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
	IL6014872	A. BUILDING: ______ B. WING ______	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY REHAB & HCC	3298 RESOURCE PARKWAY DEKALB, IL 60115

(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
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.1220b)3) 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.	S9999	Attachment A Statement of Licensure Violations	

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

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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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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.

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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 indicated by the resident's condition. The plan shall be reviewed at least every three months.

These Requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify pressure injuries prior to becoming unstageable, as a result of this failure R8 developed multiple pressure injuries to her heels. The facility also failed to ensure current wound treatments were completed, failed to ensure pressure ulcer prevention measures were in place and failed to clean a pressure wound in a manner to prevent cross contamination for 2 of 3 residents (R34, R51) reviewed for pressure injuries in the sample of 17.

The findings include:

1. R8's Admission Record shows she was admitted to the facility on 4/11/23. The June 2023 POS (physician order summary) shows an order to float heels while in bed every shift for prevention of skin breakdown. The orders include skin prep daily and as needed for wound care to the right heel and the left heel starting 6/23/23.

The 4/18/23 Facility Admission Assessment documents R8 to have severe cognitive impairment. The same assessment shows she is dependent on staff for bed mobility and transfers

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between her bed and wheelchair. R8's Skin Condition Assessment shows she was admitted with 1 stage 4 pressure injury and no unstageable wounds. This same assessment also shows she is at risk of developing pressure ulcers/injuries.

The nursing progress notes for R8 were reviewed for 6/22/23 and 6/23/23 and does not indicate any new wound to the right or left heel. The progress notes show on 6/26/23, R8's daughter was notified of breakdown of heels.

The 6/26/23 the Pressure Ulcer Weekly Wound Evaluation for R8 shows a DTPI (deep tissue pressure injury) and is 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. The Wound Evaluation shows the identification on 6/22/23 during the wound doctor visit, and the family was not notified until 6/26/23. The wound was noted to be a facility acquired DTPI to the right heel measuring 1.5 cm (length) by 1.5 cm (width). A second Pressure Ulcer Weekly Wound Evaluation for 6/26/23 documents a DTPI to the left heel identified on 6/22/23. The left heel measured 2.2 cm by 1.5 cm and was identified on the doctor wound visit.

On 6/28/23 at 10:40 AM, V4 LPN (Licensed Practical Nurse)/ wound nurse said he was notified last week of R8's breakdown of both of her heels. He said the wounds were identified on 6/22/23. He said R8 should have had her heels floated and/or wearing boots. V4 said the heel wounds were due to pressure on her heels being in the same place for an extended time. The wounds could have been prevented. He said the staff should have ensured she had on her protective boots and check on her heels more

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often.

On 6/28/23, R8 was observed lying in bed with boots to both feet. Her right and left heels were noted to have reddened circular areas.

On 6/29/23 at 9:10 AM, V2 DON (Director of Nursing) said staff should ensure all interventions are in place for pressure injury prevention. The aides and nurses should be monitoring residents skin condition daily with care and showers. V2 said any skin breakdown should be noted on Shower Sheets and reported to the nurse and wound nurse. V2 said any pressure injury should be identified prior to becoming unstageable or a stage 2.

R8's Care Plan for impaired skin integrity was revised on 6/23/23 with the addition of the left and right heel DTPI, and no new interventions added to the plan of care.

The facility's 3/2022 policy for pressure ulcer/ pressure injury prevention documents to minimize pressure: turning and repositioning every two or three hours when in bed, or more frequent depending on the need of the resident. Relieve pressure to heels by using pillows or other devices. Do not depend on heel protectors, they do not provide pressure reduction/relief. Pressure reduction/relief devices should serve as adjuncts and are not replacements for repositioning protocols.

2. R51's Admission Record, printed by the facility on 6/29/23 showed she had diagnoses including multiple sclerosis, generalized muscle weakness, a stage 3 pressure ulcer of right heel, and unspecified dementia.

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S9999	Continued From page 6 On 6/27/23 at 2:49 PM, R51 was sitting in her geriatric chair. R51 was alert and oriented. R51 did not have any pressure relieving boots on her bilateral heels. There was no pillow or cushion under R51's legs to offload pressure to her bilateral heels. R51's heels were resting against the leg rest of the geriatric chair. R51 said she only wears the pressure-relieving boots when she is in bed. R51 said she has never refused to wear the pressure-relieving boots. R51's Facility Assessment dated 6/2/23 showed she was cognitively intact and was dependent on staff for bed mobility, transfers, dressing, personal hygiene, toileting and eating. The same assessment showed R51 had a stage 3 pressure ulcer. R51's Braden Scale for Predicting Pressure Sore Risk dated 5/25/23 showed she was at high risk (score of 12) for developing pressure sores. R51's 6/9/23 Pressure Ulcer Weekly Wound Evaluation showed she had a stage 3, full thickness tissue loss pressure ulcer to her right heel measuring 1.4 cm (centimeters) x 0.6 cm x 0.2 cm. The evaluation showed the pressure ulcer was identified on 5/25/23. The evaluation also showed the pressure ulcer was debrided on 6/8/23 R51's Wound Specialist Assessment dated 6/15/23 showed the right heel pressure wound measured 0.2 cm x 0.2 cm x 0.2 cm on that day. The 6/22/23 Wound Specialist Assessment showed R51 refused the assessment on that day. R51's Order Summary Report, showing active orders as of 6/29/23, showed "bunny boots (pressure-relieving boots) every shift check for placement." The order summary report also	S9999		

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showed "Right heel pressure wound- cleanse with wound cleanser, pat dry, skin prep to wound bed and LOTA (leave open to air) daily and as needed.

