STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005292	A. BUILDING: _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

(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 Complaint 2212417/IL145127	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)2)3) 300.1210d)5) 300.1220b)3) 300.3220f) 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 300.1010 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999		

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S9999	Continued From page 2 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new	S9999		

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S9999	Continued From page 3 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. (Section 2-104(b) of the Act) 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 interview and record review the facility failed to ensure weekly assessment and monitoring of pressure ulcers were completed for residents (R1 & R2). The facility failed to ensure pressure ulcer treatments were being done as ordered for residents (R1 & R7) and a care plan was in place for a resident with pressure ulcers (R2). These failures resulted in R1 developing a sacral abscess and osteomyelitis. This applies to 3 residents (R1, R2 & R7) reviewed for pressure ulcers. The findings include: 1. The MDS (Minimum Data Set) dated 12/12/21 for R1 showed extensive cognitive impairment; limited assistance required for bed mobility, transfers, toilet use, and personal hygiene. The Nurse's Notes for R1 showed, "12/17/21 - Shower given this morning. Buttocks remain macerated. R1 resting in recliner at this time; 12/22/21 - Shower given. No new skin issues observed. Open area to buttocks remains."	S9999		

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S9999	Continued From page 4 The wound consultant's Visit Report dated 1/4/22 for R1 showed, "Wound #1 is a Stage 3 pressure and has received the status of not closed. Initial wound encounter measurements are 5 cm (centimeters) x 1 cm x 0.1 cm.... Tunneling has been noted at 1:00 (o'clock position) with a maximum distance of 3 cm. No sinus tract has been noted. No undermining has been noted. Wound bed has 1-25% slough, no granulation; no eschar and no epithelialization present. Plan-Wound orders: sacral pressure ulcer; apply collagen powder 1 gram to the wound every day for 21 days. Border dressing 4.3" x 4.3", pad 3" x 3" every other day for 21 days. Cleanse wound with wound cleanser or normal saline per facility, apply collagen, cover with bordered dressing. Change every other day." The January 2022 TAR (Treatment Administration Record) for R1 did not show the wound orders from the wound consultant's Visit Report dated 1/4/22 entered as an order or the treatment being done after the order was given from 1/4/22 through 1/20/22 when the wound care order was changed. The facility did not have weekly wound measurements or wound assessments completed for R1 after 1/4/22 through 1/24/22 (20 days) when the next Skin/Wound Note was documented. The January 2022 TAR for R1 showed, "1/20/22 - Treatment to coccyx - cleanse outer wound with wound wash, pat dry, gently pack with iodoform. Change twice a day, days, and nights with skin prep to the peri-wound and cover with a 3" x 3" foam dressing. Re-evaluate in one week." On 1/22/22 at 8:00 AM the dressing change was not	S9999		

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S9999	Continued From page 5 documented as being completed. R1's Nurse's Notes did not show that R1 was out of the facility or refused care on 1/22/22. The Skin/Wound Note dated 1/24/22 for R1 showed, "Open area present and measures 2 cm x 1 cm x 1 cm. Wound Consultation with wound provider. Treatment orders after consultation = calcium alginate, collagen, and bordered dressing. Change daily and PRN (as needed). The facility did not have weekly wound measurements or wound assessments documented as being completed for R1 between 1/27/22 through 2/14/22 (a seventeen-day time period). On 3/20/22 at 3:20 PM, V3 DON (Director of Nursing) stated that they were unable to locate weekly wound assessments for R1. V3 stated V7 was the wound nurse but she quit on 1/27/22. Wound Measurements are to be done weekly and assessments are to be done with each dressing change. Assessments were supposed to be on the Wound - Weekly Observation Tool or in the progress notes." On 3/20/22 at 3:30 PM, V3 DON stated, "The last time I saw R1's wound it was macerated and that was in December 2021. On 1/4/22 they put down R1's wound was acquired then because it was macerated before." R1's TAR dated January 2022 showed, "1/26/22 - Wound orders to coccyx - calcium alginate, collagen, bordered dressing. Change daily and as needed in the evening." The wound treatment was not documented as being completed on 1/28/22 at 9:00 PM.	S9999		

