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
	IL6009294	A. BUILDING: ________ B. WING ________	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE SKILLED NUR & REHAB	333 SOUTH WRIGHTSMAN STREET VIRDEN, IL 62690

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S 000	Initial Comments Complaint Investigations: 2341971/IL157302, 2341905/IL157216 & 234887/IL157223	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3 300.1210d)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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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: This Licensure Findings Require two DPS statements: A) Based on interviews and record review, the facility failed to notify resident representative of a worsening condition to a coccyx wound for 1 (R2) out of sample of 3 and failed to consult with Physician and/or Physician's Assistant. This	S9999		

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failure resulted in R2 being sent to the Emergency Room for treatment per family request.

B) Based on observations, interviews and record review the facility failed to provide treatment for a pressure ulcer for 1 of 3 (R2, R5, R6) residents reviewed for pressure ulcers. This failure resulted in R2 being sent to the Emergency Room for treatment per family request on 3/6/2023 and wound specialist consultation on 3/8/2023 with diagnosis of deep tissue injury measuring 11.5 x 15.5 with 60% necrotic tissue, 30% devitalized necrotic tissue.

Findings include:

R2's diagnosis include essential tremors, hypothyroidism, peptic ulcer, anxiety and osteoporosis.

R2's Minimum Data Set, (MDS), dated 1/18/2023 documents a brief interview of mental status of 14 which indicates R2 is cognitively intact. MDS documents that R2 requires supervision with eating, dressing, toileting, transfers and personal hygiene.

Facility document, titled Skin Inspection Assessment, completed by V4, (Director of Nursing), dated 2/23/2023, R2 documents redness to coccyx, barrier cream applied.

On 3/8/2023 at 9:50am V4, stated, R2 had a redness to her coccyx on 2/23/23, when V4, CNA, assisted her to the bathroom. V4 stated, she completed the weekly skin checks and noted the redness on the Skin Inspection Assessment. V4 stated, she did not measure the redness on 2/23/23. V4 stated, the CNAs were to apply

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S9999	Continued From page 3 barrier cream. R2's Progress Note, dated 2/28/2023, at 5:34pm documents, while in her room the bedside table was knocked over and hot coffee spilled onto R2's back & buttocks. Redness is present with a slight blister to coccyx. No pain reported. No s/s of distress. DON, MD & Administrator notified of incident. On 3/7/2023 at 3:15pm V6, (RN), stated, she did not call the Doctor, on 2/28/2023. Facility fax document dated 3/1/2023 documents, during dinner, (in room), bedside table was knocked over and hot coffee was spilled onto R2's back/buttocks. Area is red and starting to slightly blister V/S stable-no pain reported. V9, (Doctor), signature and order to monitor. On 3/8/2023 at 9:50am V4 stated, she expected V6 to notify Doctor and family about R2's condition changes. V4 stated, she expected V6 to call Doctor not to send a fax. V4 stated, she observed R2's coccyx on 3/1/2023 and the skin was starting to peel but, she did not see any blisters. On 03/08/23 at 11:20am V11, LPN, stated, the first time he saw R2's wound, on her coccyx was on 03/02/23, stated, it was pink/red and with some open blisters on the left side of coccyx. V11 states he saw the wound again on 03/02/23 and it was more red. On 03/08/23 at 11:40am, V10, CNA, stated, the first time she saw R2's coccyx was on 03/02/23 and she had two white bandages it. V10 stated, on 03/03/23 it was red and bleeding and had open areas. V10 stated, she told the nurse, that is looked horrible. V10 stated, she did not apply any	S9999		

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barrier cream because, she thought the nurses had a treatment for it.

On 03/09/23 at 2:20pm, V14, CNA stated, she took care for R2 on the dates of 03/03/23, 03/04/23 and 03/05/23 from 7pm-7am. V14 stated, R2's coccyx was red, and skin was peeling with bleeding and spots of discoloration on 03/03/23, V14 stated she notified the nurse, unknow which one. V14 stated on 03/04/23 and 03/05/23 it looked about the same. V14 stated, I did not put barrier cream on area because, I thought the nurses were treating it.

R2's Treatment Administration Record, dated 3/2023 documents, monitor bilateral buttock for proper healing and s/s of infection r/t burn, Order Date 03/01/2023 start date of 3/2/2023 with the following dates 3/2/2023, 3/3/2023,3/4/2023, 3/5/2023 containing nurses' initials.

