STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007025	A. BUILDING: _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTSIDE HEALTH & REHAB CENTER	1400 EAST WASHINGTON STREET PITTSFIELD, IL 62363

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procedures:
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess and identify, treat, and provide turning and repositioning for 2 of 4 residents (R15, R45), reviewed for pressure ulcers in a sample of 24. This failure resulted in R45 developing facility acquired unstageable pressure ulcers to his buttock.

Findings include:

1. R45's Physician Order Sheet (POS) dated 5/22/19 documents diagnoses of Dementia, Anemia, Senile Dementia, Hypertension, Chronic Kidney Disease and Hypothyroidism.

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R45's Minimum Data Set (MDS) dated 6/5/19, documents that R45 has severe impaired cognitive skills for daily decision making; indicating he is moderately impaired, having an indwelling catheter and "always incontinent of bowel." The MDS further documents R45 requires total assistance from staff with bed mobility, transfers and personal hygiene.

R45's Braden Scale for Predicting Pressure Ulcer Risk dated 5/22/19 documents 13, indicating high risk for skin breakdown.

R45's Care Plan, initiated on 11/25/17, documents that he is at risk for skin breakdown, Certified Nurse's Aides (CNAs) will conduct skin checks daily during care and baths/showers and staff report any new skin concerns to the doctor for treatment and follow-up. The Care Plan further documents R45 had a Stage 2 pressure ulcer on his right buttock on 2/12/19 that was "healed" on 2/27/19 and had a Stage 2 pressure ulcer to his left buttock on 2/12/19 that was "resolved" on 3/5/19.

R45's Wound Documentation notes for R45, dated 4/3/19, documents "Skin w/d (warm and dry), no excoriated areas noted, OA (open area) to R (right) outer heel that measures 1 by 1.4 centimeters (cm). 0 (no) other concerns noted."

R45's Nurse's Notes dated 4/10/19 at 9:15AM, document in part, "Resident noted to have pressure areas to bilateral buttocks. Doctor notified for treatment orders. Resident to lay side to side in bed. Spoke with wife about fresh fruit for snacks. Special cushion provided for wheelchair. Care plan updated." The Nurse's Notes did not describe the size, color or condition

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of the pressure ulcers.

R45's Care Plan dated 4/10/19 documents R45 having bilateral Stage 2 pressure ulcers to his right and left buttock.

R45's Treatment Administration Record (TAR) dated 4/12/19 documents "Area to right buttock 4.5 X (by) 3.0 cm. left (lower) buttock 2.0 X 3.0 cm." The TAR documented the areas were yellow and black with moderate drainage.

R45's TAR entry, dated 4/22/19, documents R45's pressure ulcer to right buttock measured 4.5 cm by 3.0 cm and the pressure ulcer on his left buttock 4.0 cm by 1.5 cm. The TAR documented the pressure ulcer was unstageable.

R45's TAR entry, dated 4/30/19, documents R45's pressure ulcer to his right buttock measured 5.0 cm by 3.0 cm and his left buttock pressure ulcer measured 3.7 cm by 1.5 cm. The TAR documented the pressure ulcer was unstageable.

Interdisciplinary Team (IDT) notes dated 5/1/19, documents the IDT met and R45's skin was reviewed, and the findings were that each of R45's areas to each buttock were worsening. The documentation further documents the doctor was notified and a referral was received for R45 to go to the wound clinic.

Wound clinic notes dated 5/7/19, documents in part R45 having unstageable pressure ulcers to his right and left buttocks.

The facility matrix dated 6/16/19, documents R45 has a Facility acquired pressure to right and left buttock discovered on 4/12/19. There is no entry

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noted for R45's pressure ulcers for 4/10/19.

On 6/20/19 at 2:00PM, V2, Director of Nursing (DON), stated the facility was not aware of R45 having pressure ulcers until they were open on 4/10/19, but were not measured until 4/12/19, and that the pressure ulcers should have been measured at the time they were noted. V2 stated she could not explain why R45's pressure ulcers weren't discovered prior to becoming unstageable.

The Facility Policy entitled "Decubitus Care/Pressure Areas", revised on 1/18, documents "Policy: It is the policy to ensure a proper treatment program has been instituted and is being closely monitored." The Policy documents "Procedure: 1) Upon notification of skin breakdown, the QA (Quality Assurance) form for Newly Acquired Skin Condition will be completed and forwarded to the Director of Nurses. 2) The pressure area will be assessed and documented. 3) Complete all areas of the Treatment Administration Record or Wound Documentation Record. i) Document size, stage, site, depth drainage, color, odor, and treatment." The Policy further documents in part, "5) Documentation of the pressure area must occur upon identification."

2. On 6/17/19 at 11:43 AM, R15 was asleep sitting in his high back chair in a reclining position in his room, leaning to the left side with no positioning devices in his chair. At 3:13PM, R15 remained up in his chair.

On 6/17/19 at 3:13PM, V16, CNA, stated R15 had been sitting up prior to the noon meal.

On 6/18/19 at 11:50PM, R15 was noted sitting in

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his high back chair in a reclining position at the nurse's station. R15 had no positioning devices in his chair.

On 6/18/19 at 2:10PM, surveyor asked V7 and V17, CNAs, how long R15 had been sitting in his high back chair. V7, CNA, stated in part, "He's been up since 11:40 (AM), so yes, longer than 2 hours." After R15 is then transferred from his chair to bed by V7 and V17. Once in bed, R15 was rolled onto his right side and his pants and incontinent brief were removed. R15 had deep red creases on his left buttock, extending down to his mid right thigh. When R15 was rolled onto his left side, deep red creases were noted extending from his right mid back down to his right mid-thigh.

R15's MDS, dated 4/21/19, documents R15 having severely impaired Cognitive Skills for Daily Decision Making. The MDS further documents R15 requiring total dependence on staff for Activities of Daily Living (ADLs).

R15's Pressure Ulcer Risk Assessment dated 4/19/19, documents R15 scoring a 12, indicating a high risk for skin breakdown. The Assessment further documents in part R15, "Requires moderate to maximum assistance in moving. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance."

R15's Care Plan dated 4/19/19, documents in part, R15 having Dementia with psychosis and Alzheimer's. The Care Plan further documents R15 having self-care deficits and dependent on staff for ADLs, being incontinent, and to use pillows for positioning and is to be turned at least every 2 hours and as needed.

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S9999	Continued From page 6 On 6/19/19 at 10:51 AM, V2, DON, stated she would expect for staff to turn and position R15 even while up in a chair timely. On 6/20/19 2:30PM, V1, Administrator, stated in part it is the expectation for staff to reposition residents at least every 2 hours, and depending on the resident's condition, it may be more frequently, but at the very least every 2 hours. V1, Administrator, further stated the facility did not have a specific policy on turning and positioning for dependent residents. Facility Policy entitled Pressure Sore Prevention Guidelines, revised on 11/12, documents in part, "Policy: To provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale." The policy also documents as an intervention, "Turn and reposition every two hours" for those residents with moderate or high-risk potential for pressure ulcers and "Turning and positioning may be more often than every 2 hours for high risk." (B)	S9999		