STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.300.1210d)2)5) 300.1220b)2) 300.3240 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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. Restorative measures shall include, at a minimum, the following 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:

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 300.1220 Supervision of Nursing Services

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

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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S9999	Continued From page 2 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 are not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify pressure injuries prior to becoming a Stage two or greater, failed to offload pressure to prevent pressure injuries and worsening of pressure injuries, and failed to use infection control measures to prevent wound contamination for three of five residents (R5, R23, R64) reviewed for pressure in the sample of 18. This failure resulted in R64 acquiring six unstageable pressure injuries. The findings include: 1. On 4/6/21, R64 was observed, supine with feet in waffle boots, with heels resting on mattress at 10:45 AM and 1:45 PM. On 4/7/21, R64 was supine in bed at 8:13 AM, 8:44 AM, 8:48 AM, 9:54 AM, 11:07 AM, 12:02 PM, 1:00 PM and 2:12 PM. R64 had waffle boots on both feet which were in contact with the mattress. On 4/7/21 at 8:13 AM, V4 wound nurse said she just finished R64's dressings and is going to change the treatment because the wounds "are getting ugly". V4 said the blister on R64's right wrist opened up and has slough. "I would say the wounds are due to pressure on the bed,	S9999		

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especially the feet". At 12:30 PM, V4 said ways to prevent pressure injuries include repositioning, waffle boots, air mattresses, waffle cushions for chairs, and verbally tell/educate residents to reposition. Some ways to offload pressure include waffle boots, elevate feet on pillows, repositioning every two hours to adequately remove pressure from an area. I do the weekly wound assessments. I am not wound care certified. We do not have a wound doctor that comes to the facility. Pressure injuries should "definitely" be found before becoming a stage 2-4. If a wound is not identified prior to becoming a stage 2-4 there could be an infection, the resident could become septic, the wound could get to the bone, cause pain and then they don't eat. If ordered treatments are not being done the wound is not going to heal, the wound could get worse and have delayed wound healing. A superficial wound can become very serious. I don't do a head to toe assessment. The staff nurses would do the skin checks and the Certified Nursing Assistants (CNAs) during care and showers.

On 4/8/21 at 9:11 AM, V13, Director of Rehab, said all of R64's functional transfers required moderate to maximum assistance on admission. R64 could only minimally move his right leg on his own.

On 4/8/21 at 10:40 AM, V12 Nurse Practitioner (NP) said "Waffle boots do not offload pressure if the feet are still laying on something. They're still sitting on something softer, but pressure is not offloaded. Anyone recovering from a hip fracture would be at increased risk for pressure injuries due to immobility. R64's pressure injuries could have been prevented or reduced had preventative measures been put in place. Just because orders are written doesn't mean it's getting done,

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necessarily. The residents obviously aren't getting the preventative care they need. I would expect preventative interventions to be put into place for pressure injury prevention. V4 gives me wound care recommendations."

R64's face sheet showed admission to the facility on 12/9/20 from a local hospital after a right hip fracture.

R64's hospital history and physical dated 12/5/20 showed R64 slipped (at assisted living facility) while trying to get into his pants, lost his balance and fell backwards landing on his hip. This note showed R64 was scheduled for right hip surgery on 12/6/20 and was otherwise quite functional and independent.

R64's physical therapy assessment dated 12/10/20 showed R64's discharge plan was to return to the assistive living facility. This assessment showed he required moderate assistance with bed mobility, maximum assistance with transfers and R64 was highly motivated to regain abilities and had the potential to do so.

R64's facility assessment dated 12/15/20 showed R64 required extensive assistance of two plus persons to physically assist him to move in bed and for hygiene. This assessment showed no pressure injuries and functional impairment of one lower extremity.

R64's 12/15/20 care plan showed R64 was able to turn and reposition himself.

R64's pressure injury risk assessment dated 12/9/20 showed R64 was not at risk for developing pressure injuries.

