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	IL6008684	A. BUILDING: _____ B. WING _____	05/25/2023

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RUSHVILLE NURSING & REHAB CTR	135 SOUTH MORGAN STREET RUSHVILLE, IL 62681

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2) 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 300.1010 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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S9999	Continued From page 2 following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as 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 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, record review and interview, the facility failed to implement pressure relieving interventions and perform daily Diabetic foot skin assessments for one of two residents (R47) reviewed for impaired skin integrity, in a sample of 27. These failures resulted in R47 developing unstageable pressure ulcers to the right and left heel after being admitted to the facility, which lead to osteomyelitis of the left heel and a delay in his discharge back to home. Findings include: The facility policy, titled "Pressure Ulcer and Wound Prevention/Management Program (updated 12/05/2006)" documents, "Purpose: To identify residents who are at risk for pressure ulcers and skin breakdown. To prevent pressure	S9999		

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ulcers and skin breakdown. To provide a guideline for the appropriate nursing management of skin breakdown when it occurs. Responsibility: Director of Nursing, Licensed Nurses, Certified Nursing Assistants, Restorative Nursing, Care Plan Coordinator, Dietitian, Physician and Medical Director. Policy: It is the policy of this facility to ensure that residents who enter the facility without pressure ulcers do not develop pressure ulcers unless the individual's clinical condition demonstrates that the pressure ulcers were unavoidable; ensure a resident who has been admitted with pressure ulcers or develops pressure ulcers in-house receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, when possible." The policy further documents, "3. Residents' skin will be inspected during daily bathing, dressing, showering, and incontinence care with special attention to bony prominences by CNAs (Certified Nursing Assistants) and staff nurses. Bony prominences include: Occipital, chin, scapula, elbow, sacrum, ischium, iliac crest, trochanter, knee, malleolus, and heel. Other common areas of breakdown include lower extremities and toes. 4. Weekly skin assessments will be completed for residents who are mild and moderate risk for breakdown. Daily skin assessments will be completed for residents who are high and severe risk for breakdown. Facility will determine where documentation of skin assessments will be completed."

The Electronic Medical Record documents R47 was admitted to the facility on 1/10/23 for aftercare following a left total hip replacement, with the goal of returning to his home after completing Physical and Occupational Therapy. R47's admitting diagnoses include: Type 2

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Diabetes Mellitus, Long Term (current) use of Insulin, Left Femur Fracture, Osteoarthritis and Anemia. An Initial/Baseline Care Plan dated 1/10/23 documents R47 required "extensive assistance" for bed mobility, was at risk for pressure sore/ulcer/skin injury and needed "Positioning-turn and reposition every two hours and as needed." R47's Comprehensive Plan of Care, with a start date of 1/10/23, documents R47 is "at risk for pressure ulcers (related to) weakness, related to (Diabetes Mellitus Type II), Folate Anemia, Primary Osteoarthritis", with a short term goal of "(R47's) skin will remain intact." The Comprehensive Plan of Care instructs staff to do the following to prevent R46 from experiencing skin breakdown: Avoid shearing skin during positioning, transferring and turning; Keep clean and dry as possible, Keep linens clean, dry and wrinkle free, Pressure relieving device to chair and bed, Provide incontinence care after each incontinent episode, Report any signs of skin breakdown, Use absorbent, skin-friendly pads/briefs, Use moisture barrier product to perineal area." The Comprehensive Plan of Care failed to include instruction to staff for turning and repositioning R47 or frequency of R47's skin assessments. A Minimum Data Set assessment, dated 1/16/23, documents R47 as having a BIMS (Brief Interview of Mental Status) of 15, which indicates R47 is cognitively intact, requires the extensive assistance of 2+ staff members for bed mobility (turning/repositioning), and as at risk for developing pressure ulcers/injuries. The 1/16/23 Minimum Data Set assessments documents, under "M1200. Skin and Ulcer/Injury Treatments" the following marked as implemented: Pressure reducing device for chair and bed; however, "Turning/repositioning program" and "Nutritional or hydration intervention" were not marked as

