

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000756	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/02/2022
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-JACKSONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET JACKSONVILLE, IL 62650
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S 000	Initial Comments Complaint 2243190/IL146144	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)1)2)3) 300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview, observation and record review, the facility failed to assess, monitor and provide pressure ulcer treatments as ordered for 2 of 2 residents (R1, R3) reviewed for pressure ulcers. This failure resulted further skin breakdown and larger pressure ulcers for R3.</p> <p>Findings include:</p> <p>1. R3's Order Summary, print date of 4/28/22, documents R3 was admitted on 10/29/21 with diagnoses of Dementia and Atrial Fibrillation.</p> <p>R3's Minimum Data Set (MDS), dated 1/25/22</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>documents R3 is severely cognitively impaired, requires extensive assistance of 2 staff members for bed mobility and is totally dependent on 2 staff members for transfers.</p> <p>R3's HH (Health History) Ulcer / Wound documentation, dated 2/28/22, documents that R3 has a newly identified unstageable pressure ulcer on the right side of right toe measuring 1.5 (Centimeter) (cm) (Length) (L) x 1.3 cm (Width) (W), the wound bed tissue is necrotic and has no drainage.</p> <p>R3's HH Ulcer / Wound documentation, dated 2/28/22, documents that R3 has a newly identified unstageable pressure ulcer on the right side of right foot measuring 1.4 cm L x 1.6 cm W, the wound bed tissue is necrotic and has no drainage.</p> <p>R3's Treatment Administration Record (TAR), dated 2/28/22, documents, "Right foot lat (lateral) prox (proximal) and distal: cleanse with area with NS (normal saline), apply xeroform cover with dry dressing every day shift for skin integrity." This TAR documents that the wound treatment was done on 2/28/22.</p> <p>R3's TAR, dated 3/1/22 - 3/30/22, documents, "Right foot lat (lateral) prox (proximal) and distal: cleanse with area with NS, apply xeroform cover with dry dressing. every day shift for skin integrity." This TAR documents that the wound treatment was done daily.</p> <p>R3's TAR, dated 3/31/22 - 4/20/22, documents, "Right foot lat prox and distal: cleanse with area with NS, apply cal alginate with silver cover with dry dressing. every day shift for skin integrity." This TAR documents that the wound treatment</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>was done daily.</p> <p>R3 has no other HH / Wound documentation on these 2 wounds identified on 2/28/22 for review. However on 4/20/22, R3 does have HH / Wound documentation for her right foot in similar areas just described using different verbiage.</p> <p>R3's HH Ulcer / Wound documentation, dated 4/20/22, documents that R3 has a newly identified unstageable pressure ulcer on the right lateral foot distal measuring 4.5 cm L x 1.0 cm W x 0.1 D (depth), the wound bed tissue is necrotic and has moderate drainage.</p> <p>R3's HH Ulcer / Wound documentation, dated 4/20/22, documents that R3 has a newly identified unstageable pressure ulcer on the right lateral foot proximal measuring 1.5 cm L x 1.2 cm W x 0.3 D, the wound bed tissue is granulation tissue and has moderate drainage.</p> <p>R3's Nurses Note, dated 4/20/22, documents, "(V3, Assistant Director Of Nurses- ADON) looked at an open area on right foot outer area - changed treatment order - order faxed to (V12, Physician)." R3's Nurses Notes have no other documentation on the condition of R3's right foot from 2/28/22 to 4/20/22 for review.</p> <p>On 4/26/22 at 2:00 PM, V3, ADON, stated that the wound doctor wants to get the areas very moist with the xeroform and then he will debride the areas next week when he sees her. V3 also stated that he believes that R3 got the wound from crossing her feet but he is not sure.</p> <p>On 4/28/22 at 11:50 AM, V7, Licensed Practical Nurse (LPN), stated, "(R3's) lateral foot has been treated for a long time. It didn't just pop up on the</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>20th (4/20/22). It originally started out as blisters and turned into this."