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S9999	Continued From page 6 The Nurse's Note dated 1/29/22 for R1 showed, "Treatment to coccyx completed. R1 had no packing and no dressing on the wound. Unsure of how long the wound was exposed but there was a large amount of musty smelling drainage light to faint green color and thin in consistency." The February 2022 TAR (Treatment Administration Record) for R1 showed the facility was doing the following wound orders: to open macerated area on gluteal cleft/coccyx - cleanse daily, apply skin prep to the peri wound. Put a small piece of calcium alginate in the wound bed, cover with a piece of gauze and secure with tape every evening. The order was dated 9/8/21 and showed that it was marked off as being completed on the 3-11 shift on 2/1/22 and 2/2/22; 2/4/22 through 2/10/22; 2/12/22 - 2/15/22; and 2/18/22. The current wound order to be completed by the facility was entered under the wound order dated 9/8/21 on R1's 2/2022 TAR and showed, "wound orders to coccyx - calcium alginate, collagen, bordered dressing. Change daily and as needed in the evening with a start date of 1/27/22." The treatment was marked as being completed at 9:00 PM on 2/1/22 and 2/2/22; 2/4/22 through 2/10/22; 2/12/22 - 2/15/22; and 2/18/22. The Nurse's Note dated 2/16/22 for R1 showed she was transferred to the hospital on that date and never returned to the facility. The February 2022 TAR showed both treatments were documented as being completed on 2/18/22 and R1 was not in the facility. On 3/30/22 at 1:04 PM, V3 DON (Director of Nursing) stated when a treatment is done it is marked on the TAR (Treatment Administration Record). If the box on the TAR is not checked then the treatment was not done. V3 stated it is important to do wound care treatments as	S9999		

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S9999	Continued From page 7 ordered otherwise the wound will not get better." The Order Summary Report for R1 showed, "2/12/22 - Observe wound dressing to ensure placement and integrity of the dressing. Location of dressing to coccyx, every day and night shift related to pressure ulcer of sacral region, unstageable. Please note if dressing required replacement." The Wound-Weekly Observation Tool dated 2/14/22 for R1 showed R1 had a facility acquired stage 4 pressure ulcer to her coccyx, infection was suspected and there was a "green slimy exudate noted." The evaluation of the wound progress showed a worsening wound bed with increase in size, purulent drainage, odor, and fecal matter noted in the wound from stooling. The wound consultant's Visit Report dated 2/15/22 for R1 showed, "Wound #1 sacral is an unstageable pressure injury; obscured full-thickness skin and tissue loss pressure ulcer and has received the status of not closed. There is a heavy amount of purulent drainage noted which has a strong odor. Possible infection due to fecal matter invasion of the wound bed. Green discharge noted in the wound bed. Plan: apply collagen sheet 2" x 2" silver to the wound every day for 30 days. Apply gel fiber silver rope 18" to the wound every day for 30 days. Cover the wound with bordered foam dressing 4" x 4" every day for thirty days. Cover the wound with a bordered super absorbent 3.5" x 4" every day for 30 days. Cleanse wound with wound cleanser of normal saline, gently pat dry, apply collagen to wound bed, apply ropes into all undermined areas of wound snuggly, dress with a bordered dressing. Change daily." The order was not entered into the physician orders for R1.	S9999		

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S9999	Continued From page 8 The Hospital Assessment and Plan History & Physical dated 2/16/22 showed, "Stage 3 pressure ulcer of the sacral region. Infected decubitus ulcer." The Hospital Wound Care Progress Note dated 2/16/22, "Abscess, sacrum. Osteomyelitis of vertebra, sacral and sacrococcygeal region. Suggest follow up with general surgery for the sacral ulcer." R1's Care Plan initiated 2/18/21 and revised 2/21/22 showed, "Risk for impaired skin integrity. Consult wound, ostomy and continence nurse as appropriate. Evaluate for bowel continence. Evaluate for urinary continence. Evaluate skin areas for blanching or redness. Monitor for moisture, apply barrier product as needed. Monitor resident's nutritional intake. Documented pressure ulcer - sacral. Encouraged resident to frequently shift weight. Monitor nutritional status. Monitor ulcer for signs of progression or declination. Provide skin care per facility guidelines and as needed. Provide wound care per treatment order." The facility's Skin Treatment - Guidelines for Pressure Injuries (3/2020) policy showed, "Identify the underlying cause as pressure, sheer, friction, maceration, or a combination of these factors. Confirm the physician has been notified that the resident has a pressure injury and is aware of the current status. Document in the progress notes. Indicate dressing change date, time and initials on dressing. Complete this (Weekly Pressure Injury Evaluation) form in the clinical software weekly until the injury is resolved. Document dressing completion on the TAR".	S9999		

