STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005334	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHVA CARE OF WINFIELD	28 WEST 141 LIBERTY STREET WINFIELD, IL 60190

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1010h) 300.1210b) 300.1210d)3),4)A),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 accident, injury or change in condition at the time of notification.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 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	S9999		

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S9999	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent and identify an area of pressure prior to becoming a deep tissue injury, failed to implement offloading interventions, and failed to assess new pressure injuries for 2 of 6 resident (R38, R70) reviewed for pressure in the sample of 24. This failure resulted in R70 suffering three deep tissue injuries. The findings include: 1. R70's face sheet listed diagnosis including encephalopathy, kidney disease stage 3, heart failure, acute respiratory failure, bipolar disorder, adult-onset fluency disorder, and dementia. On 02/28/23 at 02:02 PM, R70 was in bed with her eyes closed and positioned to her right side. R70 had heel boots on, and her toes were exposed with no dressings. R70's heels were not offloaded and were in lying on the mattress. On 03/01/23 09:08 AM, R70 was in bed supine with the head of the bed elevated. R70 had bilateral heel boots on with heels resting directly on the mattress. R70's heels were not offloaded. R70 did not have socks or dressing to her feet and her toes were in direct contact with the sheet covering her. R70 was able to say her name but	S9999		

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S9999	Continued From page 3 was otherwise disoriented. R70 was unable to move her legs when requested. On 03/01/23 at 01:56 PM, R70 was supine in bed. A top sheet and blanket rested directly on R70's uncovered toes. R70's heels were not offloaded. Examination of the wounds with assistance of V4 (Wound Nurse) showed left great toe tip had a reddened-purplish area of intact skin, right great toe tip wound (larger than left) showed a flattened dried blood blistered area which was unopened, left heel had area had a discolored, non-blanchable reddened area. None of the wounds had dressings. R70's right heel had a large, discolored area that was blanchable, and the right medial bony prominence of the right foot had a reddened area. On 3/2/23 at 11:04 AM, V2 (Director of Nursing/DON) said, to offload pressure we use air loss mattress, turning frequently, and heel boots. Heel boots off load pressure to the heel. You still need to put pillows under the lower legs to ensure the feet are off the bed. Heels should not be resting on anything. Offloading pressure to the toes is done by using open toed boots, no tight-fitting socks and no blankets tight on the toes. It's important to offload so the skin doesn't open. You don't want other injuries, deeper injuries, or worsening of an injury. The key to pressure prevention is to remove pressure. If pressure is not relieved the wound is going to open, ulcer and worsen. Other wounds may develop as well. On 3/2/23 at 11:30 AM, V2 said I don't consider a blister a pressure ulcer. It can come from things other than pressure. On 3/2/23 at 1:11 PM, V13 (Wound Doctor) said	S9999		

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S9999	Continued From page 4	S9999		

"ideally, yes" he "would expect the facility to identify areas of pressure prior to becoming a stage 3". Ways to offload pressure from the heels may include use of a pillow to float the heel or use offloading boots. They don't have foot cradles here but that would keep the bed covers from rubbing the tips of R70's toes. V13 said he assessed R70 once and determined she had three deep tissue injuries. We discussed the sheets rubbing as the cause of the DTI's. Since they don't have foot cradles, they were going to use ABD (thick gauze pads) pads over the areas. If offloading isn't done, wounds could deteriorate. The blisters did not have clear fluid. That's why they were DTI's. Pressure injury prevention is better than treatment.

During the survey, V4 (Wound Nurse) said he was not certified in wound care and does not officially stage wounds. V4 states his assessments are preliminary until confirmed by V13 (Wound Doctor). V4 does not know V13's name.

R70's 1/25/23 facility assessment showed severe cognitive impairment extensive assistance of two plus persons required for bed mobility, transfer, toilet use, personal hygiene, and total dependence for bathing.

R70's 1/18/23 pressure sore risk assessment showed a high risk.

The facility's weekly wound report showed R70 had three facility acquired (2/14/23) Deep Tissue Injuries (DTI's). Noted on this report was a DTI to the right first toe, left first toe, and the left heel.

