

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009245</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUNNY ACRES NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19130 SUNNY ACRES ROAD PETERSBURG, IL 62675</b>
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S 000	Initial Comments	S 000		
S9999	<p>Annual Licensure and Certification Survey</p> <p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a)</p> <p>300.1210b)</p> <p>300.1210d)5)</p> <p>300.1220b)3)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological</p>	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>These requirements were Not Met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement pressure ulcer prevention measures for two of two residents (R63, R20) reviewed for pressure ulcers in a sample of 35. These failures resulted in R63 and R20 developing stage 4 pressure ulcers.</p> <p>Findings include:</p> <p>A Wound and Ulcer Policy and Procedure policy dated as revised 1/10/2018 states, "It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management." This policy states that a Specialty mattress with enhanced pressure reducing/relieving properties may be placed on the resident's bed and chair as indicated and skin contact surfaces may be padded to protect boney prominences with approaches/interventions placed in the resident's care plan. In addition, this policy states, "When an existing or newly developed pressure ulcer(s) is present, a skin assessment ("skin check") will be documented each shift to monitor the individual resident's tolerance to the current repositioning schedule ("tissue tolerance") and the facility will re-evaluate the frequency of repositioning if indications of further breakdown occur."</p> <p>1. R63's Minimum Data Set (MDS) assessment dated 1/23/23 documents R63 requires extensive</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>assistance of two people for bed mobility, transfers, toilet use, and personal hygiene.</p> <p>R63's Braden Scale for Predicting Pressure Ulcer Risk, dated 11/1/2022, documents R63 is at risk for developing pressure ulcers because R63 responds to verbal commands but cannot always communicate discomfort or the need to be turned, or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities; R63's skin is often but not always moist requiring R63's linen needing changed at least once a shift; R63's ability to walk is severely limited or non-existent and R63 cannot bear own weight and/or must be assisted into chair or wheelchair; R63 moves feebly or requires minimum assistance and during a move, R63's skin probably slides to some extent against sheets, chair, restraints, or other devices; R63 maintains relatively good position in chair or bed most of the time but occasionally slides down.</p> <p>R63's admission nursing progress note dated 12/8/22 at 1:50p.m. states R63 was readmitted from the hospital on that date with, "skin is intact with bright redness noted to BLE (bilateral lower extremities) from knees down with 2-3+pitting edema." This same note states, "per hospital RN (Registered Nurse) in report, 2 different doctors looked at (R63's) legs with no concerns or new orders." R63's nursing progress note dated 12/12/22 at 8:39p.m. documents, "Writer observed a pressure area to outer aspect of left heel. Measuring 3.25 L x 2.5 W. No pain from area. Bil lower extremities remain very tender to touch, bright red/purple in color." This note does not document whether any interventions were developed to treat R63's pressure area or to prevent R63's pressure area from getting worse. R63's nursing progress note dated 12/15/22 at</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>8:39p.m. documents, "Blister to left heel remains intact, skin prep applied to try and toughen skin. This nurse tried to elevate R63's heels off bed, but R63 began screaming, "that hurts! I don't like it this way, removed pillow and advised that I will look for booties for protection." There are no nursing progress notes indicating whether "booties for protection" were ever applied to R63's feet. R63's nursing progress note dated 12/19/22 at 11:21a.m. documents R63 was evaluated by a Wound Physician on that date, who diagnosed R63's left heel wound as an unstageable pressure ulcer measuring 3.0cm (centimeters) x 3.5cm.</p> <p>R63's Medication and Treatment Administration Records (MAR/TAR) dated 12/8/2022 to 12/31/22 do not document R63 was receiving skin assessments every shift after R63 returned from the hospital with bright red lower extremities on 12/8/22, after a pressure area was assessed on 12/12/22, after V14 diagnosed R63's left heel as having an unstageable pressure ulcer on 12/19/22, after V7 (Wound Physician) diagnosed R63's left heel ulcer as deteriorating to a stage 3 pressure ulcer on 12/28/22, or after V7 diagnosed R63's left heel as deteriorating to a stage 4 pressure ulcer on 1/4/23.</p> <p>An Initial Wound Evaluation and Management Summary dated 12/19/22 documents that R63 was evaluated by V14 (Wound Physician) on that date and diagnosed with an unstageable deep tissue pressure injury to the posterior lateral left foot measuring 3.0cm long x 3.5cm wide and without depth which developed 12/12/22.