On 3/7/2023 at 3;30pm V7, CNA stated, R2 had red area and blistering on 3/1/2023 to coccyx that was starting to bleed. V7 stated, R2's skin was starting to peel and that she applied barrier cream as told.

R2's treatment administration record dated 3/2023 documents Silvadene External Cream 1 % (Silver Sulfadiazine) Apply to sacral/buttocks topically every shift for wound for 5 Days Active 03/04/2023 start 03/05/2023 end 03/10/2023. R2's only entry on Treatment Administration Record, (TAR), is for 3/5/2023 which includes nurse note documenting Silvadene External Cream 1 % topically applied to Foot - Both feet.

On 03/07/23 at 9:00am V3, Physician's Assistant, (PA), stated, the last time he saw R2 was 01/17/23. V3 stated, he expects nursing staff to

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notify him and report any new concerns, with residents. V3 stated, he is in the facility at least every week and willing to see any residents if a needed. V3 stated, he expects the nurses to tell him if someone needs to be seen.

On 03/09/23 at 12:45pm, V9, Physician, stated on 03/08/23 was the first time that he saw R2's wound on her coccyx. V9 stated, that he was not notified of a red area to R2's coccyx on 02/23/23. V9 stated, himself or V3, PA, are at the facility twice or more a week and that he expects staff to notify them when a resident needs to be seen by one of them. V9 stated, he relies on the nurses to keep him updated of changes and any needs of the residents. V9 stated, he relies on the nurse's judgement to determine that.

R2's progress noted dated 3/6/2023 at 9:30am documents R2's sister-in-law was here and upset regarding res., (resident), bottom. She wanted res. sent to the burn unit at hospital. Ambulance here and took res.

On 3/8/2023 at 10:25am V12 (R2's POA) stated, she came in on 3/6/2023 and saw wound on coccyx and demanded R2 be sent to the hospital for evaluation of her burn. V12 stated, that on 3/8/2023 she was told by V11 that the area on her bottom was due to pressure.

R2's Physicians Orders dated 3/7/2023 documents Wash lower back/sacrum every day with warm soapy water. Ok to take baths. Apply Santyl to bum. Cover with Xeroform gauze and ABD, (Abdominal), pad dressing. Secure with tape or mesh underwear every evening shift.

R2's Progress Notes dated 3/7/2023 from V3 documents, there is a large sacral wound, (see

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S9999	Continued From page 6 nursing measurements), symmetrical full thickness with erythema and no blanching dermas centrally. Perirectal area/vaginal area not included in wound. Dx sacral wound. ER referral to SIU. On 3/8/2023 at 9:00 am V8, (Wound Doctor) stated, wound looks like a deep tissue injury. V8's initial wound evaluation dated 3/8/2023 documents, R2 had a coffee spill and there was question whether the area on her sacrum was caused by the burn of the coffee, to me the wound looks like a very typical pressure sore not a burn. Necrosis was very adherent and not ready to be removed. Deep tissue injury is still progressing will let Santyl work and will reassess next week for possible debridement. Off load wound, reposition per facility protocol. Limit sitting to 60 minutes twice per day 2 hours max. chronic stable wound with insignificant amount of necrotic tissue an no signs of infection. Monitor closely for now. Wound measures at 11.5 X 15.5 with light serous drainage, 60% necrotic tissue, 30% devitalized necrotic tissue and 10% granulation tissue. Facility provided pressure ulcer policy documents includes the following: it is the responsibility of the charge nurse/designee to care for pressure areas and provide treatments as ordered. It is the responsibility of the charge nurse/designee to measure and document on the pressure areas weekly. It is the responsibility of the charge nurse/designee to monitor for healing progress and ensure appropriate treatment are in use. It is recommended that DON/Designee make frequent pressure ulcer rounds with the charge nurse. It is the responsibility of the CNA to report any skin conditions to the charge nurse	S9999		

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S9999	Continued From page 7 immediately upon identification. When a pressure ulcer is identified whether in house or upon a resident's admission the area will be assessed using the skin and wound assessment and initial treatment started per Physicians' Orders. Facility provided document titled "Pressure Ulcer Prevention, Identification and Treatment" documents the following: the Physician is to be notified when A) pressure ulcer develops B) when there is a noted lack of improvement after a reasonable amount of time C) and/or upon signs of deterioration. (B)	S9999		