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S9999	Continued From page 5 R64's Admission Observation form dated 12/9/20 showed no skin integrity impairments besides the surgical incisions to the right hip, bruises, a rash and abrasion to the left knee. This assessment showed R64 was unable to walk and had right lower extremity weakness and impaired functional range of motion. R64's skin integrity event report dated 12/16/20 showed a right heel deep tissue injury fluid filled blood blister. R64's 12/16/20 pressure ulcer care plan showed to apply treatment as ordered to right and left heel blisters. R64's wound assessments have no mention of a left heel blister. R64's 12/29/20 pressure injury risk assessment dated 12/29/20 showed R64 was not at risk for developing pressure injuries. R64's 3/8/21 skin integrity events showed a stage two pressure injury to the medial ball of the left foot and a stage two pressure injury to the dorsal aspect of the right heel. R64's 3/10/21 wound assessment showed the right heel wound was unstageable and the left foot wound had increased in depth. This assessment showed additional wounds; an unstageable wound to the right outer ball of the right foot, an unstageable wound to the inner right foot and a stage two wound to the right inner ankle. R64's 3/24/21 wound assessment showed worsening of the right heel wound, right inner foot wound, right outer foot wound, right ankle wound (unstageable), left outer ball of foot	S9999		

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S9999	Continued From page 6 (unstageable). This assessment showed a new pressure injury to the left heel for a total of six pressure injuries. R64's 3/31/21 wound assessment showed a new unstageable pressure injury to the outer ball of the left foot. R64's 4/7/21wound assessment showed a new unstageable blister to the right hand. R64's physician order report for April 2021 showed no orders for pressure injury wound treatments for the wounds to the right hand, right outer foot, and left heel (unstageable wounds). R64's treatment administration record for April 2021 showed no treatment done for the right hand, right outer foot and left heel. 2 On 4/6/21 at 8:22 AM, V4 wound nurse performed wound care for R5. V4 washed R5's feet and wounds using a single washcloth with soap and water. V4 then applied iodine to the foot wounds, applied waffle boots to both feet. V4 said "Oh shoot. I forgot to measure them". V4 removed the waffle boots and measured all wounds except for the scabbed area to the right great toe area. V4 recorded all measurements on a paper measuring tape with a pen. All of the washing of wounds, handling of the waffle boots, and touching the sheets, measuring tape, and pen were done with the same gloves on. V4 pulled the room door open with the same gloved hands to retrieve dressing supplies from the treatment cart in the hall. V4 removed and replaced the gloves in the hallway. V4 cleaned R5's involuntary stool then proceeded with the same gloves on to do the wound treatment to R5's coccyx and buttock. There were two open	S9999		

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areas to the coccyx and V4 said "I just measure and treat it as one wound". A new open area to the right buttock was observed. V4 measured all three wounds with the paper measuring tape and recorded her measurements on the tape with a pen. Then, V4 put "hydrogel" on her gloved finger and applied it directly on the coccyx wound bed with her gloves. V4 then applied a collagen alginate dressing over the hydrogel and then applied additional hydrogel on the dressing. V4 used scissors to cut a foam dressing and tape then touched the foam dressing with her gloved hands and placed it over the coccyx wound. V4 laid the scissors on R5's bed. V4 again applied hydrogel to her gloved hand and applied it directly on the new wound on the buttock. V4 applied a "collagen alginate" dressing over the buttock wound. V4 again used the scissors to cut the foam dressing and tape and laid the scissors back on the bed before touching the foam dressing and placing it over the wound. The two coccyx wounds and new buttock wound were not cleaned after removing the old dressing and applying the new ones. V4 never changed her gloves from the time she entered the room or after cleaning feces. The same gloved hands were used.

On 4/6/21 at 8:15 AM, V4 said R5's wounds were "from friction and shear".