</p> <p>R63's Wound Evaluation and Management Summary dated 12/28/22 and entered by V7 (Wound Physician) documents R63's left heel</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>wound had deteriorated to a stage 3 pressure ulcer by that date measuring 3.0cm long x 3.5cm wide. This note documents that the facility was only using pillows to elevate R63's left heel at that time. V7's recommendation at the end of this visit was for R63 to have a specialized pressure relieving boot for R63's left foot and to "off-load" R63's wound.</p> <p>R63's Wound Evaluation and Management Summary dated 1/4/23 documents that R63's left heel wound was now assessed to be a full thickness stage 4 pressure wound of R63's left, posterior, lateral heel measuring 3cm long x 2.9cm wide with the depth not measurable. This same summary documents R63 required surgical excisional debridement to her left heel stage 4 wound to remove necrotic tissue and establish margins of viable tissue.</p> <p>R63's Wound Evaluation and Management Summary dated 1/11/23 documents that R63 again required surgical excisional debridement of R63's stage 4 left heel pressure ulcer to establish margins of viable tissue.</p> <p>R63's care plan, dated as revised on 1/31/23, documents R63 is at risk for impaired skin integrity and that R63 developed a stage 4 pressure ulcer to her left lateral heel on 12/12/22. This same care plan does not include any new interventions were added to prevent the development of pressure ulcers since the care plan was initiated 10/5/2022. The only addition to R63's impaired skin integrity care plan was to "monitor wound dressing to make sure it is intact and adhering," on 12/12/22.</p> <p>On 2/1/23 at 9:50a.m., V4 (Wound Nurse/Assistant Director of Nursing), V3 (Director</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>of Nursing /DON) and V7 (Wound Physician) entered R63's room to evaluate R63's stage 4 pressure ulcer to R63's left lateral heel. V4 removed R63's dressing. R63's wound was an oval area approximately 3.0cm long by approximately 2.5cm wide with a tannish/orange wound bed and without drainage. V7 stated R63's wound looked 80% (percent) improved from the week before. At 10:10a.m., V7 stated he took over R63's care from V14 at the end of 12/2022. V7 stated R63's left lateral heel wound was already a stage 3 or 4 when he assessed the wound for the first time on 12/28/22. V7 stated that R63's stage 4 left heel pressure ulcer was avoidable and could have been prevented if staff had performed daily skin assessments and implemented pressure relieving interventions while R63's pressure ulcer was only a stage 1.</p> <p>On 2/1/23 at 11:40a.m., V4 stated she is considered the Wound Nurse for the facility. V4 stated she has only been working at the facility since 10/2022. V4 stated she did not know when R63's wound first developed and did not know what interventions were in place for pressure ulcer prevention before R63 developed her initial pressure wound on 12/12/22, before R63's wound became an unstageable pressure ulcer on 12/19/22, before R63's wound became a stage 3 pressure ulcer on 12/28/22 and before R63's wound became a stage 4 pressure ulcer on 1/4/23. V4 verified that R63's wound was not identified until 12/12/22, four days after R63 was readmitted from the hospital. V4 also verified that nursing documentation from 12/8/22 shows that R63's skin was intact at the time of readmission. V4 stated she does not know when R63 was provided with pressure-relieving boots, but states V7 wrote an order for the boots on 12/28/22.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>2. On 2/1/23 at 10:32 a.m., R20 was lying in bed and did not have a low air loss mattress in place.</p> <p>R20's Minimum Data Set assessment dated 11/22/22, documents R20 has severely impaired cognition, requires extensive assist of two staff for bed mobility and transfers, and is unable to ambulate.</p> <p>R20's Care Plan dated 12/7/22, documents R20 has a Stage IV pressure ulcer on her coccyx and is to have a "low air loss mattress on (her) bed."</p> <p>R20's Ulcer/Wound documentation dated 1/27/21, documents R20 developed a facility-acquired stage II pressure ulcer on the coccyx on 1/25/21.</p> <p>R20's Wound Physician Evaluation and Management Summary, dated 2/1/23, documents R20's pressure ulcer to the coccyx first identified on 1/25/21, is now a stage IV pressure ulcer that is 2.5 cm (centimeters) by 1.3 cm. with four cm. undermining.</p> <p>On 2/2/23 at 9:58 a.m., V4 (Assistant Director of Nursing/Wound Nurse) stated R20's bed does not have a low air loss mattress in place. V4 stated R20's care plan interventions for the stage IV pressure ulcer include putting a low air loss mattress in place. V4 stated the low air loss mattress is very helpful for residents that have mobility deficits. V4 stated during her investigation of R20's wound, she discovered R20's coccyx wound was facility acquired. V4 stated R20's coccyx wound was identified as a stage II on 1/25/21 and at some point, worsened to a stage IV.</p>	S9999		



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