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
	IL6007306	A. BUILDING: ______ B. WING ______	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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 Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1of 2 300.610a) 300.1210b) 300.1210d)2) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to treat, monitor, and prevent new and worsening pressure ulcers that required surgical debridement for one (R69) of five residents reviewed for pressure ulcers in a sample of 26. This failure resulted in house acquired pressure ulcers and worsening pressure ulcers, that required surgical debridement for R69.

Findings include:

Facility Pressure Ulcer and Skin Care Management Policy, effective 3/2000,

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S9999	Continued From page 2 documents: a resident who enters the facility without pressure ulcers does not develop pressure ulcers; a resident having pressure ulcers receives treatment and services to promote healing, prevent infection and reduce the risk of new pressure ulcers developing; a licensed nurse checks the resident's body for the presence of pressure ulcers, wounds and other skin conditions on admission and weekly; the presence of any pressure ulcer, wound or other skin condition is documented weekly on pressure ulcer or skin report forms in the progress notes and care plan; implements treatment procedures in accordance with professional standards of practice; nursing staff reviews the pressure ulcer prevention and treatment procedures with resident physician; a licensed nurse completes a pressure ulcer or skin report when a pressure ulcer, wound or other skin condition is identified and weekly until healed; and the interdisciplinary team considers and includes interventions for pressure ulcer prevention and treatment to provide an aggressive program of consistent interventions by all staff involved. R69's Nursing Evaluation/Data Collection Form, dated 7/27/22 at 3:30 pm, documents that R69 readmitted to the facility from the local hospital. The Nursing Evaluation Form, skin condition, documents that R69 admitted with a fissure to the coccyx, reddened bilateral heels and a left 5th toe area. The Nursing Evaluation Form does not document measurements or descriptions of the wounds. R69's Treatment Administration Records/TAR, dated 7/27/22 through 8/31/22, documents that R69's bilateral heels treatment was not initiated until 7/29/22, two days after admission and documents a treatment of ointment (betadine)	S9999		

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daily and leave open to air. R69's coccyx wound treatment was not initiated until 7/29/22, two days after admission, and documents to cleanse with normal saline and gauze, apply a thin layer of ointment (bacitracin) to the wound bed three times a day and as needed and leave open to air every shift for the fissure. R69's TAR does not document a completed treatment to R69's coccyx on 8/6/22 and 8/7/22 (day shift) and 8/8/22 (night shift). The TAR does not document a completed bilateral heel treatment on 8/6/22 and 8/7/22.

R69's TAR, dated 9/1/22 through 9/12/22, documents an order that was started on 8/3/22, for an ointment (Santyl/Collagenase) to R69's left heels, and does not document a completed treatment on 8/6/22, 8/7/22 and 8/23/22. The TAR also does not document a completed coccyx treatment for 9/1/22 and 9/5/22, left heel treatment on 9/1/22 or 9/5/22. The TAR also documents a new treatment for a blister to R69's left foot.

R69's Nursing Progress Note, dated 8/30/22 at 3:39 pm, documents that R69 has a "new area on left ankle, called wound clinic, waiting on call back." R69's Nursing Progress Note, dated 8/30/22 at 4:38 pm, documents that the facility received a call back from the wound clinic and "they will evaluate resident" when they see him "next week." A dry dressing was applied at that time until R69 seen at wound clinic.

R69's Nursing Progress Note, dated 9/9/22, documents that R69 has a new area to the left hip (1.5 centimeters/cm by 1.0 cm).

R69's Nursing Notes, dated 8/2/22, document that R69 has a new pressure ulcer to the left posterior heel (2.0 centimeter/cm X 2.5 cm) and

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S9999	Continued From page 4 is unstageable. Facility Wound Report, dated 9/5/22 through 9/11/22, does not document the measurement or description of R69's left heel/left foot, coccyx or left hip wound. The computer generated Report does document, in handwriting, that R69's left hip was house identified as house acquired on 9/9/22 (no measurements), left lateral ankle blister was identified as house acquired on 9/5/22 (4.0 cm x 4.0 cm, unstageable deep tissues) and a blister was identified as house acquired on 9/2/22 to the fifth toe (unidentified left or right foot and no measurements or wound description). R69's Wound Clinic Notes, dated 9/2/22 through 9/15/22, document that R69 has an unstageable pressure ulcer injury of the left heel. The Notes also document a conversation on 9/15/22 at 9:22 am with V4 (Wound Nurse) requesting "something else and they do not have orders to the left hip." The Clinic Notes also document that a pressure reducing mattress is recommended. R69's Wound Clinic Notes, dated 9/2/22, documents the size of R69's left heel wound as 2.6 cm x 6.5 cm x 0.2 cm and black eschar (moderate serous drainage) and the left lateral ankle wound size is 3.2 x 2.5 x 0.1 (moderate serous drainage). On 9/15/22, at 1:20 pm, V4 (Wound Nurse) was changing R69's wound dressings. When V4 removed R69's left heel soiled dressing it was undated and not signed by a nurse. R69's entire heel was completely covered with black eschar (approximately 2.5 inches by 2.5 inches, with scant brown drainage). V4 verified that a new scabbed area to R69's right outer heel was	S9999		

