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
	IL6011373	A. BUILDING: ______ B. WING ______	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF STERLING	612 WEST ST MARY'S STREET STERLING, IL 61081

(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 Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)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. 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.	S9999		

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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:

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.

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. 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

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modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify a pressure injury prior to be becoming a Stage 3, failed to assess a new pressure injury, and failed to implement pressure relieving interventions after a new wound was found for 1 of 6 of residents (R82) reviewed for pressure in the sample of 19.

These failures resulted in R82 having a Stage 3 pressure injury for a week before an assessment was done, pressure relieving interventions were put into place and the pressure care plan interventions were updated.

The findings include:

R82's face sheet showed a 79-year-old female with diagnosis of mild protein calorie malnutrition, conversion disorder with seizures, intellectual disabilities, hypertension, dysphagia, malignant neoplasm of the uterus, and cognitive communication deficit.

On 9/24/24 at 10:23 AM, R82 was in the hallway in a wheelchair. R82 was self-propelling the chair and leaned to the left.

On 9/24/24 and 9/25/24, R82 was seen in her wheelchair and consistently leaned to the left.

On 9/26/24 at 7:41 AM, V8 (Wound Doctor) said he expects a wound to be assessed by the nurse at the time it is found. V8 said, "They shouldn't

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wait a week for me to look at it. The wound could deteriorate. [R82's] left mid back wound is a Stage 3 pressure injury". V8 measured the back wound as 3.0 centimeters (cm) X 2.5 cm X 0.1 cm. The wound had a reddened circumference, darkened center, and was circular in shape. V8 ran his finger on R82's back to show the staff present the wound was over the posterior rib cage. V8 told the staff, "You don't want it to get any worse. It's right over the chest". V8 debrided the wound at the bedside. V6 (Licensed Practical Nurse) showed V8 R82's wheelchair and said she believed R82's back rubbed on the metal bar on the left side of the wheelchair as she usually leans that way. V8 asked V6 to have therapy apply a pad to the back of the chair to pad the area and alleviate pressure from the bar. V8 said the facility "definitely" should have implemented interventions to relive pressure to R82's back. V8 said, "A cushion or something to provide pressure relief. An initial assessment is important to know if the treatment is doing the job or not. Is it getting better or worse? It helps you decide on the treatment".

On 9/26/24 at 8:07 AM, V2 Director of Nursing (DON) said when a wound is found the nurse should do an assessment and document the assessment. V2 said, "Documentation could be done in the progress note. Not every wound has a wound observation tool. There should be a wound note on the date the wound is found, and I don't see one for [R82's] wound". V2 was unable to show any care plan interventions initiated after finding the wound to R82's back. V2 said R82 is only in bed at night.

R82's 5/22/24 admission skin assessment showed no open areas.

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S9999	Continued From page 4 R82's physician order sheet showed a 9/19/24 order that she may see the wound care services. Another order dated 9/18/24 showed wound treatment orders to the mid back wound to start 9/19/24 (wound present 9/18/24). R82's wound doctor notes showed no mention or assessment of the left mid back wound. R82's pressure care plan interventions have had no updates since 5/2024. R82's 8/23/24 facility assessment showed moderate cognitive impairment. The facility's 1/3/22 Pressure Injury Prevention and Management Policy showed: The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; and modifying the interventions as appropriate. Licensed nurses will conduct a full body skin assessment on all residents after any newly identified pressure injury. Assessments of pressure injuries will be performed by a licensed nurse and documented on the____________ (left blank). After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. Evidence based interventions for prevention will be implemented for all residents who have a pressure injury present. Interventions on a resident's care plan will be modified as needed. Considerations for needed	S9999		

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S9999	Continued From page 5 modifications include new onset or recurrent pressure injury development. (B)	S9999		