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
	IL6001358	A. BUILDING: ______ B. WING ______	C 03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CC	716 EIGHTEENTH STREET CHARLESTON, IL 61920

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S 000	Initial Comments Complaint Investigation: 2362108/IL157493	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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accident, injury or change in condition at the time of notification.

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 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.

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These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to assess, notify the physician of pressure ulcers present on admission, treat, and initiate interventions for a resident having pressure ulcers. This failure affects one (R1) of three residents reviewed for pressure ulcers in a sample list of three residents. This failure caused R1 to suffer from an untreated Deep Tissue Injury and Stage Three Pressure Ulcer for 19 days.

Findings include:

The facility's policy Notification for change in resident's condition or status revised 12/7/17 states " The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, Director of Nursing, Physician, Guardian, Health Care Power of Attorney, etc) of changes in the resident's medical/mental condition and/or status. 1 The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: o. Onset of pressure ulcers or stasis ulcers."

The facility's policy Decubitus Care/Pressure Areas revised 1/18/23 states "Policy: 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. Responsibility: Licensed Nursing Personnel. 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

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S9999	Continued From page 3 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) ii) Document the stages of the pressure ulcer as follows: (a) Suspected deep tissue injury: 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. (B) Stage I: redness, which does not resolve 30 minutes after pressure is relieved, no broken skin (c) Stage II: broken skin, an abrasion, blister or shallow crater (d) Stage III: broken skin, affects full thickness and presents as a deep crater (e) Stage IV: broken skin, muscle and/or bone exposed iii) Document the color according to the following: (a) Red: pale pink to beefy red with or without healthy granulation tissue (b) Yellow: whitish yellow, creamy-yellow, yellow-green, or beige (c) Black: black, stringy gray or gray scab 4) Notify the physician for treatment orders. The physician ' s orders should include: i) Type of treatment ii) Frequency treatment is to be performed iii) How to cleanse, if needed iv) Site of application v) No PRN order is acceptable for a pressure ulcer. The order must have specific frequencies. vi) Initiate physician order on treatment sheet 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.) ii) Treatment and response to treatment 6) Reevaluate the treatment for response at least every two (2) to four (4) weeks. Most pressure areas will respond to treatment in this amount of	S9999		

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time. If no improvement is seen in this time frame, contact the physician for a new treatment order.
7) Nursing personnel are to notify dietary personnel of any pressure areas to seek nutritional support and monthly reviews by the Registered Dietician. 8) When a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers.
R1's Order Summary Report dated 2/2/23 includes the following diagnoses: Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Major Depression, Type II Diabetes, Heart Disease, Melanoma, Lung Cancer, and Peripheral Vascular Disease.

R1's Braden Scale dated 2/2/23 documents R1 was at high risk for skin breakdown and was "admitted to facility with deep tissue injury of Right buttock."

R1's Dietary Note dated 1/31/23 documents R1 was admitted with a "Stage III (pressure ulcer) left heel.

Surveyor notes no skin/wound assessments or measurements are documented for R1 during his stay at the facility. The facility's Admission/discharge summary for the past three months document R1 was admitted to the facility 1/31/23 and discharged 2/19/23. He was then taken to the emergency room at the local hospital.

There is no documentation to support R1's skin issues were ever reported to the doctor or treatment was initiated. R1's Treatment Administration Record (TAR) for January or

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S9999	Continued From page 5 February 2023 does not document any treatment was administered for R1's two pressure ulcers - left heel and right buttock. R1's consultation report dated 2/19/23 by V9, Infectious Disease Physician upon admission to the hospital documents (R1) was admitted with "Decubitus Ulcers to Sacrococcygeal area and Left heel Stage III or stage IV and a Deep Tissue injury to right foot" On 3/16/23 at 2:00PM V4, R1's family member stated "(R1) had pressure sores since before (R1) went to the hospital. (R1) was at another nursing home owned by the same company. After (R1) went to the hospital that facility couldn't do the intravenous (IV) fluids so (R1) came here temporarily to get the IV. (R1) was supposed to go back to the other facility once he got the IVs. (R1) got the pressure sores at the other nursing home. (R1) went to the hospital from this facility on 2/19/23. (R1) died on 3/2/23 at the hospital. I think he died of a respiratory infection." On 3/20/23 at 10:00AM V2, Director of Nursing (DON) stated "When (R1) came back to us (R1) was positive for COVID-19 and he was on contact precautions. Also (R1) had systemic Inflammatory Response Syndrome (SIRS). (R1) needed IV antibiotics. (R1) came to us from our sister facility. (R1) was to go back there after his IV antibiotic was complete. It wasn't on the hospital transfer that (R1) had any skin issues or pressure ulcer treatments. I see where it is documented in the dietary notes 1/31/23 (R1) had a Stage III pressure ulcer to (R1's) heel and I see (R1's) Braden 2/2/23 documents a Deep Tissue Injury to (R1's) Buttocks." V2 stated (R1) "was never seen by the wound doctor. The wound doctor was not notified of (R1's) wounds."	S9999		

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S9999	Continued From page 6 On 3/20/23 at 3:20PM V3 Registered Nurse (RN) Care Plan Coordinator stated "I did the Braden Scale (Skin assessment) on 2/2/23. I documented (R1) had a deep tissue injury to (R1's) right buttocks. I wasn't aware of the heel area. When I did the skin assessment, I talked to the charge nurse, but I don't remember who was working that day." On 3/20/23 at 3:25PM V7, Corporate Nurse verified the Stage III pressure area on R1's left heel and the Deep tissue injury on R1's right buttocks were documented upon admission. However, there is no documentation that the wound were ever assessed or measured or a treatment was ever initiated or that a physician was notified. On 3/20/23 at 3:30 V8, Attending Physician stated "As far as I know the Nurse Practitioner or me were not notified of the pressure ulcers (R1) was admitted with. I would expect to be notified or the Nurse Practitioner so we could order appropriate treatment. I would say if the wounds were not treated from 1/31/23 until 2/19/23 they would have deteriorated. It is the standard of practice wounds are assessed and treated and reassessed." (A)	S9999		