On 4/7/21 at 1:30 PM, V4 wound nurse said "Infection control during wound care is important because a superficial wound can become very serious. Gloves should be changed from wound to wound and when visibly soiled. If good infection control is not done you can make wounds worse and spread organisms to other wounds and other residents." V4 said she was "embarrassed" when observations of not

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S9999	Continued From page 8 changing gloves were shared. On 4/8/21 at 10:40 AM, V12, Nurse Practitioner, said if infection control measures are not used during wound care, then infections and wound decline could absolutely occur. R5's wound assessment dated 4/7/21 does not mention the new open buttock wound or treatment done. There is no assessment of the new wound. There is no staging of any of the wounds. There are no assessments of the peri wound, absence or presence of drainage or odor, and no identification of wound types. There is no assessment of the wound beds except for the coccyx wound. R5's April 2021 physician order sheet for coccyx wound treatment does not show to apply hydrogel. It showed to apply the collagen alginate dressing directly to the wound bed. R5's face sheet showed diagnosis of multiple sclerosis, malignant neoplasm of the kidney, and admission to hospice on 12/29/20. The facility's Infection Control Policy, dated 12/17/19, showed gloves will be changed after direct contact with resident's secretions or excretions, even if care of resident has not been completed. Standard Precautions are based upon the principle that all blood, body fluids, secretions, excretions, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions should be applied to the care of all residents regardless of the suspected or confirmed presence of an infectious agent. Standard Precautions include but are not limited to: 1. Hand Hygiene, 3. Proper Use of PPE, 6. Handling of Equipment. Hand washing is	S9999		

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the foundation of controlling infectious disease. Personnel must wash their hands when coming on duty; when they are visibly soiled; after they handle dressings;

3. On 4/6/21 at 10:00 AM and 2:16 PM, R23 was lying in bed on her back. There were bilateral support hose on and both feet/heels were on the mattress. There were no offloading measures in place.

On 4/6/21 at 10:00 AM, R23 said her right heel hurt and rated the pain a 10 on a scale of 0-10. It's been hurting about half an hour. I let staff know. I don't know why anyone isn't doing anything. "I'm tired and sore and frustrated". At 11:55 AM, V5 Certified Nursing Assistant (CNA) and V7 CNA transferred R23 with a total mechanical lift from the bed to the wheelchair. R23 asked V5 and V7 if anything was going to be done about her foot and complained about pain to her right heel. R23 grimaced and moaned when a non-slip booty was placed on her right foot. V7 asked R23 if she had a good nap and R23 responded "no, because my foot hurts". V7 told R23 she would "tell the nurse about her leg again".

On 4/7/21 at 8:11 AM, 9:53 AM, 11:05 AM, 12:02 PM, and 1:36 PM, R23 was lying in bed on her back with both bare feet /heels on the mattress. At 1:36 PM, this surveyor requested assistance from V8 CNA to inspect R23's heels. R23's posterior right heel had a non-blanchable dark brown, light black colored closed wound present. V8 said "there is something there".

R23's face sheet showed admission to the facility on 1/29/21 after hospitalization for a right hip fracture. R23 was hospitalized and readmitted on

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S9999	Continued From page 10 3/4/21 after having a stroke. R23's care plan dated 1/29/21 showed R23 was in the facility for short term rehab following a right femur fracture. Prior to hospitalization, R23 was ambulating independently with a wheeled walker and was able to complete her own cooking and cleaning. R23 wished to return home once her therapy stay was complete. R23's care plan dated 2/1/21 showed to assist resident with turning and repositioning and to reposition every two hours. R23's Admission assessment dated 3/4/21 showed weakness to the right lower extremity and no skin issues besides bruises to the left forearm. R23's facility assessment dated 3/10/21 showed R23 required extensive assistance of two plus persons to physically assist with bed mobility, transfers, dressing and hygiene. R23 was totally dependent on two plus persons for bathing. This assessment showed functional limitation of one lower extremity and no pressure injuries present. (B)	S9999		