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S9999	Continued From page 9 On 3/30/22 at 5:00 PM, V14 NP (Nurse Practitioner) stated, "On 1/19/22 I got a text about R1's wound from them. I told them to send R1 to the wound clinic. It was the first I had heard of the wound; it was on her bottom. I told V7 LPN (Licensed Practical Nurse/Wound Nurse) to get R1 to the wound clinic. I told the facility four times to take R1 to the wound clinic and I considered that an order. I still have the text on my phone to show I ordered it. R1 ended up with a good wound infection. R1's wound really needed better care, proper dressings and to get R1 off her butt. R1 never went to the wound center for her sacral wound. Every time I went to the facility R1 was up in a chair. I saw a picture of R1's wound on 1/24/22. I told the facility to lay R1 down more. I saw R1's wound on Superbowl Sunday when I walked down the hall and the CNA (Certified Nursing Assistant) was putting R1 into bed. R1 was soiled and having loose stools. I helped her clean R1 and she had feces in the wound. There wasn't a dressing on the wound. The wound should have been assessed weekly and should be documented. R1 had an osteomyelitis; it can happen to sacral wounds. I was never alerted about dressing change orders or that there was brown drainage. R1 needed more expert care. Nurse's complained to me that dressing changes were not being done the way they are supposed to be:" On 3/31/22 at 3:01 PM, V8 LPN stated, "I wasn't doing all of R1's dressing changes. R1's dressings were supposed to get changed more frequently, get packed, and have a dressing on it. When I started a couple of months ago, I put some of R1's treatment orders in. The wound care consultant would put recommendations in, but I don't know where she would write them. If I	S9999		

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S9999	Continued From page 10 saw the recommendations, I would turn them into an order. The latest order takes priority." 2. On 3/30/22 at 9:57 AM, R7 was lying on her back in her bed. The air mattress was not turned on or plugged in. At 12:36 PM, R7's air mattress was unplugged. R7 stated her bed mattress felt different and that it had been like that for a while. The Order Summary Report dated March 2022 for R7 showed: "2/7/22 - Pressure relieving device (air mattress/pump) is plugged in and working properly every shift for preventative - skin." The Wound - Weekly Observation Tool dated 3/20/22 for R7 showed a facility acquired stage 2 pressure ulcer to her left buttock. On 3/30/22 the facility did not provide any information for a pressure ulcer to R7's right buttock. The wound consultant's Wound Orders dated 3/30/22 for R7 showed she has a stage 2 pressure ulcer to her left buttock and an unstageable pressure ulcer to the right buttock. The wound orders for the right buttock pressure ulcer were to apply collagen powder 1 gram to the wound every day for thirty days. Cover with an allevyn bordered dressing every day for 30 days. Cover with a bordered super absorbent dressing for 30 days. Apply triad cream to the wound every day for 30 days. The wound orders for the right buttock showed to apply collagen powder 1 gram to the wound every day for 30 days. Apply a cool border pad dressing to the wound every day for 30 days. On 3/30/22 at 1:04 PM, V3 DON (Director of Nursing) stated, "Having the nurses check off the TAR for the air mattresses is on there as a part of	S9999		

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S9999	Continued From page 11 a plan of correction. R7's bed should be plugged in because it is a preventative measure for pressure. It is important to do wound treatments as ordered because how will it get better unless you do it." On 3/31/22 at 2:25 PM V9 CNA (Certified Nursing Assistant) and V10 CNA were in R7's room and transferred her back to her bed. V9 and V10 provided incontinence care because R7's catheter was leaking. They turned R7 onto her side and the resident had a slit to her right buttock and open areas to her left buttock. both buttocks were reddish-purple in color. There were no dressings in place to her buttocks. On 3/31/22 at 3:01 PM, V8 LPN (Licensed Practical Nurse) stated, "I come in on Mondays and try to see everyone for wound care. Another nurse and I split up wound care. We each have a list. R7 is my resident, and she has a treatment of triamcinolone cream with nystatin cream and no dressing. R7's bottom looks the best that it has. R7 has been noncompliant in the past. R7 has totally changed now and is more compliant. The wound care consultant would put recommendations in, but I don't know where she would write them. If I saw the recommendations, I would turn them into an order. The latest order takes priority. The wound care consultant and I had done wounds, and I would measure, and she would document. We would then enter those. When the wound care consultant left, she took my notebook and I never got it back." The facility's Skin Treatment - Guidelines for Pressure Injuries (3/2020) policy showed, "Indicate dressing change date, time and initials on dressing. Complete this (Weekly Pressure Injury Evaluation) form in the clinical software	S9999		

