STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003487	A. BUILDING: _____ B. WING _____	02/14/2022

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 d)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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.

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 requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to effectively monitor and

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apply interventions to prevent new pressure wounds from forming for 2 of 5 residents (R4 and R44) reviewed for residents at risk for skin breakdown in the sample of 45. This failure resulted in R44 acquiring an unstageable pressure ulcer to the right heel causing pain and discomfort.

Findings include:

1. R44's EHR (Electronic Health Record) showed R44 was admitted to this facility on 2/17/2015, with diagnoses of Cerebral Palsy, Abnormal Posture and Wheelchair Dependency among others.

R44's most recent MDS (Minimum Data Set) assessment, completed on 2/10/2022, documents R44 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R44 is cognitively intact. R44's MDS further documents R44 is wheelchair dependent, has impaired movement in both legs, is unable to walk, and is totally dependent on staff for all transferring needs.

R44's Current Care Plan documents, in part, R44 is, "At Risk For Alteration in Skin Integrity, Category: Baseline CP (Care Plan)- Skin Integrity.. Start Date 3/14/2020, Status Active.. Care Plan Goal: Will not develop Skin Breakdown.. Intervention.. Float heels while in bed. Start Date 3/14/2020.. Observe for signs and symptoms of breakdown/infections. Start Date 3/14/2020."

R44's Nurses Note, dated 2/6/22 at 5:42 AM, documents, "Res (resident) noted to have an unstageable pressure ulcer to his right heel measuring 3cm (centimeters) x 3cm. Black

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necrotic tissue covers the wound and there is no drainage present at this time. Staff was educated they must float residents heels with pillows and reposition him often. Res stated he has not been eating much since he got sick with COVID. Res should be encouraged to get plenty of nutrition and to make sure his heels are floating at all times and off the bed.. PCP (Primary Care Physician) notified via fax and day nurse to follow up Monday for tx (treatment) orders."

R44's Wound Assessment, dated 2/6/22, documents, in part, "Wound type: Pressure Ulcer, Wound Location: Right heel; unstageable pressure ulcer, Date wound identified: 2/6/22, Present upon admission: No, Assessment Occasion: New Wound, Stage Unstageable due to slough/eschar, Measurements: Length- 3.00cm, Width- 3.00cm, Depth- 0.00 com ...Pain with wound/treatment; Yes, Pain Intensity: Grimacing, Pain Management: Yes ... Physician notified: Yes (PCP via fax), Date Physician Notified: 2/6/22.. Date electronically signed: 2/6/22 (V18, Registered Nurse/RN)." Under notes, "Some questions asked in the wound manager I was unsure how to answer. The wound I completely covered with hard black eschar and perfectly round 3cmx3cm, there is no drainage present, but I am unsure if there is tunneling or any type of sloughing underneath. Applying calcium alginate and dry dressing unless PCP suggests something different."

On 2/7/2022 at 2:30 PM, R44 was heard yelling for help from R44's room on the 600 hallway, which is the Covid isolation unit. R44 said R44 was told by some girl (V3, Certified Nursing Assistant) R44 was able to leave the isolation unit earlier in the day, and R44 was tired of waiting and was ready to go. According to R44's EHR

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(Electronic Health Record), R44 was diagnosed with Covid-19 on 1/20/2022, and was placed into isolation in the facility's Covid unit on the 600 hallway until recovered. R44 was observed in R44's bed on the Covid unit in a gown, without foot coverings, and both heels setting directly on R44's mattress. V3 (Certified Nursing Assistant) said R44 had completed R44's isolation period, and V3 planned on giving R44 a shower before R44 returned to R44's usual room. V3 said V3 was new, and had only worked at this facility for two days. At 2:55 PM, V3 got R44 up for a shower, and R44 was observed with a large round black wound to R44's right heel. At that time, V3 did not acknowledge the wound, or make any comments about it.

On 2/9/2022 at 9:45AM, R44 said R44 developed a sore on R44's heel while R44 was sick with Covid on the Covid unit, and it causes R44 pain when touched. R44 said R44 did not know how the wound developed, but it did. R44 was observed in R44;s room sitting in R44's bedside recliner. R44 had R44's feet elevated on the recliners footrest, and had a pair of tennis shoes on both feet, and no pressure relieving interventions were noted to be in place.

On 2/9/2022 at 2:00 PM, R44 was observed up in R44's electric wheelchair. R44 had tennis shoes on, and no pressure relieving interventions were noted to be in place.

On 2/9/2022 at 10:30 AM, V2 (Director of Nursing) said R44's wound was first documented on 2/6/2022 at 4:30 PM as a new wound, developed in house, and was completely covered with hard black thick skin and perfectly round 3cm X 3cm, and was without drainage. V2 said when V2 last saw R44's right heel, it was red and

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"mushy" and not black, but did not remember the date of V2's observation. V2 said V2 thought the staff was treating the heel appropriately with pressure relieving interventions, and did not know the right heel had continued to decline. V2 said R44's doctor ordered a treatment of Calcium Alginate and dry dressing to be applied daily.