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implemented at that time. A Braden Scale assessment (scores risk of pressure ulcer development), dated 1/25/23, documents R47 is at "Moderate Risk" for the development of pressure ulcers, based on his ability to respond meaningfully to pressure related discomfort, level of physical activity, limited ability to make changes in body position independently, inadequate oral/nutritional intake, and requiring moderate to maximum assistance to move his body. The 1/25/23 Braden Scale assessment checks off the following interventions as being implemented: Pressure relieving device for chair and bed and "other preventative or protective skin care"; again, "turning/repositioning program" and "nutrition or hydration intervention" was not checked off as being implemented by staff. Nursing Progress notes, dated 1/27/23, document R47 continues to require extensive staff assistance with bed mobility. On 2/01/23, R47 experienced weight loss when his weight decreased from 176.8 pounds (1/11/23) to 169.8 pounds in three weeks.

A Nursing Progress note dated 2/06/2023 at 5:58 AM, documents "(R47) noted to have (two) areas to right heel and one area to left heel. No (sign/symptoms) of infection noted. Heels offloaded. (Physician) notified via fax and will have wound doctor evaluate today." Skin Integrity Conditions reports, dated 2/06/23, documents R47 was found to have the following wounds: 1.) Right heel, facility acquired, unstageable wound measuring 1.0 cm (centimeters) x 0.5 cm; 2.) Right heel, facility acquired, unstageable Deep Tissue Injury, measuring 4.5 cm x 2.5 cm, with a "black" and "purple" wound bed; and 3.) Left heel, facility acquired, unstageable Deep Tissue Injury, measuring 5.0 cm x 4.0 cm, with a "black" and

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"purple" wound bed, and serosanguineous exudate. The 2/06/23 Skin Integrity Conditions report documents staff then implemented a turning and repositioning program, ulcer/wound care and treatment and a nutrition/hydration intervention for R47. On 2/06/2023, a Daily Diabetic foot inspection was initiated for R47 as well according to the documented Daily Skin Checks. On 2/09/23, Nursing Progress notes document, "Resident was seen by wound physician via telehealth this afternoon for evaluation of bilateral heels. Left heel: diabetic wound. 3.4 (cm) x 5.0 (cm) Wound is closed. Cleansed and betadine applied and left (open to air). Placed off-loading boot on. Right heel: diabetic wound 4.0 (cm) x 4.0 (cm). Wound is closed. Cleansed and betadine applied and left (open to air). Placed off-loading boot on. Resident was having poor blood sugar control which contributed to the development of these wounds. He states that he rubs his heels on his sheets at night when he is trying to sleep. Wound doctor suggests to continue painting heels with betadine and leaving (open to air) and to continue with off-loading boots at all times except when bathing, transferring, ambulating, etc. Physician did order the following labs to be performed: CBC (Complete Blood Count), CMP (Complete Metabolic Pane), A1C (Hemoglobin A1C), pre-albumin. He also ordered a multivitamin daily, Vitamin C 500 mg (twice per day), and zinc sulfate 220 mg (orally for) 14 days as well as a protein supplement with meals or per dietary. Will have dietary manager ask dietician. Resident did state during rounds that he is not going to be taking any extra medications to help the healing process. Education provided." On 2/15/23, Nursing Progress notes document the following, "This RN (Registered Nurse) sent fax to (Primary Care Physician) updating her on (R47's) wounds.

