STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

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S 000	Initial Comments Annual licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 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. 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.	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 identify pressure ulcers prior to becoming advanced stages and failed to cleanse a stage two pressure ulcer in a manner to prevent cross contamination for two of five residents (R29, R17) reviewed for pressure in the sample of 15. This failure resulted in delayed identification and treatment of pressure ulcers for R29 and R17. The findings include: 1. R29's face sheet printed on 1/19/23 showed diagnoses including but not limited to dementia, heart failure, chronic obstructive pulmonary disease, and stage 2 pressure ulcer of buttock. R29's facility assessment dated 11/3/22 showed severe cognitive impairment and extensive staff	S9999		

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assistance required for bed mobility, transfers, and dressing. The assessment showed total staff dependence required for transfers, toilet use and personal hygiene. The facility assessment showed R29 was frequently incontinent of urine and bowel.

R29's pressure score risk assessment dated 11/2/22 showed R29 was at risk.

R29's physician orders showed an order start dated 1/12/23 for: "Apply zinc barrier cream every shift and prn (as needed) to R (right) buttocks ...Dx: Pressure ulcer of unspecified buttock, stage 2".

On 1/17/23 at 10:17 AM, V5 and V6 (CNAs-Certified Nurse Aides) were observed while performing incontinence care for R29. V5 put on gloves, opened the urine soaked brief, and washed R29's groin area. V5 and V6 rolled R29 from side to side to remove the wet brief. V5 continued wearing the contaminated gloves to roll R29 while touching the bed linens and resident's gown. An eraser size open wound was observed on the right buttock. R29's buttocks and backside were visibly wet with moisture and urine. V6 applied barrier cream to the buttocks and R29 was again rolled from side to side while V5 continued wearing contaminated gloves. R29's new brief was put on with the buttocks still contaminated from the urine. V5 and V6 were asked by the surveyor to remove R29's socks for heel observations. A golf ball size, dark purple-reddish area was present on the right inner heel. V6 stated the discolored area had been there for a while so they try to keep the heel elevated. V5 and V6 put R29's socks back on, covered him with the blanket, and exited the room with the heels flat on the bed.

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S9999	Continued From page 3 On 1/17/23 at 11:25 AM and 2:34 PM, R29's heels were flat on the bed. On 1/18/23 at 8:39 AM and 11:27 AM, R29's heels were flat on the bed. On 1/19/23 at 8:55 AM, V7 (CNA) stated aides do skin checks during all resident cares. It is a full head to toe observation on shower days. We watch the buttocks, heels, and other high-pressure points carefully. Changes need to be reported immediately to stop it from becoming more severe. Incontinent residents are never left with urine on the skin. It can cause skin breakdown and infection. Dirty gloves are changed before touching clean areas to stop cross contamination of germs. On 1/19/23 at 8:20 AM, V4 (Registered Nurse) stated she had done the weekly skin check for R29 just yesterday (1/18). V4 said there was an opening on his bottom which was being treated with a zinc barrier cream. V4 said that is the only skin issue R29 has and there was nothing noted on his feet. V4 said the weekly skin checks are done by the floor nurses. It is a head-to-toe assessment. Any skin issues are immediately measured, and the doctor is notified for treatment orders. V4 said the CNAs do skin checks during all daily cares. Any skin changes or new areas found are to be reported immediately to the nurse. On 1/19/23 at 8:30 AM, V4 and the surveyor went to R29's room. R29 was lying in bed with his heels flat on the bed. R29's socks were removed and V4 stated, "Wow, this is something new." V4 stated she would get another nurse for a second opinion and to get a tape to measure the wound.	S9999		

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S9999	Continued From page 4 V4 and V3 (Registered Nurse) entered the room. Both nurses assessed and measured R29's right heel. Measurements were recorded by V4 as "3 centimeters by 3.5 centimeters, purple rusty". V4 stated she wound classify this as an "unstageable pressure ulcer". V3 and V4 stated it was the first time they had knowledge of the pressure ulcer to the heel, and nothing had been reported prior to today. V3 and V4 said there are no treatment orders or interventions in place for the unstageable pressure ulcer to the heel. V3 and V4 said the aides should have reported it right away to prevent it from getting worse. On 1/19/23 at 10:46 AM, V2 (Director of Nurses) stated gloves should be changed between dirty and clean areas. Incontinence care involves cleansing both the front and back of residents. Urine left on open pressure wounds has the potential for infections and further skin breakdown. V2 said any new skin changes need to be reported immediately so it doesn't get worse. Skin that is dark purple or red and still closed like a blister is classified as unstageable. Finding wounds at advanced stages have the potential of becoming infected, residents can become septic, and have increased pain. R29's care plan showed a focus area of risk for increased pressure injuries relate to dementia, gout, depression, decreased mobility and generalized weakness. Interventions included weekly skin checks as ordered, provide incontinent care after each incontinent episode and compression socks on each morning and off each night. R29's 1/19/23 wound assessment (performed after report by surveyor) showed a 3 x 3.5 centimeter and 100% necrotic tissue area to the	S9999		

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right heel. The report also showed two additional wounds discovered during the same assessment, one to the bottom of the right foot and another to the right great toe.

The facility's Pressure Ulcer Prevention and Treatment Protocol policy revision dated 7/16 states under the objective section: "To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury that might develop." The policy further states under the principles section: "3. All high and moderate risk residents may have the following, and if so, they will be addressed on the Care Plan. E. Skin checks."

The facility was unable to provide any policy related to the frequency, process, or reporting for skin checks.

The facility's Perineal Care policy revision dated 11/18 states: "4. Begin cleansing from the cleanest area in front to the most soiled area in back." The facility's Standard Precautions policy revision dated 8/09 states under the glove section; "c. Change gloves between tasks and procedures on the same resident after contact with material that many contain infectious agents."
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2. On 1/17/23 at 2:45 PM, R17's wound was 2 x 1 cm (centimeters) with slough in the wound bed.

On 1/17/23 at 10:45 AM, R17 said, "They are doing a dressing on my right ankle." R17 was unsure how he got the pressure sore.

R17's face sheet shows his diagnoses to include type 2 diabetes, muscle wasting, cognitive

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S9999	Continued From page 6 communication deficit, difficulty walking, thrombocytopenia, and dementia. R17's Facility Wound Summery Report shows, a facility acquired pressure ulcer starting on 11/06/22, measuring 5.2 x 5.3 cm with necrotic tissue in the wound bed. The skin surrounding the wound was dark purple. On 1/19/23 at 2:00 PM, V9 RN (Registered Nurse) said, she didn't know how the wound formed, it seemed to come from out of nowhere. 01/19/23 at 12:26 PM, V3 RN said, pressure ulcers should be found at a stage one or a reddened area, it should be found before it is an unstageable pressure ulcer. (B)	S9999		