AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		IL6011688			11/0	11/03/2022
	PROVIDER OR SUPPLIER	G HOME 520 NOR	DDRESS, CITY, S TH PRICE AV CITY, IL 6266	ENUE		· .
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED E		D PROVIDER'S PLAN OF		ACTION SHOULD BE TO THE APPROPRIATE	
S 000	Initial Comments		S 000			66 65
	Annual Licensure	and Certification				
S9999	Final Observations	3	\$9999	<i>97</i>	**	
	Statement of Licer 300.610a) 300.1210b) 300.1210d)5)	nsure Violations:		85 85 W		
EQ.					mn 1 0	
\$	a) The facility shal procedures govern facility. The written be formulated by a Committee consist administrator, the amedical advisory of nursing and other policies shall compart written policies the facility and shall consist a	advisory physician or the committee, and representatives or services in the facility. The ply with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed				€ n
335	Section 300.1210 Nursing and Perso b) The facility sha and services to att practicable physica well-being of the re each resident's co plan. Adequate and care and personal	General Requirements for mal Care III provide the necessary care ain or maintain the highest al, mental, and psychological esident, in accordance with imprehensive resident care diproperly supervised nursing care shall be provided to each te total nursing and personal	31  0	Attachment A Statement of Licensure Vic	lations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Illinois D	epartment of Public	Health	2//		FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6011688		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.00	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		B. WING	11/03/2022		
NAME OF PROVIDER OR SUPPLIER STREET A			DRESS, CITY,	STATE, ZIP CODE	<del></del>
MASON	CITY AREA NURSING	INUME	TH PRICE AND STY, IL 626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ILD BE COMPLETE
S9999	Continued From pa	ge 1	S9999	e e	
	Nursing and Person d) Pursuant to subs	section (a), general nursing at a minimum, the following sed on a 24-hour,			e 24
	5) A regular program pressure sores, her breakdown shall be seven-day-a-week enters the facility we develop pressure so clinical condition de	n to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who ithout pressure sores does not ores unless the individual's monstrates that the pressure table. A resident having			
	services to promote and prevent new pr	Il receive treatment and healing, prevent infection, essure sores from developing.  Were not met as evidenced by:			40 · · · ·
	review the facility fa equipment or device residents at risk for	on, interview and record illed to provide necessary es for pressure relief for developing pressure ulcers or sive or total assistance from			5 5 5 A
#() +()	staff for positioning, increased risk for the ulcers or the worse affected two of two	placing those residents at ne development of pressure ning of existing wounds which residents (R37, R49)		U F	200
	This failure resulted pressure ulcers include two pressure ulcers 4 pressure ulcer; and	tre ulcers in a sample of 20.  I in R37 developing multiple uding a right buttocks stage which deteriorated to a stage and R49 developing an tiliac crest which deteriorated re ulcer.		= 1 HP	

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6011688 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE MASON CITY AREA NURSING HOME** MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 Findings include: AWound and Ulcer Policy and Procedure policy dated 1/10/18 states, "It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management," This policy also states, "Residents with existing pressure ulcers will be deemed as high risk for impaired skin integrity despite the Braden Risk Assessment score," and "Specialty mattress (low air loss, alternating pressure, etc.) with enhanced pressure reducing/relieving properties may be placed on the resident's bed and chair as indicated." In addition, this policy states, "Skin contact surfaces may be padded to protect bony prominences." This same policy documents. "A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear," and states that a stage 2 pressure ulcer is defined as, "Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed (without bruising or slough)." This policy states that a stage 3 pressure ulcer is defined as, "Full thickness tissue loss involving damage of necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia (a thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place). Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of tissue loss." This policy documents that a stage 4 pressure

