STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	4343 KENNEDY DRIVE EAST MOLINE, IL 61244

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S 000	Initial Comments Complaint Investigation: 2320373/IL155340	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 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. 300.1210b) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 were NOT MET as evidenced by: Based on observation, interview and record review the facility failed to prevent the development of pressure wounds for one resident (R1) of three residents reviewed for incontinence care. This failure resulted in R1 acquiring a Stage 2, Stage 4 and two Deep Tissue Injuries. Findings include: Facility Policy/Skin Integrity Guideline dated 2011 documents: To provide comprehensive approach for monitoring skin conditions To decrease pressure ulcer and/or wound formation by identifying those patients/residents at risk, and implementing appropriate interventions Patients/Residents will be assessed or observed for skin breakdown as necessitated by change in condition.	S9999		

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S9999	Continued From page 2 The interdisciplinary plan of care will address problems, goals, and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified. Patients/Residents will be observed by the CNA (Certified Nurse Assistant) daily for reddened/open areas, edema of feet or sacrum. Changes will be reported to the licensed nurse and documented. Initiate positioning schedule to meet individual patient/resident needs and minimize concentrated pressure to skin as indicated by the individualized care plan. Care plan is to be implemented, evaluated and revised based on the needs of the resident. If patient/resident is refusing or choosing not to receive treatment, review risks, benefits and alternatives. Re-evaluate and attempt other interventions. Treatment Protocol for Reddened, Denuded Areas: Protect from moisture, pressure and further injury Current Physician's Order Report Summary indicates R1 was admitted to the facility 1/7/23 with diagnoses that include Left Humerus Fracture, Heart Disease with Pacemaker, Defibrillator and Heart Valve Replacement and Obesity. Initial/Admission Skin Assessment dated 1/7/23 and Weekly Skin Check dated 1/11/23 indicates no alteration in skin on R1's buttocks or coccyx. Progress Note dated 1/15/23 at 8:49 am indicates a small open area noted to R1's coccyx "approximately 0.3 cm (centimeters)" circular in size, R1 repositioned off buttock, refusing to get out of bed at this time. Note indicates dressing applied and wound NP (Nurse Practitioner)	S9999		

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S9999	Continued From page 3 notified. Progress Note dated 1/17/23 indicates V7, Wound NP attended and examined R1, orders received and noted. Wound NP Report dated 1/17/23 indicates R1 was assessed on that date and found to have scattered denuded areas, large erythema to buttocks and coccyx associated with incontinent dermatitis; open wounds left and right buttocks. Report Assessment Note: New onset of multiple areas to buttocks/coccyx; multiple comorbidities; history of non-compliance. Refer to wound flow sheet for specific measurements and assessments. Due to noncompliance - these areas have a high potential for decline related to incontinence of stool and urine. Weekly Wound Evaluation dated 1/17/23 indicates rash on R1 coccyx, scattered area of erythema (redness), wound margins defined "Incontinent Dermatitis." On 1/18/23 at 11:15am V9, LPN (Licensed Practical Nurse) administered wound care to R1's coccyx wound. At that time R1 was noted to have a large area of red denuded skin across his buttocks/coccyx and several open areas of various size as well as one oval shaped wound covered with black tissue. Two open areas were noted under R1's scrotum. V9 stated R1 just moved to this unit yesterday and his notes only indicated one small open area and "incontinent dermatitis." V9 stated she would notify V7, Wound NP of the identified open areas. On 1/19/23 at 3pm V10, LPN stated she did not physically round with V7, Wound NP (on 1/17/23)	S9999		

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S9999	Continued From page 4 and only documents the wound assessment from the sheet given to her by V7. V10 stated "We still don't have V7's dictated report from 1/17/23." Weekly Wound Evaluation, completed by V10, dated 1/17/23 was completed based solely on handwritten notes from V7. No facility staff visualized, assessed and/or documented on R1's wounds on 1/17/23. On 1/19/23 at 4pm V2, DON (Director of Nursing) stated they do not get V7's full dictated report until several days after V7 rounds. V2 stated facility staff do not round with V7 "(V7) rounds with his own nurses and they've only just left the handwritten notes." V2 stated they currently do not have a designated wound care nurse - floor nurses do the treatments." On 1/18/23 at 4pm V7, Wound NP stated when he assessed R1 on 1/17/23 at the facility R1 was full of stool and he told the staff they needed to keep R1's skin clean in order to prevent further skin breakdown. V7 stated the combination of R1's skin being moist, wet and pressure was "the perfect storm" for a rapid decline in R1's skin. V7 stated he told facility staff they cannot put R1 in a chair and leave him up all day. V7 stated that given R1's age, comorbidities, weight and noncompliance "(R1) is going to be hard to heal." V7 stated he is aware R1 was transferred to another facility (today) and will be seeing R1 at the receiving facility in the morning (1/19/23). V7's Wound/Skin Consult to Eval/Treat Report dated 1/19/23 indicates R1 transferred to another facility (on 1/18/23). Assessed coccyx/buttocks incontinence dermatitis wounds appear to be related to pressure this assessment. Right buttock to coccyx pressure ulcer Stage 4/proximal coccyx pressure ulcer Stage 2/new	S9999		

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S9999	Continued From page 5 onset multiple wounds. Presents with wound to scrotum trauma related to undergarment/right ischium DTI (Deep Tissue Injury)/traumatic wound to left and right knee/right heel with blanchable erythema/left heel DTI. Wound Assessments as follows: 1) Right buttock to coccyx: pressure ulcer Stage 4; 4.5cm x 4.9cm x 0.1cm, 50% black slough 2) Proximal coccyx: pressure ulcer Stage 2; 1.0cm x 0.6cm x 0.1cm 3) Right ischium Deep Tissue Injury: 3.1cm x 1.0cm x 0.1cm 10% purple black, erythema large, slough 80% yellow 4) Scrotum traumatic wound: 1.2cm x 0.8cm x 0.1cm 5) Right heel: mild to moderate blanchable erythema 6) Left heel Deep Tissue Injury: 0.7cm x 1.0cm x 0cm deep purple Report Indicates R1 was transferred to receiving facility (on 1/18/23) and were not acquired at the receiving facility. No wound care plan was initiated after identification of a new skin impairment on 1/15/23. (B)	S9999		