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S9999	Continued From page 12 weekly until the injury is resolved. Document dressing completion on the TAR." R7's Care Plan dated 12/21/21 showed, "The resident has pressure ulcers, 2 stage 2 pressure ulcers of the buttocks and 1 venous stasis ulcer of the left lower extremity. Administer treatments as ordered and monitor for effectiveness. Educate me/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; frequent repositioning. The Diagnosis Report dated 3/30/22 for R7 showed diagnoses including dehydration, urinary tract infection, cellulitis, syncope and collapse, sepsis, acquired absence of right leg above the knee, acute pyelonephritis, hypertension, heart failure, muscle weakness, diabetes, peripheral vascular disease, difficulty walking, idiopathic progressive neuropathy, major depressive disorder, and atrial fibrillation. 3. The Nurse's Notes for R2 showed, "12/14/21 - Received a shower. No new skin concerns noted. Slight redness to buttocks. Barrier cream applied; 12/19/21 - coccyx wound clean with no drainage - skin prep reapplied and optifoam; 12/29/21 - Shower given this shift. Open area remains to coccyx. Dressing changed; 1/11/22 - new dressing to buttocks early this AM per nurse." No measurements, staging or assessments of R2's coccyx wound were documented in these Nurse's Notes. The Nurse's Notes didn't have staging, measurements or assessments of the wound from 12/19/21 through 1/11/22. R2's medical record did not have any other weekly assessments completed to includ the stage, measurement, and description of the wound. The Skin/Wound Notes dated 1/12/22 for R2	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005292	A. BUILDING: _____ B. WING _____	C 03/31/2022

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LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

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S9999	Continued From page 13	S9999		

showed, "Open area to coccyx remains, dressing applied per orders." No wound measurements, staging of the wound, or description of the wound were documented. The next wound assessment was 12 days later on 1/24/22.

The Skin Only Evaluation dated 1/24/2 for R2 showed a stage 2 pressure ulcer/injury to the coccyx.

The Skin/Wound Note dated 1/24/22 for R2 showed, "Assessment to coccyx wound, area measures 2.1 cm x 1.4 cm x 0.2 cm. Wound consultation; treatment orders after consultation - collagen powder, triad cream and bordered dressing. Change daily and as needed."

The Wound - Weekly Observation Tool dated 2/2/22 for R2 showed the status of the form as "still in progress" for a coccyx wound that was facility acquired with no date given when it was acquired. Pressure was marked on the form, but no stage was given. The current treatment plan was documented as collagen powder, triad cream, bordered dressing. Change daily and as needed.

R2's Care Plan was closed on 2/7/22 after her death. R2's Care Plan that was closed and then printed on 3/31/22 did not show that she had a focused care area with interventions in place for pressure ulcers.

On 3/30/22 at 2:56 PM, V3 DON (Director of Nursing) stated, "Our previous wound nurse (V7) worked here from 9/28/21 to sometime in December. V7 LPN (Licensed Practical Nurse/Wound Nurse) did not use the skin notes or weekly wound observation tool in the computer. V7 did a spreadsheet and binder. At

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3:20 PM, V3 came back and stated there was only one wound assessment per resident with wounds in the binder and it is the same as what is in the computer. V3 stated they could not find the weekly assessments. V3 then stated V7 quit on 1/27/22 after being cited related to wound measurements. V3 stated the wound assessments will pop up for the nurse's to do. V3 stated, "Measurements are to be done weekly. Assessments are to be done with each dressing change and should be documented on the wound - weekly observation tool or in the progress notes."

On 3/30/22 at 5:00 PM, V14 NP (Nurse Practitioner) stated, "I saw R2 for her monthly visit and she had a bad wound to her bottom. I think the pressure ulcers get so bad there (facility) because I don't think the residents get turned the way they should be. The preventative measures could be better."

The MDS (Minimum Data Set) dated 2/2/22 for R2 showed impairment of memory and cognition; extensive assistance needed for bed mobility, transfers, dressing, toilet use, and personal hygiene; stage 2 pressure ulcer.

The facility's Skin Treatment - Guidelines for Pressure Injuries (3/2020) policy showed, "Identify the underlying cause as pressure, sheer, friction, maceration, or a combination of these factors. Confirm the physician has been notified that the resident has a pressure injury and is aware of the current status. Document in the progress notes. Indicate dressing change date, time, and initials on dressing. Complete this (Weekly Pressure Injury Evaluation) form in the clinical software weekly until the injury is resolved. Document dressing completion on the

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S9999	Continued From page 15 TAR". (A)	S9999		