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ulcer is described as, "Full thickness loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6011688 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 wound bed." In addition, this policy describes an unstageable pressure ulcer as, "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/ or eschar (dead or devitalized tissue that is tan, brown, or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth. cannot be determined." This policy describes a Deep Tissue Injury as, "Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear." This policy documents that equipment to be included in pressure ulcer prevention and treatment should include," Positioning aids; special mattress and/or chair cushion (low air loss, alternating pressure, etc.) with pressure reducing/relieving properties." A Facility mattress manufacturers information sheet, marked by the facility to indicate the model used by R37 and R49, states this mattress is recommended, "For the prevention and treatment of pressure ulcers up to stage II (2)." 1. R37's Minimum Data Set (MDS) assessment dated 9/16/21 documents R37 required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. R37's 3/17/22 MDS documents during that assessment R37 required extensive assistance of two people for bed mobility, and extensive assistance of one person for transfers, dressing, toilet use, and personal hygiene. R37's MDS dated 6/16/22 documents during that assessment R37 required extensive assistance of

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two people for bed mobility, transfers and toilet use. R37's MDS dated 9/16/22 documents R37 requires extensive assistance of two people for bed mobility, transfers, toilet use and is totally

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE	SURVEY
		40	7. 00.00.00			
IL6011688 B. WING				11/03/2022		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE		8
MASON	CITY AREA NURSING	4 11 11001	TH PRICE AV			
		MASON C	ITY, IL 6266	<del></del>		THE STATE OF THE S
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE DATE
S9999	Continued From pa	age 4	S9999			30
	dependent on staff	for personal hygiene.				
	R37's Braden Scal Risk dated 12/9/21 for developing pres this same assessm	e for Predicting Pressure Ulcer documents R37 was at risk ssure ulcers. At the bottom of nent is a list with boxes to be I suggestions to prevent R37	-			8.3
	from developing pr of the boxes are ch indicates R37 had Predicting Pressure and 10/9/22, all do	ressure ulcers, however, none necked. R37's medical record 13 more Braden Scales for e Ulcer Risk between 1/9/22 cument R37 is at risk or high pressure ulcers, none of which	5			7 20
ļ	have the clinical su	ggestion boxes marked.		a		녆
85 <sup>50</sup>	12/27/21 as an initi R37 had developed pressure ulcer to R 5.5 cm (centimeter Ulcer/ Wound docu documents that on	d documentation dated ial assessment document that d a facility acquired stage 2 to 37's right buttock measuring s) long x 2 cm wide. R37's umentation dated 1/18/22 that date R37 still had a stage	445	61 98	1981 19	20 50 - 44 70
er a	additionally had de ulcer to R37's coco 0.4 cm wide x 0.1 of bed contained yello	the right buttock and, veloped a stage 2 pressure cyx measuring 0.8 cm long x cm deep in which the wound ow or white slough tissue that	Ř	S		1. 34
	documentation date right buttock wound	e ulcer bed in strings or in thick cinous. R37's Ulcer/ Wound ed 2/8/22 documents R37's d had deteriorated to an	. XX			
	long x 2.5 cm wide wound bed contain Ulcer/ Wound docu documents R37's r unstageable wound	x 0.1 cm deep in which the ed black necrotic tissue. R37's umentation dated 2/22/22 ight buttock wound was still and but had deteriorated in size	. B.	W.		
1.6	wide x 0.3cm deep	suring 3.7cm long x 3.2 cm  This note also documents  draining a serosanguineous		st us	9 5	

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**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6011688 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 (bloody) drainage during this assessment. R37's Ulcer/ Wound documentation dated 3/1/22 documents R37's right buttock wound was still unstageable and measured 3.7 cm long x 3 cm wide x 0.4 cm deep and was draining copious amounts of serosanguineous drainage. R37's Ulcer/ Wound documentation dated 3/22/22 documents R37's wound had deteriorated to a stage 3 pressure ulcer measuring 5 cm long x 3.5 cm wide x 2 cm deep. R37's Ulcer/ Wound documentation dated 4/18/22 documents R37's pressure ulcer to the right buttock had deteriorated to a stage 4 pressure ulcer measuring 6.5 cm long x 3.8 cm wide x 2 cm deep. R37's Ulcer/ Wound documentation dated 10/5/22 documents R37 still had a stage 4 pressure ulcer to the right buttocks but had also developed a new facility acquired Deep Tissue Injury to R37's left heel which measured 2.0 cm long x 2.8 cm wide. R37's Ulcer/ Wound documentation dated 10/25/22 documents that R37 had also developed a Deep Tissue Injury to R37's left elbow as of 10/5/22, although there is no ulcer/wound assessment for this wound on 10/5/22. R37's current care plan documents that since 12/10/20 R37 has had a plan of care for R37's "risk for impaired skin and pressure injury (related to) age, sedentary behavior, decreased bed mobility, cognitive impairment, frequent incontinence of (bowel and bladder), and edema in (bilateral lower extremities.)" This same care plan does not document any pressure relieving measures were implemented once R37's right buttocks stage 2 pressure ulcer developed on 12/27/22, or when R37 continued to have a stage 2 pressure ulcer during R37's Ulcer/Wound

