TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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 Complaint #1641732/IL84460	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.1010h) 300.1210b) 300.1210d)2)5) 300.3240a) 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 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 1	S9999		

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
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. (Section 2-107 of the Act)

These requirements are not met as evidenced by :

Based on observation, record review and interview the facility failed to implement effective interventions, failed to identify new pressure ulcers, and failed to follow prescribed orders for 2 of 4 residents (R1, R3) reviewed for pressure ulcers in the sample of 4.
This failure resulted in R3's hospitalization with sepsis from infected Stage 4 pressure ulcer.

Findings include:

1. R3's Minimum Data Set (MDS), dated 3/18/16 for a significant change, documents R3 has severe cognitive impairment, requires extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 2	S9999		

assist for Activities of Daily Living (ADL), and is always incontinent of bowel and bladder.

R3's Treatment Administration Record (TAR), dated 1/21/16, documents an open area to coccyx noted 0.4 X 0.4 X 0.1.

R3's Physician Order Sheet (POS), dated 1/21/16, documents orders from Z2, Medical Doctor (MD), to cleanse right buttock with wound cleanser, apply Duoderm, change every 3 days and as needed.

R3's TAR, documented on 1/29/16, "Skin is warm, dry and intact, no reddened areas noted. Treatment to buttock continues with healing noted. 0.3 X 0.3 X 0.1."

R3's TAR documented on 2/4/16, "Wounds noted to right inner heel 2 X 1.5 X 0.1 and left outer ankle 1 X 3."

R3's wound management consultant records, dated 2/4/16, document Z1, wound management consultant Nurse Practitioner (NP), started seeing R3 to evaluate and treat for pressure ulcers to right medial heel and left ankle.

R3's POS, dated 2/11/16, documented orders from Z2 to discontinue treatment to buttock, area healed.

R3's TAR, documented on 2/29/16, wound to coccyx reopen, 0.5 X 0.5, stage 2 with new orders from Z2 to apply Duoderm to coccyx, change every 3 days and as needed.

R3's TAR, documented on 3/3/16, wound measurements to coccyx as 2.8 X 1.2 X 0.1. There was no documentation in the Nurses Notes

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
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 3	S9999		

that the doctor had been notified of the worsening pressure ulcer.

R3's March 2016 TAR documented the treatment cleanse buttock with wound cleanser, apply Mepilex, change 3 times per weekly and as needed. This was documented by E5, Licensed Practical Nurse (LPN), as being done from 3/1/16 to 3/10/16. There was no order for this treatment in R3's POS.

R3's POS and wound management documentation, dated 3/10/16, documents Z1 was informed of the pressure ulcer to R3's coccyx and orders were written to cleanse wound with cleanser, protect periwound with skin prep, apply Hydrocolloid to wound bed, change every 72 hours and as needed for soiling and/or saturation.

R3's Nurses Notes, dated 3/15/16 3:30 PM, documented worsening sacral area now measuring 12 centimeters (cm) X 4 cm X 2 cm deep. The Nurses Note also documents Z3, Z2's NP, was notified and ordered Santyl with dry dressing two times per day, have wound management consultant evaluate on Thursday, 3/17/15.

R3's March 2016 TAR documented the treatment to cleanse sacral area with wound cleanser and apply Santyl with dressing two times a day (BID). R3's March 2016 TAR documented this dressing change was done only one time per day from 3/15/16 through 3/19/16.

R3's POS, dated 3/17/16, documented orders from Z1 to send cultures of coccyx/sacral wound and (indwelling urinary) catheter to be placed. There was no documentation in R3's Nurses Notes that indwelling urinary catheter was placed.

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
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 4	S9999		

R3's SBAR (Situation, Background, Assessment, Recommendation), dated 3/20/16 by E6, Registered Nurse (RN) documented a change in condition for R3, low urine output, poor appetite, increased bleeding, decreased level of consciousness, hard nodule to left groin. E6 also documented on the SBAR that there was no output after 2 hours when (indwelling urinary) catheter was placed.

R3's intake of fluid for March 2016 documented, 3/15/16- 240 cubic centimeters (cc), 3/16/16- 1200 cc, 3/17/16- 0 cc, 3/18/16- 840 cc, 3/19/16- 0 cc, 3/20/16 -240 cc.

On 4/6/16 at 1:55 PM, E2, Director of Nurses (DON), stated that the facility usually only monitors resident's output if they have a (indwelling urinary) catheter. E2 stated she was not aware of the order for the (indwelling urinary) catheter for R3 on 3/17/16. E2 stated she would expect the nurse follow the orders for the (indwelling urinary) catheter on the day the order was given. E2 also stated she could not find the order to cleanse R3's buttocks with wound cleanser, apply Mepilex, change 3 times weekly and as needed.