On 6/28/23 at 1:47 PM, V4 (Wound Nurse) cleaned R51's right heel with wound cleanser and gauze. V4 moved the gauze in a circular motion, going from periwound to the wound bed. V4 covered the wound with silicone dressing.

On 6/28/23 at 2:52 PM, this surveyor reviewed R51's orders with V4. V4 said the wc in the bunny boots order stands for wound care. V4 said the order showed to make sure the boots are on every shift. When asked when the boots should be on, V4 said mostly in bed. V4 said the order does not specify. This surveyor asked V4 to read the treatment orders for R51's right heel wound. V4 read them. V4 was asked if that was the treatment, he performed for R51's right heel. V4 said no. V4 said he did the treatment that was listed on the weekly wound report. V4 said R51 still has a small open area to her right heel.

On 6/28/23 At 3:32 PM, V2 (Director of Nursing-DON was shown the order for the pressure-relieving boots. V2 said the boots should be on R51 at all times. On 6/29/23 at 10:30 AM, V2 you should wipe from the center out when performing wound care, you do not want to get any bacteria from the surrounding skin into the wound bed. V2 said the wound treatment should be done according to the current orders. V2 said if a resident has a stage 3 pressure ulcer on their heel, and there is an order to have pressure-relieving boots on you, would want to make sure the boots are in place, to keep pressure off the area.

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On 6/29/23 at 12:20 PM, V4 said he should have dabbed the wound to clean it and not have gone in a circular motion to prevent bacteria from the periwound entering the wound bed.

6/29/23 12:22 PM, V15 (Wound Specialist) said R51 should have the boots on when she is up in the chair to reduce pressure on her heel and to promote healing. At 12:28 PM, V15 said as long as there is a pillow under the posterior calf in the chair, it would offload the heels.

The facility's Weekly Pressure Ulcer report dated 6/21/23 showed R51 had a deep tissue injury to her right heel that was facility acquired and identified on 5/25/23. The weekly wound report showed the pressure injury to her right heel measured 2.0 cm x 0.9 cm x unknown.

R51's Skin Integrity Care Plan, with a revision date of 6/5/23, showed "Administer medications as ordered and monitor for effectiveness."

The facility's policy and procedure titled Pressure Ulcer/Pressure Injury Prevention, with a revision date of 3/2022, showed "A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A facility must: Identify whether the resident is at risk for developing a PU/PI upon admission and thereafter; Evaluate resident specific risk factors and changes in the resident's condition that may impact the development and/or healing of a PU/PI; Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors; and if a PU/PI is present, provide treatment to heal it and prevent the development of additional PU/PIs." The policy showed one of the interventions that should be implemented for residents at high risk for

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developing pressure ulcers (score of 10-12) is "Protect heels, float heels."

3. R34's FaceSheet printed on 6/29/23 indicates R34's diagnoses including but not limited to cerebral infarction, diabetes mellitus, dementia, heart disease, palliative care, and stage 2 pressure ulcer of the sacral region. R34's Facility Assessment dated 5/5/23 showed severe cognitive impairment and staff assistance needed for bed mobility, dressing, toilet use, and hygiene. The same assessment showed R34 is always incontinent of urine and bowel. R34's Braden Scale for Predicting Pressure Sore Risk dated 5/1/23 showed at risk for pressure ulcer development.

R34's electronic medical record showed a current weight on 6/29/23 of 162.6 pounds.

On 6/27/23 at 10:24 AM, R34 was lying in bed on his back. R34 stated he never gets out of bed because he can't walk. At 1:06 PM, R34 was in the same position. On 6/28/23 at 8:13 AM, R34 was in the same position. On 6/29/23 at 9:55 AM, R34 was in the same position. R34 was not observed out of bed at any time during the survey from 6/27 to 6/29/23.

On 6/29/23 at 10:00 AM, R34's pressure ulcer mattress setting was observed with V4 (Wound Care Nurse). The mattress setting was at the 300-to-425-pound level. V4 stated (R34) had a stage 2 pressure ulcer on his coccyx. It is closed now, but interventions are needed to keep it closed. The mattress setting is based on weight. It helps him because he doesn't get out of bed much. He refuses to get out of bed most of the time and doesn't change position well by himself. If the mattress setting is not at the right level, it

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S9999	Continued From page 10 could cause skin breakdown again. Too hard of a mattress can cause too much pressure on the area already prone to pressure ulcers. V4 said the mattress is definitely at the wrong level and should be checked by the nurses during each shift to ensure it is correct. (B)	S9999		