documentation on 1/18/22 when R37 was also assessed to have a new stage 2 pressure ulcer

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Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6011688 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 6 S9999 with slough on R37's coccyx; or when R37's right buttock wound deteriorated to an unstageable on 2/8/22, or when R37 had worsening depth to his right buttocks wound on 3/1/22. This care plan documented a pressure relieving cushion was provided for R37's wheelchair on 3/9/22 after R37's right buttock wound had deteriorated to an unstageable pressure ulcer, but no changes were made to R37's bed mattress. R37's care plan does not indicate R37's mattress was changed to a specialty mattress as per the facility's policy or any additional pressure relieving measures were implemented when R37's right buttocks wound deteriorated to a stage 3 pressure ulcer on 3/22/22 or when R37's wound deteriorated to a stage 4 pressure ulcer on 4/18/22, R37's care plan documents that R37 was provided with pressure relieving boots after R37 developed an unstageable pressure ulcer to the left heel on 10/5/22. R37's care plan does not document that R37 is on a turning and repositioning program. On 11/1/22 at 11:15a.m. R37 was lying on a regular facility mattress turned slightly to the right with a blanket under R37's left hip. V6 (Wound Nurse) and V7 (Restorative Nurse) entered R37's room and were preparing to change R37's right buttocks wound dressing. V6 and V7 removed the blanket from under R37 then using total assistance, turned R37 to his right side, V6 removed R37's dressing then measured R37's wound. R37's right buttock wound was a large round open area measuring 5 cm long x 4 cm wide x 1.5 cm deep with tunneling at the 9:00 o'clock position measuring 2 cm deep. R37's wound bed was a pale pink with some white/yellow areas visible deep within the wound. On 11/2/22 at 9:38a.m. V6 stated she is also the care plan/MDS coordinator but assesses wounds

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	INSTRUCTION (X3) DATE S		
		fL6011688	B. WING		11/0	3/2022	
NAMEOFI	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY !	STATE, ZIP CODE			
			TH PRICE AV	•	la.		
MASON	CITY AREA NURSING	HOME	ITY, IL 626				
(X4)ID		TEMENT OF DEFICIENCIES	l ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		N SHOULD BE	D BE COMPLETE	
S9999	Continued From pa	ge 7	S9999				
\$	noncompliant with I R37's buttocks prior	stated that R37 had been ying down to take pressure off r to developing his right 17/21. V6 stated that R37		A		88	
	prefers to sit up in h but that R37 will sle stated that despite	nis wheelchair during the day ep in his bed at night. V6 R37's preference to sit up in	‡ı	- C		e e	
×	R37 with a pressure wheelchair until 3/9.	ay, the facility did not provide e relieving cushion for his /22 after R37 had developed					
Fi W	buttock. V6 stated t mattress on his bed	ssure ulcer to his right hat R37 has a regular facility  I. V6 stated the facility thought lized pressure relieving					
	mattress it would in from the bed using verified that no new	terfere with how R37 transfers a standing mechanical lift. V6 pressure relieving measures	29	8			
	pressure ulcer to the after R37 developed	after R37 developed a stage 2 e right buttocks on 12/27/22, d a stage 2 pressure ulcer to 22, after R37's right buttocks					
	wound deteriorated 2/18/22, or when it	to an unstageable wound on deteriorated in depth on V6 stated the facility				÷	
	implemented R37's his wheelchair on 3	pressure relieving cushion for /9/22 after R37's right buttock an unstageable pressure	=	€ _			
·	buttock pressure ule on 3/22/22, and the	t even after R37's right cer deteriorated to a stage 3 n deteriorated again to a		© <u>.</u>		s#s	
	R37 with a specialize in the facility's press	the facility did not provide red air mattress as indicated sure ulcer policy. V6 stated the	÷			ųΣ	
36	hour turn and repos 7/22/22 after R37's deteriorated to a sta	age 4. V6 verified that R37 did			×.	п	
+	his feet until R37 de	ure relieving boots to protect eveloped an unstageable s left heel on 10/5/22. V6					