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S9999	Continued From page 5 identified (approximately 1.0 cm x 1.0 cm) and needed a treatment order. R69's coccyx peri-wound area was reddened and open, measuring approximately 2.0 X 1.0 cm, with no drainage, and did not have a treatment/dressing in place. R69 had an area to the left outer 5th toe, that was black with eschar and no treatment/dressing was in place. R69's right hip was open and did not have a dressing in place. R69 was not on an air mattress. On 9/15/22, at 1:20 pm, V4 (Wound Nurse) stated, "I am brand new at the facility. I just saw this new area on (R69's) right outer heel just now. I will have to get a treatment order for that. It is about the size of a dime and is scabbed. (R69's) wounds were getting treated here in the facility, but because they have all gotten worse, now we have to send him to the wound clinic for treatment. He just started going there towards the end of August. His wounds have gotten worse. Every time I contact the wound clinic, for help, they just tell me to wait until his next visit, so I have not always put treatments in place, but recently I have started just calling our Medical Director for advice. I think (R69) was sent to the Wound Clinic to rule our vascular issues, but (R69's) left hip, heel and outer foot are all pressure ulcers. I think that left 5th great toe is not pressure, but the others probably are due to the location." On 9/15/22, at 1:42 pm, V3 (Assistant Director of Nursing/ADON) stated, "(R69) admitted back to the facility on 7/27/22, with just reddened bilateral heels that were not open, a fissure on his coccyx and an area on the 5th left toe. (R69's) areas have gotten worse and now he goes to the wound clinic for treatment. We did not have a wound nurse and our wound documentation is not very	S9999		

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good and does not document all of (R69's) weekly measurements or wound description information, as we should have been doing. We have a new wound nurse now that just started a week or so ago. "

On 9/15/22, at 9:22 am, V18 (Wound Clinic/Registered Nurse) stated, "(R69's) first visit here was on 8/19/22 and has only been seen three times. Some of R69's wounds did worsen, and some did require surgical debridement."

(A)

2 of 2

300.1210 b)
300.1210 c)
300.1210d)5)
300.1210d)6)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general

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nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents

These requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to investigate and prevent multiple injuries for one resident (R44) of three residents reviewed for wounds from injury in the sample of 26. This failure resulted in an infection of an elbow wound requiring antibiotics and isolation precautions. The facility also failed to use the assessed number of individuals needed to transfer residents for two residents (R57 and R322) of eight residents reviewed for falls in a sample of 26.

Findings include:

1) Facility Policy/Resident Accident/Incident Policy dated/revised 8/22/21 documents:
It is the policy of (the facility) to provide a safe environment for all residents. Residents that end up with an unexplained bruise or skin tear will be investigated to ensure there has been no abuse. On a daily basis incidents/accidents will be

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S9999	Continued From page 8 investigated and reviewed by the facility administrative staff. Necessary intervention changes will be made in the resident's care plan. The ADON (Assistant Director of Nursing) will discuss, instruct, supervise and/or inservice the staff or residents' plan of care (interventions) in an effort to improve the safety of our residents. Changes will be made as often as necessary to keep our residents as safe as possible. Current Physician's Order Report indicates R44 was admitted to the facility on 10/16/21 with diagnoses that include Huntington's Disease. Physician's Order dated 9/5/22 indicates R44 is on Contact Isolation due to MRSA (Methicillin Resistant Staphylococcus Aureus) infection right elbow. Physician's Order indicate antibiotics were initiated on 8/18/22 and completed on 8/29/22 for MRSA right elbow wound. Current Care Plan indicates R44 has risk for skin injury to due abnormal movements and identifies right elbow wounds from 7/12/22 and left elbow wounds from 7/31/22. Care plan indicates interventions identified on 12/11/19 include elbow protectors and (fabric protective arm sleeves) "ordered by the MD (Medical Doctor)." Intervention dated 12/11/19 also include to pad bed rails, wheelchair arms or any other source of potential injury if needed. On both 9/13/22 and 9/15/22 R44 was sitting in a recliner style-high back wheelchair with legs stretched out fully on the bed. R44's recliner chair was pushed up completely to the side of the bed to allow R44's legs to be supported. R44's door had posted signs indicating R44 was on Contact Precautions. R44 had a gauze wrap wound dressing on both	S9999		

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elbows - no elbow or fabric arm/skin protectors. On both days R44 was wearing a short sleeve T-shirt with exposed skin from mid upper arms to fingertips. Both of R44's exposed upper arms were noted to be resting directly on the metal portion of the arm rest on both sides of the chair. The non-metal portion of the arm rest was made of a hard rubberized material. R44's head rested on plastic support straps and not on the cushioned headrest due to R44's position in the chair. R44 had severe frequent uncontrolled jerking movements of bilateral arms, legs and torso. During these movements R44's arms were noted to jerk and flail against various surfaces of the chair including the unpadded arm rests.