R70's 2/17/23 hospice note showed redness to the lower legs and both big toes. The facility

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S9999	Continued From page 5 nurse was notified. R70's 2/18/23 nurses note showed discoloration to the top of bilateral big toes. The nurse notified hospice. R70's 2/18/23 nurses note showed the hospice nurse visited and recommended the facility wound nurse assess the resident for Deep Tissue Injury (DTI) to bilateral great toes, and bilateral heels. The facility wound nurse was updated. The facility's initial wound assessment by the facility was requested an a 2/20/23 Skin Evaluation was received. This document was authored by V4 (Wound Nurse.) R70's 2/20/23 wound evaluation by V13 (Wound Doctor) showed wound #1 unstageable DTI of the right first toe, partial thickness blood filled blister, etiology, pressure. V13 recommended to offload the wound and place an ABD pad to the area daily. Wound #2 unstageable DTI of the left, first toe partial thickness, etiology, pressure. V13 recommended to offload the wound and place and ABD pad over the area daily. Wound #3 unstageable DTI of the left heel partial thickness, etiology, pressure. V13 recommended to offload the wound and float heels while in bed. The National Pressure Injury Advisory Panel (NPIAP) pressure injury stages showed a pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact or open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear	S9999		

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S9999	Continued From page 6 may also be affected by microclimate, nutrition, perfusion, comorbidities, and condition of the soft tissue. A Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. The facility's 1/2023 Assessment of Skin Alteration/Skin Checks Policy showed residents with skin alteration will be assessed, and the physician will provide treatment. The assessment of any alteration should be started immediately upon identification of a pressure ulcer and findings need to be documented in the medical record. Wound assessment/measurement should be completed and documented in the medical record upon identification and weekly until healed to reflect progress. The resident's plan of care should be reviewed and updated as needed. The facility's 2/2022 Wound Prevention Program showed implementation of preventative measures and/or appropriate treatment modalities for ulcers are put into place according to the standard of care. Develop a plan of care and implement intervention according to the resident risk factors identified. 2. Identification of risk factors that can impact developing unavoidable ulcer or will affect healing process if resident does have an ulcer. The following are risk factors: a. acute illness or change in condition i.e., upper respiratory	S9999		

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S9999	Continued From page 7	S9999		

infection, pneumonia c. cognitive loss d. decreased mobility or bedfast g. edema h. elderly residents with very dry skin and/or poor skin turgor i. ends stage disease/ terminal illness m. history of pressure ulcers. 4. Activity Mobility and Positioning Interventions: establish an individualized turning and repositioning schedule if the resident is immobile. If the resident is on bed, position the resident body on bed with pillows, or other supportive devices and/or low air loss mattress to protect boney prominence susceptible to pressure. Offload heels using pillows as needed. Elevate resident heels off the bed as indicated (e.g., place pillows under calf (not under ankles) to raise heels off the bed, unless contraindicated due to medical condition).

2. R38's face sheet printed on 3/1/23 showed diagnoses including but not limited to respiratory failure, heart failure, hypertension, obesity, schizophrenia, mood disorder, intellectual disabilities, and bilateral embolism and thrombosis of lower extremity deep veins. R38's facility assessment dated 1/18/23 showed extensive staff assistance needed for bed mobility, transfers, dressing, and toilet use.

R38's Braden Scale for Predicting Pressure Sore Risk dated 2/19/23 showed a moderate risk.

On 2/28/23 at 10:36 AM, R38 was seated in a wheelchair on the second-floor unit. R38 had yellow anti-skid socks on and both feet were flat on the floor. R38's foot appeared to have a bandage sticking out over the top of the sock. At 12:30 PM, R38 was in his wheelchair in the main dining room wearing the yellow socks. His feet were flat on the floor. At 1:12 PM, R38 was in his wheelchair by the second-floor elevator. R38's

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S9999	Continued From page 8	S9999		

feet were bare, and his feet were flat on the floor. V6 (Registered Nurse) was questioned about the bandage on R38's heel. V6 stated she did not know but guessed it was likely from a recent "treatment".

On 3/1/23 at 8:55 AM, V11 and V12 (Certified Nurse Assistants) toileted R38 while V4 (Wound Nurse) was present. V4 was asked to remove R38's socks and a white bandage was observed on the right heel. V4 removed the dressing. A half-dollar size split open white area with a dime size dark purple center was observed. V4 cleansed and measured the white area and stated it was "3.8 by 4.0 centimeters". V4 said it looked like a blister that had opened. V4 said he would classify the dark purple bruising area as a DTI (deep tissue injury). V4 said it was approximately 25% the size of the blistered area. V4 said it was the first time he was aware of any wounds on R38's heels. V4 said it appeared to have been caused by R38 rubbing his heels on the floor. V4 said R38 propels himself all around the units and should have something protecting his heels to prevent the breakdown. V4 said it should have been off-loaded as soon as it was found. V4 said it should have been documented in the resident chart and verbally passed on between shifts. At 9:20 AM, V4 and the surveyor reviewed R38's electronic medical record together and V4 confirmed there was no documentation of the wound to R38's right heel. V4 said resident skin should be inspected during all care by the aides. Nurses inspect skin two times weekly on shower days. The physician should be immediately notified of any skin changes to get treatment started and get the wound healing right away.

