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
	IL6009237	A. BUILDING: ________ B. WING ________	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	**100 EASTVIEW PLACE SULLIVAN, IL 61951**

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S 000	Initial Comments Complaint #2369828/IL167081	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 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:

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S9999	Continued From page 2 Based on record review and interview, the facility failed to provide treatment and services to prevent the development and worsening of a residents pressure ulcer. These failures affect one (R1) of three residents reviewed for pressure ulcers in the sample list of five. These failures resulted in R1's facility acquired pressure ulcer worsening. Findings include: R1's undated Face Sheet document R1's diagnoses as Alzheimer's Disease, Fracture of unspecified part of neck of unspecified femur, subsequent encounter for closed fracture with routine healing, methicillin resistant staphylococcus aureus infection as the cause of disease classified elsewhere. R1's March 2023 Weekly Wound Tracking documents on 3/9/23 R1's Stage Four pressure ulcer measured 0.5 cm by 0.2 cm by 0.1 cm. There are no documented measurements/assessments after 3/9/23 until 3/31/23 when R1's ulcer was larger and measured 2.5 cm by 2.5 cm by 0.8 cm. R1's Treatment Administration Record (TAR) dated March 2023, documents no treatments being completed on the following dates: 3/1/23 day and evening shifts, 3/3/23 day shift, 3/4/23 day shift, 3/5/23 evening shift, 3/9/23 evening shift, 3/10/23 day shift, 3/11/23 day shift, 3/12/23 day shift, 3/21/23 day shift, 3/25/23 evening shift, 3/27/23 evening shift, 3/29/23 day shift, and 3/30/23 day shift. On 12/12/23 at 12:06 PM, V13 Licensed Practical Nurse (LPN) stated that V13 found R1 lying in urine and feces all the time, R1's bed and R1	S9999		

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herself would be soaked. V13 stated R1 was only repositioned when the nurses did it because the Certified Nursing Assistant's (CNA) never did it.

On 12/12/23 at 2:08 PM, V14 LPN stated V14 worked at the facility R1 was at before they both came to this facility. V14 stated R1's wound got worse and worse at this facility. V14 stated R1 should have been repositioned but don't think the CNA's did it at all or very often and she would frequently have to remind them to do it. V14 stated she did find R1 lying in urine and feces.

On 12/12/23 at 2:37 PM, V21 Medical Doctor (MD) stated if treatments were not documented as being completed and the (R1's) wounds were not treated then yes the wounds will get worse. V21 stated wound assessments should be completed every time the dressing is changed with measurements and wound descriptions.

On 12/13/23 at 1:43 PM V15 Corporate Nurse stated the nurses should follow the facility's policy when a pressure ulcer is identified and wound assessments should include size, drainage, and depth. V15 confirmed wounds should be assessed upon identification, the stage of the ulcer should be included, and R1's initial wound assessment does not identify the stage. V15 stated barrier cream can be applied by the CNA's and applications are not recorded. V15 stated daily skin checks are documented on the Treatment Administration Record (TAR). V15 reviewed R1's July 2022 TAR and confirmed it does not document daily skin checks were completed or barrier cream application. At 1:53 PM V15 provided R1's July 2022 wound log and confirmed the log does not identify the stage of the wound prior to 7/28/22. V15 stated the nurses don't always have to stage the wound.

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R1's medical record documents the following related to pressure ulcer history:

R1's Care Plan dated 7/13/22 documents R1 has incontinence and includes interventions for use of incontinence briefs, change as needed, assess skin with each incontinence episode, and apply barrier cream as needed. This Care Plan documents to provide scheduled toileting assistance upon rising, before/after meals, and before bed. This Care Plan documents R1 is at high risk for developing pressure ulcers due to thin skin, poor safety awareness, and Alzheimer's Disease. This care plan documents interventions for daily skin checks, document any new skin conditions and to apply barrier cream to perineal area with each incontinence episode and as needed, and assist R1 to turn and reposition per schedule or at least every 2 hours.

R1's July 2022 Treatment Administration Record (TAR) does not document R1's care plan interventions for daily skin checks and barrier cream application were implemented after admission on 7/13/23.

R1's Admission Assessment dated 7/15/22, documents R1 admitted with redness to R1's sacrum. This assessment does not document R1 had any open wounds upon admission.

R1's Admission Minimum Data Set (MDS) dated 7/20/22 documents R1 has short/long term memory impairment and R1 is dependent on two or more staff for assistance with bed mobility, transfers, and toileting. This MDS documents R1 is at risk for developing pressure ulcers and did not have pressure ulcers when R1 admitted to the facility. R1's Newly Acquired Skin Conditions form

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S9999	Continued From page 5 dated 7/26/22, documents R1 has a pressure area of the coccyx that measures 6 centimeters (cm) by 5 cm. R1's Nursing Note dated 7/26/22 documents R1 has an open area to R1's coccyx and a calcium alginate treatment was applied. R1's July 2022 Weekly Wound Tracking report documents R1's ulcer began on 7/26/22 and the wound was pink with minimal drainage and the wound was classified as a Stage Four on 8/19/22. There is no documentation in R1's medical record of the stage of this pressure ulcer prior to 7/28/22. R1's Wound Evaluation & Management Summary dated 7/28/22, recorded by V20 Wound Physician, documents R1 has a full thickness pressure ulcer of the sacrum that was unstageable due to necrosis (dead tissue.) This wound measured 5.5 cm by 4.5 cm by 0.1 cm deep and 20% of the wound was necrotic tissue which was subsequently debrided. The facility's Aseptic Wound and Skin Treatment Procedure dated Reviewed 1/18, documents the purpose of this policy is to prevent contamination of a wound, to promote circulation and healing, prevent further deterioration of skin tissue, prevent necrosis of deeper body structures, and promote resident comfort. (B)	S9999		