STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 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 300.1010 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, 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 accident, injury or change in condition at the time of notification. 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 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. (Section 3-202.2a of the Act) 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,	S9999		

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S9999	Continued From page 2 and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide initial assessments, treatments and preventative measures for two of four residents (R108 & R20) reviewed for pressure in the sample of 15. This failure resulted in a resident (R108) with a DTI (deep tissue injury) not being provided any offloading to her heels or treatment to her left heel after being seen by a wound care physician on 7/14/23. . The findings include: 1. On 7/18/23 at 2:48 PM, R108 was asleep and laying on her side in bed. R108's legs were crossed and she did not have any offloading devices in place to her feet/heels. R108's left heel was visible and there was a quarter size black spot on her left heel. On 7/19/23 at 8:17 AM, R108 was laying in bed on her back. Her heels were resting on the mattress. V9 CNA (Certified Nursing Assistant) and V13 CNA were at the bedside to transfer R108 to her wheelchair. R108 had a quarter size black spot to her left heel. R108 stated she doesn't have boots or pillows placed under her heels to keep them off the mattress. V9 CNA stated, "R108 has blankets she can put under her heels." The Re-Admission Summary dated 7/12/23 at 5:38 PM for R108 showed she arrived by stretcher, from the hospital to the facility. R108 was alert and oriented to person and place but	S9999		

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S9999	Continued From page 3 was confused. R108 had a deep tissue injury to her left heel. The Skin/Wound Note dated 7/12/23 at 5:43 PM showed, Deep tissue injury noted to left heel. Will be referring resident to wound MD (medical doctor). No further concerns at this time. No other wound assessment was done to include the description or measurements of the wound. The Wound Care Physician documentation dated 7/14/23 for R108, that was not in her medical record, showed she had an unstageable DTI of the left heel that was pressure and measured 3.0 x 3.0 x not measurable in cm (centimeters). The dressing and treatment plan included the following: offload the wound; float heels in bed; reposition per facility protocol; turn side to side in bed every 1-2 hours if able. Skin prep to the left heel daily. The Physician Orders dated July 2023 for R108 did not show any treatment orders for the DTI to her left heel. The TAR (Treatment Administration Record) dated July 2023 for R108 did not show any treatment or offloading of her left heel being completed since the doctor ordered it on 7/14/23. The treatment for skin prep to R108's heel wasn't added to her TAR until 7/19/23. The order to "float heels while in bed to offset pressure and promote wound healing to the left heel DTI. Reposition every 2 hours" was not added to R108's TAR until 7/19/23. On 7/19/23 at 1:02 PM, V4 RN (Registered Nurse) stated, the facility didn't have a wound care nurse but has a wound care doctor that comes in on Fridays at 5:00 AM and does wound	S9999		

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rounds. V4 stated the wound doctor does the measurements, assessments and the documentation for wounds. V4 stated he puts the information and his orders in his notes and faxes them to the facility. V4 stated his notes are also accessible through V1 (Administrator) email. V4 stated the nurse that works on Friday enters the orders. No one else does wound assessments or measurements. Any resident in the facility with a wound is seen by the wound doctor. The floor nurse's do the treatments that are ordered and should be on the TAR. V4 stated she did not do a treatment for R108's ankle wound today. V4 stated there should be an order that goes on the treatment sheet so the nurse's know what treatment needs to be done. V4 stated she did not see an order for any treatment for R108; it was not on the treatment sheet. V4 stated no treatments have been done for R108's left heel. V4 stated R108's heels should be offloaded for prevention of wounds and for healing of the pressure area.

On 7/20/23 at 10:05 AM, V2 DON (Director of Nursing) stated the last time she saw R108 was Saturday night (7/15/23) when she worked third shift. V2 stated she knew R108 had a wound to her left heel. V2 stated residents are seen weekly by the wound doctor on Friday mornings. V2 stated they get the doctor's assessments, measurements and orders from his website. V2 stated she thinks the wound doctor faxes his notes to the facility. V2 stated the wound doctor's treatment plan are orders and are to be entered into the electronic medical record as orders. V2 stated after the orders are entered it will cross over and show up on the resident's MAR and TAR so the orders can be completed. V2 stated its important to follow the doctor's so there is not further injury to the pressure ulcer and to help it

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heal. V2 stated she was not aware that the orders were not being done and stated they need to be followed. V2 stated staff should be encouraging offloading to help R108's DTI heal.

On 07/19/23 at 1:10 PM, V4 went to R108's room and confirmed resident's heels were not offloaded and stated the resident had a DTI to her left heel.

The Face Sheet dated 7/19/23 for R108 showed diagnoses including schizophrenia, bipolar disorder, hypertension, hyperlipidemia, asthma, morbid obesity, and insomnia.

