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
	IL6007306	A. BUILDING: ______ B. WING ______	C 10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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 Investigation 2228342/IL152405	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	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure physician ordered pressure relief boots to prevent skin breakdown were in use for one of three residents (R3) reviewed for pressure ulcers in a sample of four. This failure resulted in R3 developing a stage four pressure ulcer to the right ankle.

Findings include:

A Skin Assessment Policy and Procedure dated 2005 states, "It is the policy of this facility to monitor the skin integrity for signs of injury and irritation. In addition to ongoing assessment of the skin, the facility will implement measures to protect the resident's skin integrity and to prevent

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skin breakdown."

R3's Minimum Data Set (MDS) assessment dated 9/8/22 documents R3 is severely cognitively impaired and is totally dependent on staff for all care including bed mobility, transfers, dressing, toilet use and personal hygiene.

R3's Braden Scale for Predicting Pressure Ulcer Risk assessment dated 9/7/22 documents R3 only responds to painful stimuli, cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over one-half of R3's body. R3's pressure ulcer risk assessment documents that R3's skin is kept moist almost constantly by perspiration or urine and dampness is detected every time R3 is moved or turned. R3's pressure ulcer skin assessment documents R3 is chairfast and does not make even slight changes in body or extremity position without assistance and requires moderate to maximum assistance in moving. This assessment also documents that complete lifting of R3 without sliding against the sheets is impossible and R3 frequently slides down in the bed or chair, requiring frequent repositioning with maximum assistance. In addition, this assessment documents R3 has spasticity, contractures or agitation leading to almost constant friction.

R3's Treatment Administration/Medication Administration Records (TAR/MAR) document R3 has been receiving skin assessments every day.

R3's current care plan dated as created on 12/1/14 documents, "(R3) is at risk for pressure ulcers due to immobility and quadriplegia and has a history of right ankle and right foot pressure

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ulcer." This same pressure ulcer care plan intervention dated 7/09/2019 documents, "Protective Boots as ordered by MD (physician)."

On 10/20/22 at 11:30a.m. V7 (Licensed Practical Nurse/LPN) stated that she is R3's floor nurse. V3 stated that the floor nurses do not assess residents' skin. V7 stated that skin assessments are only performed by V11 (Wound Nurse) on a weekly basis.

A Skin Only Evaluation dated 10/13/22 documents R3 was assessed to have a friction wound to R3's right medial ankle measuring 1.5 centimeters (cm) long by 1.5 cm wide with an undetermined depth on that date.

R3's Wound Physician Evaluation and Management Summary dated 10/18/22 documents that R1 had a new stage four pressure wound to the right medial ankle which was a full thickness wound measuring 1cm long x 0.8 cm wide with the depth not measurable and with a wound bed which was 50% (percent) slough (dead tissue). R3's Wound Physician also documented that R3 required a surgical excisional debridement to remove necrotic tissue (nonviable tissue) to aide in healing of viable tissue around the wound. This physician's summary also documented that at the time of R3's wound evaluation, R3 was only using socks and a pillow around R3's feet.

On 10/20/22 at 1:05p.m V11 (Wound Nurse) stated that she assesses residents at risk for pressure ulcers for skin breakdown on a weekly basis. V11 stated that the floor nurses are supposed to assess residents' skin daily. V11 stated that she assessed R3's skin on 10/13/22 and found a wound to R3's right lateral ankle. V11

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S9999	Continued From page 4 stated that R3 did not receive pressure relieving boots to prevent her ankles and feet from developing pressure ulcers until after R3's wound was found on 10/13/22. V11 stated that V12 (Wound Physician) assessed R3's right lateral ankle wound on 10/18/22, at which time, V12 called R3's right ankle wound a stage four pressure ulcer. On 10/20/22 at 1:20p.m. V11 (Wound Nurse) entered R3's room to assess R3's right ankle pressure ulcer. R3's upper and lower extremities were contracted towards R3's chest with R3's lower legs crossed at the ankles making R3's right outer ankle bone rest against the bed. V11 had some difficulty visualizing R3's wounds because R3's legs were stiff and fixed in their contracture position. V11 proceeded to remove the dressing from R3's right ankle to reveal a round open wound over R3's right outer ankle bone which appeared to be approximately 1.5 cm long x 1.5 cm wide with a red/brown wound bed and with white tissue bordering the wound. On 10/20/22 at 2:35p.m. V2 (Director of Nurses/DON) stated that residents developing pressure ulcers has been a problem in the facility. V2 stated that the facility no longer has their floor nurses perform many resident assessments, including skin assessments. Instead, V2 stated, the floor nurses are supposed to take "a good look" over each resident's skin every day. V2 stated this "good look" is not the same as a full skin assessment but basically just "a look" during cares to see if there are any concerns. When asked why R3 would not have had pressure relief boots in place when R3 is contracture with constant pressure against her feet and ankles, and because pressure relief boots are an intervention documented on R3's care plan, V2	S9999		

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S9999	Continued From page 5 replied that the facility is working to get their nursing staff to implement pressure relief interventions as they are ordered, or care planned to prevent residents from developing pressure ulcers. (B)	S9999		