On 4/7/16 at 10:05 AM, E6 stated that R3 had a really bad pressure ulcer and she had never seen a pressure ulcer that bad. E6 said the pressure ulcer was bleeding quite a bit and had a foul smell. E6 stated she found the order in the chart, dated 3/17/16, for the (indwelling urinary) catheter on 3/20/16 when she was notifying Z2 about R3's decline and bleeding. E6 stated she inserted the catheter and got no urine output, inserted another one, she still had no urine output. E6 stated Z2 told her to send R3 to the hospital for evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 5	S9999		

Z5's Emergency Room Report, dated 3/20/16, documented R3's decubitus measurements to bone sacral region 10 cm X 12 cm with purulent drainage. R3's History and Physical from the hospital medical records by Z4, MD, dated 3/21/16, documented R3 was admitted with diagnoses including "1. Sepsis, most likely related to the large sickle decubitus ulcer. 2. Large sacral decubitus ulcer, most likely infected given the drainage and the strong odor. 3. Left ankle ulcer. 4. Hypercalcemia, most likely related to dehydration. 5. Hypernatremia. 6. Acute kidney injury. 7. Dysphasia. 8. Dementia. 9. Urinary tract infection. 10. Recent deep vein thrombosis (DVT)."

On 4/6/15 at 2:30 PM, Z1 stated that she would expect staff to notify her of worsening pressure areas for the residents that she sees.

2. R1's Admission Face Sheet, dated 3/20/15, documents R1's diagnoses which include Coronary Artery Disease, Chronic Kidney Disease, a history of Cellulitis of the lower extremities and a history of Clostridium Difficile.

R1's MDS, dated 1/8/16, documents that R1 is at risk for pressure ulcers, is totally dependant on staff for all activities of daily living, has contractures of his upper and lower extremities, and is also incontinent of stool.

R1's Nursing Admission Note, dated 3/20/15, documents that R1 was admitted with two open areas of Cellulitis on his lower extremities and a history of multiple wounds before admission.

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
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 6	S9999		

R1's wound management consultant records from January 2016 documents that since his admission to the facility, R1 has once again developed multiple open areas, and has seen multiple wound care providers.

On 4/6/16 at 2:00 PM, Z1, wound management consultant, stated that she is currently following and treating R1 for 10 chronic open pressure areas/wounds. Z1 stated the current wounds were unavoidable, and related to a significant decline in R1's overall condition and extensive weight loss after several hospitalizations.

On 4/4/16 at 1:00 PM, E5, Licensed Practical Nurse (LPN), the Facility wound care nurse, cleansed and re-dressed R1's wounds. The dressing covering the wound on R1's left great toe was removed by E5, who discussed one open area on the great toe. When asked if he was aware there were two open areas on the left great toe, E5 stated he was not aware of the second open area. During this same dressing change, R1's left foot and long great toenail was pressing into R1's right calf. A red intact area was noted on the right medial superior lower leg. The area was pointed out to E5. It did not blanch, and was still present at 3:00 PM. R1 had an alternating pressure/ low air loss mattress in place. The mattress felt very firm, with the pressure adjust knob set at 7.5. This setting remained for three days of the survey. R1 also had a bath blanket folded underneath being used as a draw sheet, for three days of the survey. R1 did not have any protective equipment, or sleeves covering his elbows and arms.

During the dressing change on 4/4/16 at 1:00 PM, E5 stated, "I was not aware of the second open area, which looks like it is necrotic. I measured it

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
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 7	S9999		

at 1 by 1.8 centimeters."
During the same dressing change on 4/4/16 at 1:00 PM, when asked about the blanket being used as a lift sheet under R1, E8, Certified Nurse Aide (CNA), stated,"We always use that. (R1) has continuous stool leaking all the time and it absorbs better than a regular sheet."

R1's Nurses Note, dated 4/4/16 at 3:00 PM, documents the new area on the great toe, but not the reddened area on the right medial calf.

On 4/5/16 at 11:00 AM, E3, LPN, completed the multiple dressing changes to R1's wounds. When asked if she saw the new open area on R1's right medial superior calf, which was open and draining a red/clear fluid, E3 stated she did not see the open area. This was the same area that was present, red and non-blanchable on 4/4/16. The area was cleansed, and treatment orders received by E3. E3 changed the dressing on R1's right medial back. When the bordered dressing was removed the area under the tape at the bottom of the dressing had a line of open weeping blisters. E3 cleansed the area and re-applied a new bordered dressing partially covering the open blistered area with tape. No skin protectant was applied to the blistered area before applying the new dressing.