On 2/9/2022 at 10:30 AM, V2 (Director of Nursing) provided a facility document titled "Bath Aide Skin Report", dated 1/18/2022 completed by V19 (Certified Nursing Assistant), and signed off by V20 (Licensed Practical Nurse), which showed R44 had a shower, but did not mark any old or new skin issues noted at the time of showering. V2 provided another "Bath Aide Skin Report", dated 2/7/2022 completed by V3 (Certified Nursing Assistant), and signed off by V12 (MDS-Minimum Data Set/ CPC-Care Plan Coordinator), which showed R44 received a shower on the dayshift, and neither V3 (Certified Nursing Assistant) nor V12 (MDS/CPC Coordinator) made note of R44's right heel wound, which was discovered on 2/6/2022.

On 2/9/2022 at 1:30 PM, V13 (Licensed Practical Nurse) said R44's right heel wound was discovered on 2/6/2022, but V13 was not aware of the wound until 2/9/2022, when V13 returned to work. V13 said R44 needs extensive assistance for turning and repositioning of R44's body because R44 is not able to move properly due to his Cerebral Palsy. V13 said R44's right heel had developed an unstageable pressure wound while R44 was sick with Covid.

On 2/9/2022 at 2:30 PM, V2 (Director of Nursing) said R44 should not have both tennis shoes on, and should be wearing a pressure relieving booty on R44's right heel until R44's right heel pressure

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S9999	Continued From page 6 is healed. On 2/10/2022 at 10:30 AM, V12 said at the time V12 signed off on R44's Bath Aide Skin Report, V12 was not aware of R44 having a new wound to R44's right heel, and would have indicated it on the bath form if V12 had known about it. V12 denied being R44's assigned nurse on 2/7/2022, but said V12 will sign bath sheets for the staff if V12 is present when the shower is performed. V12 said by signing the Bath Aide Skin Report, V12 was responsible for the accuracy of the skin assessment. V12 said V12 must have missed seeing R44's black right heel wound. On 2/10/2022 at 1:00 PM, V2 (Director of Nursing) reviewed R44's weekly skin assessments for the month of January 2022/February 2022 (1/7, 1/14, 1/21, 1/28, 2/4), and verified all show R44's skin assessment state R44's skin is intact and no new wounds or skin issues are documented. 2. R4's Electronic Medical Record, documents R4 was admitted to the facility on 6/27/2016, with the following Diagnoses: Cellulitis, Malignant Neoplasm of Right Kidney, Morbid (Severe) Obesity, Lymphedema, Chronic Obstructive Pulmonary Disease, and Chronic Systolic Heart Failure. R4's Current Care Plan documents a Care Plan Description of Maintain or improve Skin Integrity-See POS (Physician Order Sheet)/Treatment Record/Wound Assessment for current treatments or measurements if applicable.. Category Skin, Type On-going with Start Date 10/26/21 with Status Active.. Care plan goal: Remains free from skin breakdown/maintains/or	S9999		

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improves. Intervention: keep skin clean and dry, Status-active, Frequency each shift, Start date 10/26/21. Intervention: Provide pillows or other supportive/protective devices to assist with positioning, turn and reposition every 2 hours and PRN (resident will turn herself back even with positioning devices). Status Active, Frequency each shift, Start date 10/26/21. Intervention: Assess changes in skin status that indicate worsening of pressure ulcer and notify the physician.. Status active, Frequency each shift, Start date 10/26/21.

R4's Physician Order for February 2022 document in part, "Order date 10/27/21, Start date 11/4/21, Time code 6A-6P Weekly Skin Inspection.. Order date 10/27/21, Start date 10/27/21, Time Code BID 2 (2 times daily) Apply Barrier Cream to L (left) and R (right) hip/buttocks on (excoriation) BID.. Order date 11/29/21, Start date 11/29/21, Time code 6P-6A Give partial bed bath to peri area/bottom daily at night. Offer PRN (as needed) pain med 1 hour prior to care to increase compliance."

On 2/08/22 at 8:42 AM, during peri-care done by V25 (Nurse's Aide), a Pressure Wound 2.0 X 3.0 centimeters in diameter was noted to R4's left mid buttock. V2 (Director of Nursing) was in the room, and measured the wound on R4's buttocks, and said this was the first time V2 had seen the wound.

R4's Progress Note, dated 2/8/22 at 10:16 AM, documents: Wounds reviewed today Stage 2 to sacrum. Healthy wound bed, 100% Epithelial, Area is 2.10 X 2.80 X 0.0. No current S/S (Signs and Symptoms) of infection. Treatment is apply a foam dressing, give super cereal, fortified juice and milk, health shake for wound healing. POA

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S9999	Continued From page 8 (Power of Attorney) and M.D. (Medical Doctor) updated about wound. On 2/9/22 at 1:10PM, V13 (Licensed Practical Nurse) stated V13 normally works with R4 on R4's hall, and V13 was unaware R4 had a wound to R4's buttock. V13 stated due to R4's medical diagnosis, R4 has a history of pressure ulcers, but those wounds have healed. V13 stated there was no treatment to prevent R4's wound being given to R4. The Matrix for Providers, provided to Surveyor on 2/7/22, had no documentation R4 has a Pressure Ulcer. R4's Bath Aide Skin Reports, dated 1/25/22, 1/29/22, 2/1/22, and 2/5/22 do not document any Pressure Wound to R4's buttock. The Prevention of Pressure Ulcers/Injuries policy, dated July 2017, Documents: The purpose of this procedure is to provide information regarding identification of pressure ulcer/Injury risk factors and intervention for specific risk factors. #4 Inspect the skin on a daily basis when performing or assisting with personal care of ADLs (Activities of Daily Living). Identify any signs of developing pressure injuries. (B)	S9999		