The MDS (Minimum Data Set) dated 6/14/23 for R108 showed no cognitive impairment; extensive assistance needed for bed mobility, transfers, dressing, toilet use, and personal hygiene.

The Care Plan dated 6/27/23 for R108 did not show any plan in place regarding a DTI (deep tissue injury) to her heel. R108's Care Plan showed she will have no new open areas caused by pressure or friction for the next 90 days. There were no interventions for offloading, repositioning or treatment to her left heel DTI.

The facility's Decubitus Care/Pressure Areas policy (1/2018) showed, It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote healing of any pressure ulcer. Procedure: 1. Upon notification of skin breakdown, the QA form for Newly Acquired Skin Condition will be completed and forwarded to the Director of Nurses. 2. The pressure area will be assessed and documented on the Treatment Administration Record or the Wound Documentation Record. 3. Complete all areas of Treatment Administration Record or the Wound

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Documentation Record. Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician). Notify the physician for treatment orders. The physician's orders should include: type of treatment; frequency treatment is to be performed; how to cleanse, if needed; site of application; initiate physician order on treatment sheet. Documentation of the pressure area must occur upon identification and at least once each week on the TAR or Wound Documentation Form. The assessment must include: Characteristic (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc). Treatment and response to treatment.

2. On 7/18/23 at 9:43 AM, R20 self-ambulated from her room to the activity room.

R20's Face Sheet dated 7/19/23 showed diagnoses to include, but no limited to: schizoaffective disorder, irritable bowel syndrome, depression, mood disorder, anxiety, hypertension, emphysema, vascular dementia, generalized muscle weakness, and aphasia.

R20's Nursing Home Discharge/Transfer Communication form dated 6/7/23 showed R20 had redness to her coccyx.

R20's Braden Scale (a measure of potential for skin breakdown) dated 6/13/23 showed a score of 19 = "Moderate Risk."

R20's Progress Note dated 6/19/23 at 10:09 AM, showed R20 complained of pain to the right side of her bottom. The resident is alert and oriented. A Stage II pressure ulcer was noted on her right buttock. The resident is able to ambulate with walker to dining room. This note stated, "Will

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consult wound doctor for further treatment. Will continue to monitor for progression of PI (pressure injury)." This note did not contain a detailed assessment of R20's wound. There were no measurements or descriptions or the wound bed, peri-wound area, or drainage.

R20's EMR did not contain any additional Skin Assessment from 6/19/23 - 6/29/23. (A complete wound assessment wasn't documented until R20 was seen by the wound doctor on 6/30/23).

R20's Physician Order Sheet dated 7/19/23 showed an order for, "Per Wound MD. Clean with wound cleanser. Place Xeroform on wound. Place Island gauze. Offload/reposition every 2 hours. Limit sitting time, no more than 60 minutes per meal. One time a day for Wound treatment (right bottom)." The order was dated 6/20/23.

The wound doctor's documentation was not available in the EMR. V1 (Administrator) had to print all wound documents. The first assessment completed by the wound doctor or R20's right, upper, medial buttock was dated 6/30/23 (11 days after the pressure ulcer was identified). This document showed R20 had a Stage 2 Pressure Ulcer measuring 1.4 x 2.4 x 0.2 cm. The wound duration was greater than 12 days.

On 7/20/23 at 10:13 AM, V2 (DON - Director of Nursing) stated a new skin wound should be fully assessed and documented by the nurse working when the wound is found. V2 said a full assessment of the wound would answer all the questions the EMR asks in the EMR. The surveyor clarified that would include: the size of the wound, type of wound, wound appearance, peri-wound appearance, and presence of drainage. V2 replied, "Yea, I guess." V2 said the

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S9999	Continued From page 8 full assessment of R20's wound should be entered in a progress note or "Skin Assessment." R20 should have had an initial assessment completed that day (6/19/23). The initial assessment is an important tool to assist in the treatment plan. It helps the nurse determine if the wound is improving or deteriorating. V2 said their is no official Wound Care Nurse at the facility. V2 stated, "[The EMR system] is very new and I don't think most of them (the nurses) know where to chart things yet." The facility's Decubitus Care/Pressure Areas Policy (revised 1/18) showed, "It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer... Procedure: 1. Upon notification of skin breakdown, the QA form for Newly Acquired Skin Condition will be completed and forwarded to the Director of Nurses. 2. The pressure area will be assessed and documented on the Treatment Administration Record or the Wound Documentation Record. 3. Complete all areas of the Treatment Administration Record or Wound Documentation Record. i). Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician)... 5. Documentation of the pressure area must occur upon identification and at least once each week on the TAR or Wound Documentation Form. The assessment must include: i) Characteristic (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.)..." "B"	S9999		