On 4/6/16 at 10:15 AM E4, LPN, stated she had just finished all of the dressing changes for R1. When asked to assist with a skin check, E4 was unaware of another new open area on R1's left elbow. The new area was then cleansed, documented as a stage 2 pressure ulcer and measured at 1.4 X 1.0 cm and a new dressing was applied.

On 4/5/16 at 11:00 AM, E3 stated she was,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 8	S9999		

"Unaware of the open area on (R1's) calf. I did not see it." When asked about not applying any skin protectant to R1's blistered area on his back from the previous dressing, E3 replied, "I didn't put any skin protectant on the blistered area. We do use that some time, I just turned the bandage a little bit."

On 4/6/16 at 2:45 PM, E3 confirmed that R1's low air loss mattress was very firm to the touch and the pressure adjust knob was set at 7.5.

On 4/6/16 at 10:15 AM, E4 stated, "I didn't even look under his shirt at that other elbow, I just did the dressing on the right elbow. When asked about the wound on the right medial superior calf, E4 stated she "did not change that area and was unaware that the dressing needed to be changed, because it wasn't on the treatment record. I checked the chart and saw the order, but it was never put on a treatment record. I just made one out now after we discussed the wound."

On 4/6/16 at 11:20 AM, E2, Director of Nurses, stated "Skin checks are to be done daily on (R1). Full wound documentation with measurements and descriptions is done weekly after rounds with (Z1) on the back of the Treatment Administration Record (TAR). Those are the facility notes on the wounds."

On 4/6/16 at 2:00 PM, Z1 stated, "By the time I was called in to see (R1), he already had multiple wounds and was placed on hospice. Our goal with hospice was to maintain his wounds, monitor him for new areas and prevent infection. He has since been taken off of hospice and if that continues we will need to get more aggressive, but I do not see his wounds healing completely. When there is a new open area, the staff call the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 9	S9999		

Primary care Physician for orders. I don't know about it until I come in to do my weekly rounds. I sometimes have to change the orders when I come in, several days later. I encourage them to call me, they all have my phone number. (R1) has an alternating pressure/low air loss mattress on his bed I often find that staff turn it up for patient care and forget to turn it back down. Because (R1) has lost so much weight, he is 134 lbs I think, his mattress needs to be set between 4-6, otherwise it will be so firm it is worse for his skin than laying on a regular pressure reduction mattress. Under no circumstances should a blanket be used as a lift sheet, it defeats the purpose of the mattress."

R1's Physicians Orders, dated 3/2016, document an order for daily skin checks.

R1's wound management consultant records, dated 3/31/16, document R1 has open areas at his sacrum, left lateral foot, left hip, right medial back, left medial superior back, right elbow, left medial great toe, and right hip. New Physicians orders written 4/7/16 by Z1 document new treatments for areas at the Distal left great toe, Left elbow and medial superior right lower leg.

R1's Plan of Care, last updated on 1/20/16, documents that R1 is to have protective sleeves to both arms, and check Treatment administration record to address all wounds and treatments as ordered.

The manufacturer's User Manual for R1's alternating pressure/ low air loss mattress documents on page 4, "Generally a lighter patient will need a lower (softer) setting while a heavier patient will need a higher (firmer) setting, but pressure adjustment must ultimately be based on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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
S9999	Continued From page 10	S9999		

the patient's weight distribution. Please consult your Physician for an appropriate setting."

The Facility's Decubitus Care/Pressure Areas Policy, dated 5/2007, documents, "Policy: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing pressure ulcer, once identified." The policy also documents, "4) Notify the physician for treatment orders. The physicians orders should include: i) Type of treatment, ii) Frequency treatment is to be performed, iii) How to cleanse, if needed, iv) Site of application, v) No PRN order is acceptable for a pressure ulcer. The order must have specific frequencies. vi) Initiate physician order on treatment sheet." The policy also documents, "5) Documentation of the pressure area must occur upon identification and at least once each week on the TAR . The assessment must include:
i) Characteristic (i.e. size shape, depth, color, presence of granulation tissue, necrotic tissue etc.)
ii) Treatment and response to treatment."

R1's TAR for the months of January, February and March 2016 document inconsistent and incomplete documentation of greater than 5 weeks with no measurements which fails to follow the facility policy.

(B)