</p> <p>On 4/28/22 at 3:20 PM, V11, Nurse Practitioner, stated, "I would expect the facility to be measuring and monitoring wounds on a weekly basis and notify us if the wound worsens or is not healing with the current treatment. Unfortunately in R3's case, the lack of monitoring caused her to have further skin breakdown and resulting in a larger wound."</p> <p>2. R1's Order Summary Report, print date of 4/28/22, documents R1 was admitted on 2/11/22 and has diagnoses of Gout of the left hand, Hypertension and Major Depressive Disorder.</p> <p>R1's MDS, dated 2/26/22, documents R1 is moderately impaired cognitively, requires extensive assistance of 2 staff members for bed mobility, transfers, hygiene and toileting and in frequently incontinent of her bladder and always incontinent of her bowel.</p> <p>R1's Specialized Wound Doctor Report, dated 4/4/22, documents, "Shear wound of the left buttocks. Dressing Treatment Plan. Primary. Add Alginate Calcium. Discontinue Alginate Calcium w/ (with) Silver. Secondary. Dressing. Gauze Island w/ brd (border) once daily."</p> <p>R1's Treatment Administration Record (TAR), dated April 2022 through March 26/2022, documents, "Calcium Alginate - Silver Pad 4. Apply to sacrum topically every day shift." These TAR's document R1 has received this treatment everyday.</p> <p>R1's HH Ulcer / Wound documentation, dated 4/25/22, documents that R1 has pressure ulcer to</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>the sacrum initially found 3/21/22 measuring 1.0 cm L x 2.0 cm w x 0.2 cm D. This wound was staged as a Stage II wound. This document also documents that the wound is now a cluster wound and the peri wound was intact and the wound had moderate sanguineous drainage. At this time, R1 rated the pain from the wound a 5 on the 1 to 10 pain scale.</p> <p>On 4/26/22 at 11:04 AM, V4, Licensed Practical Nurse (LPN), entered R1's room to change R1's sacrum dressing. V4 stated that she was going to cleanse the wound with wound cleanser, dry the wound, apply calcium alginate with silver and cover the wound with an optifoam dressing. V4 removed the old dressing. The right side of the sacrum had one pressure ulcer. The wound bed was red. The edges of the wound were white. On the left side of the sacrum, there were 3 smaller areas of pressure that were noted to be open. The wound beds were red on all three wounds. V4 cleansed all 4 wounds, applied the calcium alginate with silver to the larger wound, nothing to the 3 smaller wounds and covered the sacrum with a foam dressing.</p> <p>On 4/27/22 at 3:30 PM, V3, ADON, stated that he charts wounds as cluster wounds if there are more than one wound in an area and he just measures and assesses the area not the individual wounds / ulcers. V3 stated that all the wounds are measured every week. V3 stated that he will manage the wounds if he can with the primary doctor and if the wounds get worse he will get an order for the wound doctor to see them. V3 stated that the adhesive of a dressing should not be placed over an open area.</p> <p>On 4/27/22 at 11:25 AM, V1, Administrator, stated that wounds should be assessed and measured</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>every week and charted on more if the wound deteriorates. V1 further stated that the nursing staff should be following the Physician prescribed wound treatment.</p> <p>On 4/27/22 at 4:00 PM, V1, Administrator, stated that all of the areas of the wound should be treated during a dressing change.</p> <p>The facility policy and procedure, dated 1/10/2018, documents, "When a resident is found to have a wound a licensed nurse will complete ulcer, either on admission or during their stay, the following" "Document assessment of the wound / ulcer in the medical record. Initiate the treatment protocol appropriate for the stage of ulcer or for the wound assessed." It continues, "Assessment of progress toward healing is completed at least weekly and the physician is notified at least monthly. If there is regression, the physician is notified of the condition change. Treatment continues per the physician orders until the wound and / or ulcer is healed."</p> <p>(B)</p>	S9999		