On 3/2/23 at 11:30 AM, V2 (Director of Nurses)

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S9999	Continued From page 9 stated skin checks should be done head to toe with every shower by the CNAs. Nurses do skin checks with every medication pass. If a resident is prone to pressure ulcers, then it is a head-to-toe assessment. Any skin changes should be reported to the physician, family, director of nurses and the wound care nurse right away. V2 said if skin changes are not found at an early stage there is the potential for worsening of the wound and the risk of infection. V2 was asked to describe the characteristics of a DTI and stated it is an area not open, dark purple, and non-blanchable. V4 was present and stated he does the initial assessment on wounds which he did verbally for R38 with the surveyor on 3/1 and the wound care physician does the final "diagnosis". On 3/2/23 at 1:10 PM, V13 (Wound Doctor) was asked to describe the characteristics of a DTI and stated it is a purple, boggy area and may appear as a fluid filled blister. (V13 had just entered the facility and had not yet assessed R38's heel, therefore no formal wound assessment by V13 was available.) V13 said it important to have resident heels protected from pressure and bare feet on the floor is not ideal. V13 said it is important to prevent pressure wounds from forming. It is easier to prevent them versus trying to heal them later. R38's care plan showed a focus area related to skin alterations. Interventions included: "Identify/document potential causative factors and eliminate/resolve where possible; monitor skin with care/showers; report any signs of skin breakdown (sore, tender, red, or broken areas)." The facility's Assessment of Skin Alteration/Skin Checks Policy dated 1/2023 states under the	S9999		

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S9999	Continued From page 10 procedure section: "1. Skin checks should be completed at least daily for any skin alteration. 3. The Resident's doctor should be notified of any skin alteration and obtain new orders for monitoring and treatment. Document the orders in the medical chart." The facility's Wound Prevention Program Policy dated 2/2022 states under the Activity, Mobility and Positioning Interventions section: "c. While in bed or in a wheelchair, resident should be turned/repositioned at least every 2 hours and as needed. i. Off load elbows and heels using pillows as needed. k. Occupational therapy to evaluate for wheelchair positioning as needed." "B" Statement of Licensure Violations II of II: 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. f) The facility shall check for the individual's name	S9999		

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S9999	Continued From page 11 on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to submit background checks, check the Illinois Department of Corrections (IDOC) website, and check the Illinois State Police (ISP) website within 24 hours of admission. This applies to 10 of 10 residents (R33,R47,R120,R121,R122,R276,R300,R301,R302,R306) that were reviewed for criminal backgrounds in the sample of 10. The findings include: R33's electronic face sheet showed R33 was admitted to the facility on 1/11/23. R33's background check was undated. R33's IDOC and ISP checks were completed on 2/8/23 (28 days after R33's admission). R47's electronic face sheet showed R47 was admitted to the facility on 2/3/23. R47's background check was undated. R47's IDOC and ISP checks were completed on 2/8/23. (5 days after R47's admission). R120's electronic face sheet showed R120 was admitted to the facility on 1/6/23. R120's background check was undated. R120's IDOC and ISP checks were completed on 3/1/23. (54 days after 120's admission).	S9999		

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S9999	Continued From page 12 R121's electronic face sheet showed R121 was admitted to the facility on 1/19/23. R121's background check was undated. R121's IDOC and ISP checks were completed on 2/8/23. (20 days after R121's admission). R122's electronic face sheet showed R122 was admitted to the facility on 2/3/23. R122's background check was undated. R122's IDOC and ISP checks were completed on 2/8/23. (5 days after R122's admission). R276's electronic face sheet showed R276 was admitted to the facility on 1/12/23. R276's background check was undated. R276's IDOC and ISP checks were completed on 1/14/23. (2 days after R276's admission). R300's electronic face sheet showed R300 was admitted to the facility on 12/28/22. R300's background check was undated. R300's IDOC and ISP checks were completed on 1/14/23. (17 days after R300's admission). R301's electronic face sheet showed R301 was admitted to the facility on 1/8/23. R301's background check was undated. R301's IDOC and ISP checks were completed on 2/8/23. (31 days after R301's admission). R302's electronic face sheet showed R302 was admitted to the facility on 2/2/23. R302's background check was undated. R302's IDOC and ISP checks were completed on 2/8/23. (6 days after R302's admission). R306's electronic face sheet showed R306 was admitted to the facility on 2/23/23. R306's background check was undated. R306's IDOC and ISP checks were completed on 3/1/23. (6	S9999		

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	IL6005334	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHVA CARE OF WINFIELD	28 WEST 141 LIBERTY STREET WINFIELD, IL 60190

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 days after R306's admission). On 3/2/23 at 9:35AM, V5 (Admissions Director) stated, "Once the resident is here, we do the background checks. I don't know the time frame to get them done. I believe it's 7 days that I have to get the background check done. I don't know where the guidance is at that tells me how soon it needs to be done." "C"	S9999		