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ IL6011688 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY)** S9999 Continued From page 8 S9999 stated that when R37's stage 4 pressure ulcer to the right buttock did not appear to be healing, R37's family transitioned R37 to hospice services on 6/14/22. 2. R49's Ulcer/Wound documentation dated 8/10/2022, documents "Right Iliac crest (rear) Length 0.5 x 0.5 x 0 depth. Stage N/A (non-applicable). Granulation tissue pink, no drainage, round/oval crater like with regular firm edges, no tunneling, no necrosis. Date ulcer/wound was initially identified 8/10/2022." R49's Ulcer/Wound documentation dated 8/16/2022, documents "Right Iliac crest (rear) Length 1.8 x 1.8 x 0 depth. Stage N/A. Peri wound intact. No warmth, swelling or redness noted. Granulation tissue pink. No drainage. round/oval crater like with regular firm edges, no tunneling, no necrosis." R49's Ulcer/Wound documentation dated 8/23/2022, documents "Right Iliac crest (rear) Length 2.3 x 1.8 x 0 depth. Stage N/A. Peri wound intact. No warmth, no swelling, or redness noted. Granulation pink. No drainage, round/oval crater like with regular firm edges, no tunneling. Necrosis tissue present 90% (percent)." R49's Ulcer/Wound documentation, dated 8/30/2022, documents "Right Iliac crest (rear) Length 3.4 x 2.9 x 0 depth. Stage: is unstageable. Wound Bed Tissue Type, Necrotic tissue (Eschar) - Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or

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harder than surrounding skin. Peri wound skin. 90% necrotic tissue with 10% yellow/slough tissue. Peri wound intact. No warmth or swelling.

Redness noted to peri wound."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ IL6011688 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 9 S9999 R49's Ulcer/Wound documentation, dated 9/6/2022, documents "Right Iliac crest (rear) Length 4.7 x 4.2 x 0 depth. Stage: is unstageable. Wound Bed Tissue Type: Necrotic tissue (Eschar). Peri wound is 50% necrotic tissue with 50% vellow/slough tissue, redness around peri wound." R49's Nurses Notes dated 9/9/2022, documents "(R49) is being transferred and admitted to the local hospital for wound infection." R49's Nurses Notes dated 9/20/2022, documents R49 returned from the hospital on that dated and was assessed to have, "Right posterior thigh. pressure ulcer Length (CM) Centimeters 8.1 x 5.6 x 0. Wound bed necrotic, stage 3, wound exudate: serosanguinous-thin, watery, pale/pink drainage. Moderate drainage 26-75%. Obscured full thickness skin and tissue loss." R49's Ulcer/Wound documentation dated 9/27/2022, documents "Right Iliac crest (rear) Type: Pressure. Length 8 x 5 x 0.5 depth Stage 3. Slough- yellow white tissue that adheres to the ulcer bed. Noted to the center off the wound. Moderate drainage with firm edge." R49's Ulcer/Wound documentation dated 10/4/2022 documents, "Right Iliac crest (rear) Type: Pressure. Length 7.5 x 5.8 x depth 0.5. Stage 3. Slough- yellow- white tissue that adheres to the ulcer bed. Noted to the center of the center of wound bed, moderate drainage." R49's Ulcer/Wound documentation dated 10/11/2022, documents, "Right Iliac crest (rear) Type; Pressure, Length 7.5 x 5.3 x 0.5 depth,