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S9999	Continued From page 7 She replies back: CBC, CMP, Sedimentation Rate, CRP (C-Reactive Protein) STAT (as soon as possible), MRI (Magnetic Resonance Imaging) bilateral heels- (to rule out) Osteomyelitis, -Schedule with (Wound Clinic as soon as possible) for debridement, (discontinue) Betadine to heels. (Begin treatment of) Calcium Alginate to bilateral heels and cover with ABD pad and kling/kerlix daily and (as needed), (start antibiotic) Augmentin 875 mg (orally every 12 hours for 14 days)." On 2/16/23, Nursing Progress notes document R47's heel wounds had increased in size, with the left heel measuring 4.0 (cm) x 7.0 (cm) x 0.0 (cm) and the right heel measuring 8.5 (cm) x 11.0 (cm) x 0.0 (cm) and R47 was referred to the local Wound Clinic due to the facility's Wound Doctor only being able to do telehealth. A Wound Clinic Note, dated 2/20/23 by V10 (Wound Doctor), documents "(R47) has a large wound of the right heel that measures 2.8 cm by 3.8 cm circumferentially, by 0.1 cm deep. A black eschar that is adherent occupies nearly the entire surface of the wound. No discharge. No surrounding Heat, erythema or fluctuance. There is a similar wound of the left posterior heel that measures 4.8 cm by 7.5 cm circumferentially, by 0.1 cm deep. It has the same characteristics as the wound about the right posterior heel." The Wound Clinic Note later documents, "Assessment: 1. Large multifactorial unstageable pressure wounds of both heels. 2. Contributions from immobility, pressure, diabetes, diabetic neuropathy and arterial insufficiency." A 5/16/23 MRI of R47's lower extremities documents R47 had developed "acute Osteomyelitis of the left heel. Wound Management Notes, dated 5/18/23, document R47's Left Heel wound as measuring 4.0 cm x 6.0 cm and Right Heel wound as measuring 2.5 cm x 5.5 cm.	S9999		

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S9999	Continued From page 8 On 5/23/23 at 2:08 PM, V16 (Registered Nurse/Wound Nurse) and V17 (Licensed Practical Nurse) provided wound care to R47. At that time, R47 had a left heel wound, slightly larger than a golf ball, with a black center and a right heel wound, approximately the size of a quarter, with a black center. On 5/24/23 at 11:20 AM, R47 stated he needed the help of staff to turn over and change positions in bed when he was admitted to the facility from the hospital, and R47 indicated he still needs assistance to do so. R47 stated, "When I came (to the facility), my heels would just lay flat on the bed, not up and off like now. " When R47 was asked if staff would routinely help him turn and reposition on a scheduled or regular basis after he was admitted, R47 stated "No, but they do more so now that I have sores on my feet." R47 stated, "I want to go home, but now I can't because I have these (pointing to his feet) that need taken care of." On 5/24/23 at 11:27 AM, V2 (Director of Nursing) stated, facility protocol is for all residents that have Diabetes to be placed on a nightly foot skin check upon admission. V2 confirmed that R47's daily foot skin assessments were not implemented until his heel wounds were found on 2/06/23. On 5/25/23 at 12:29 PM, V16 stated she determines if a resident needs to be on a turning and repositioning program, based on their assessed risk for pressure ulcer development based and if they are able to turn and reposition themselves. V16 concluded that R47 was not able to turn and reposition himself independently when he was admitted to the facility and R47 did	S9999		

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S9999	Continued From page 9 have multiple factors that put him at risk for skin breakdown. V16 stated it was unknown why R47 was not placed on a turning and repositioning program at the time of admission. On 5/25/23 at 8:41 AM, V10 (Wound Doctor) stated he saw R47 in his outpatient wound clinic about two weeks after R47's wounds initially developed. V10 stated R47's wounds are as a "result of pressure to his heels, over a boney prominence, along with multifactorial contributions, such as his immobility, Diabetes Mellitus, nutrition, and arterial insufficiency." V10 stated, given R47's immobility and risk factors for pressure ulcer development at the time of his admission to the facility, "nursing staff should have implemented basic interventions, like scheduled turning and repositioning and daily skin assessments." V10 stated "The key to daily skin assessments is to identify skin breakdown early, as a Stage I, and to prevent progression. Routine skin checks would prevent wounds, like (R47's) from being first identified at the size and progression his were." V10 stated, "resident wounds that are found to be necrotic on the initial assessment, indicate a lack of ongoing skin assessments by staff." V10 stated R47's left heel now has Osteomyelitis which could very likely lead to amputation of the left foot. (B)	S9999		