 3. R3's EMR documents, Physician Order Sheet (POS) dated 11/19/21 documents, "Cleanse area to coccyx/right buttock with generic wound cleanser and apply calcium alginate and cover with border gauze every day and PRN (as needed) for soiling or dislodging." R3's Care Plan dated 10/15/21, Focus: "Resident is at risk for impaired skin integrity related to	S9999		

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S9999	Continued From page 7 impaired mobility, incontinence. The resident has a stage 2 pressure ulcers to left buttock, right buttock and sacrum." The Care Plan documented "Administer treatments as ordered and monitor for effectiveness. Follow facility policy/protocols for the prevention/treatment of skin breakdown. Date initiated 10/15/21." On 2/23/22 at 9:50 AM, prior to watching V11 Licensed Practical Nurse (LPN) provide wound care for R3's pressure ulcers, no dressing was in place to R3's pressure ulcer. The facility Policy and Procedure for Wound Management Program dated June 2020 documents "It is the policy of this facility to manage resident skin integrity through prevention, assessment, and implementation and evaluation of interventions. Procedures: 1. The facility is provided with Wound Care Protocols. These are to be utilized to assist in the care and treatment of wounds." The Policy and Procedures documents "4. The facility will assess all residents weekly for current skin conditions. a. The charge nurse for each hall will do skin assessments. A schedule will be established to identified room/bed day and shift. b. Any resident that scores very high risk, high risk, or has a wound present will have a skin check documented daily to identify new or worsened areas. d. The weekly skin assessment will be documented on the skin assessment in PCC (Point Click Care). i. Indicate the location of ant identified areas on the body figure. ii. Describe the area(s) on the line provided. iii. Give a detailed description of the area in the common box. e. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it. h. The nurse responsible for treatments will review all daily documentation and review any new areas. i.	S9999		

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S9999	Continued From page 8 The nurse will measure the area; call physician to obtain appropriate treatment order, call the guardian/family member to inform him/her, and initiate the treatment. 5. The skin assessment should also be completed whenever a new skin condition is noted. 6. All wounds will be reported weekly in PCC EHR system, using the skin and wound evaluation assessment." (A)	S9999		