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Stage 3. Yellow slough and necrotic tissue noted

Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6011688 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 10 S9999 in the center of wound. Edges are sloped." R49's Nurses Notes dated 10/18/2022, documents "(R49) Stage 3 pressure ulcer to right posterior iliac crest, 7.5 CM (Centimeters) x 4.8 CM x 0.5 CM. Yellow slough and 50% necrotic tissue noted to center of wound. Pink granulation tissue noted to outer wound bed. Edges noted to be sloped. No warmth, swelling or redness noted to peri wound. Moderate serosanguineous drainage noted." R49's Nurse notes dated 10/25/2022, documents "(R49) Stage 3 pressure ulcer to right iliac crest, 6CM x 5.5CM x 0.5 CM depth. Yellow slough noted to the center of the wound. Cleansed area and applied an antiseptic solution with gauze and covered wound with Silicon foam dressing." R49's Ulcer/Wound documentation dated 11/1/2022, documents "Right Iliac crest (rear), Type: Pressure. Slough 7.2 x 4.6 x 0.5 Stage 3. Yellow slough noted in the middle of the wound." R49's Care plan, dated 10/31/2022, documents "Unstageable Pressure Ulcer to Posterior Right Iliac crest, Pressure relief mattress (also concave properties) to maintain skin integrity." The facilities mattress manufacturer guideline sheet documents that, "It is recommended for prevention and treatment of pressure ulcers up to stage 2." R49's Braden Scale for Predicting Pressure Ulcer Risk, dated 9/27/2022, documents, "Sensory Perception: Completely Limited. Moisture: Occasionally moist, Activity: Chair fast, Mobility: Slightly limited, Nutrition: Probably inadequate. Result: Moderate risk for skin breakdown."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: \_ IL6011688 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **520 NORTH PRICE AVENUE** MASON CITY AREA NURSING HOME MASON CITY, IL 62664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 S9999 Continued From page 11 On 11/1/2022 at 2:55PM, R49's wound care treatment was observed to right iliac crest. Wound measured 7.2 x 4.7 x 0.5 with yellow slough in the center of wound. Edges were sloped. Moderate drainage noted on old dressing. Wound bed was odorous, R49 did not have a specialized mattress on the bed, and had two mattresses on floor. On 11/1/2022 at 3:00PM, V6/Wound Nurse stated "The mattress (R49) has on the bed right now is the mattress that is used by all residents in the facility. This one has concave edges to help (R49) from rolling out of bed. I suppose (R49) should have a special pressure relieving mattress for (R49) wound. (R49) was admitted to hospice services on 9/20/2022, and they should provide (R49) with one." On 11/2/2022 at 9:00 AM, V2/DON (Director of Nurses) stated "On 11/1/2022, I requested a special relieving mattress for (R49) to help with (R49's) pressure ulcer. Hospice should provide this mattress." On 11/2/2022 at 10:00AM, V6/Wound Nurse stated "We did not order a special pressure relieving mattress until now. (R49) has that mattress that prevents (R49) from falling out of bed. We felt (R49) needed that one more." On 11/2/2022 at 9:30AM, V9/LPN (Licensed Practical Nurse) stated "I requested a special air loss mattress for (R49) today. Hopefully it will show up, today." On 11/2/2022 at 1:30PM, V8/Physician stated "(R49's) mental capacity isn't good. I would of like to see this type of (air) mattress on (R49's) bed. I

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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MASON CITY AREA NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  Continued From page 12  don't know why they didn't provide (R49) one, but can you take an order over the phone for a special mattress for (R49's) bed?"  SUMMARY STATEMENT OF DEFICIENCIES MASON CITY, IL 62664  DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  S9999  Continued From page 12  don't know why they didn't provide (R49) one, but can you take an order over the phone for a special mattress for (R49's) bed?"	re
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