On 9/15/22 at 10:15 am V4, Wound Nurse stated that R44's chair should have padding to cover the exposed hard surfaces especially over the metal on the armrests. V4 stated "Even the non-metal part of the armrest isn't really cushioned."
V4 stated that R44 has a new (injury) wound on his left leg that she "assumes happened the night before last." V4 stated she did not know what R44 hit his leg on or if an incident report was done. At that time a gauze wrap dressing was noted to R44's left mid shin. V4 stated "it would be helpful to know what (R44) actually caused the wound."

Nurse Note dated 9/15/22 at 6:55 am indicates R44 has a new area to left lower leg measuring 2 cm (centimeter) x 1.4 cm.

Wound Physician Notes dated 9/13/22 indicates R44 has five different wound sites:
Site #2: right upper elbow partial thickness wound; etiology "infection"
Site #3: non-pressure wound of left elbow; etiology trauma/injury
Site #4: non-pressure wound of right anterior

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S9999	Continued From page 10 elbow due to traumatic injury; etiology trauma/injury Site #5: Stage 3 pressure wound right hip Site #6: non-pressure wound of right lower elbow due to trauma/injury Each of the elbow wound sites list the wound physician's recommendations as "Off-load wound, reposition per facility protocol and Elbow protector." Current facility wound log indicates R44's right upper elbow wound type as "friction.' On 9/15/22 at 11:45 am V3, ADON (Assistant Director of Nursing) and V4, Wound Nurse stated that R44's Site #2 etiology is friction and friction would be classified as trauma/injury. On 9/16/22 at 1:18 pm ADON acknowledged that R44's chair should be padded better, and no incident/accident reports were done for the injuries R44 sustained. On 9/16/22 at 2:00 pm V1, Administrator stated, "(R44's) whole environment needs to be reviewed for safety." The facility's "Transfer Between Surfaces" policy dated 3/00, documents "It is better to have another staff member assist with a transfer than to risk injury. Determine the required sequence of the activity and determine when and how the client will require physical assistance." 2. R57's minimum data set (MDS) dated 7/22/22 documents "Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). Two plus person physical assist."	S9999		

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S9999	Continued From page 11 R57's X-ray results dated 9/9/22 documents "Chronic proximal fibula fracture." On 9/13/22 at 9:45 AM, R57 observed sitting in wheelchair with her right leg propped up with an immobilizing brace on it. On 09/13/22 at 9:46 AM, R57 stated "I was dropped during a transfer last week. They wound up fracturing my right knee. (V11, Certified Nursing Assistant (CNA)) was transferring me when I fell. It happened last Monday or Tuesday. They had a mobile X-ray come in on Friday to X-ray my knee and come to find out, my knee is fractured. So now I have to wear this knee brace." On 09/14/22 at 1:32 PM, V11, CNA, verified he was transferring R57 last week and had to lower her to the floor. V11, CNA, stated "I was transferring her (R57) by myself when she lost her balance and I had to lower her to the floor. I reported it to the nurse." On 9/14/2 at 1:40 PM, V3, Assistant Director of Nursing (ADON) verified R57's MDS documents she is a two person assist with transfer and stated, "There should have been two people helping her." On 9/15/22 at 12:35 PM, V12, CNA stated "(V11, CNA) reported to me that (R57) fell. I reported it the nurse. (V11, CNA) was the only one in the room when (R57) fell. " On 9/15/22 at 3:10 PM, V18, Physician, stated "(R57)'s fracture is not from the fall. She had a pre-existing fracture that was exacerbated from the fall." 3. R322's fall report dated 2/8/22 documents	S9999		

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S9999	Continued From page 12 "CNA to this nurse stating when transferring residents to wheelchair, resident leaned forward and went to knees. Resident did not hit head. Resident to be transferred with two for assist in the future." R322's MDS dated 12/6/21, documents "Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). Two plus person physical assist." On 9/14/22 at 1:42 PM V3, ADON, stated "(R322) required two staff members for transfers during his fall on 2/8/22. However, only one staff member was transferring him. It's in the fall investigation and we put the intervention in the care plan to insure there's always two people when transferring him." (B)	S9999		