STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015317	A. BUILDING: _____ B. WING _____	C 07/06/2022

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HAWTHORNE INN OF DANVILLE	3222 INDEPENDENCE DRIVE DANVILLE, IL 61832

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S 000	Initial Comments Complaint Investigation #2264979/IL148377	S 000		
S9999	Final Observations Statement of Licensure Violations: 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 remove a splint during skin assessments to assess for and prevent pressure ulcers for one resident (R2). This failure resulted in R2 developing an unstageable necrotic wound to the right heel. The facility also failed to implement pressure relieving interventions and notify the physician timely of a new pressure ulcer for one (R2) of three residents reviewed for wounds in the sample list of 14. Findings include: R2's Face Sheet dated 7/6/22 documents R2 has a diagnosis of "Unspecified fracture of shaft of	S9999		

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S9999	Continued From page 2 right fibula, subsequent encounter for closed fracture with routine healing (Primary)". R2's Minimum Data Set dated 5/11/22 documents: R2 is cognitively intact, requires extensive assistance of two staff for bed mobility, and is dependent on two staff for transfers and one staff for dressing. R2 has one stage 2 pressure ulcer and one unstageable pressure ulcer, and both wounds were not present upon admission/reentry to the facility. R2's Admission Braden Scale for Predicting Pressure Sore Risk dated 1/22/22 documents R2 is at risk for developing pressure ulcers. R2's Care Plan dated as revised on 6/24/22 documents: R2 "is at risk for skin breakdown related to impaired mobility, incontinence, vitamin deficiency and congestive heart failure." Interventions include to assist R2 with turning and repositioning and provide incontinence care with each incontinent episode. R2's care plan does not document R2 refuses pressure relieving interventions. R2's Physician Order dated 1/26/22 and discontinued on 2/24/22 documents "check skin under bilateral lower extremity immobilizers q (every) shift for redness, increased swelling, increased warmth, increased pain". R2's Physician order dated 1/24/22 and discontinued on 3/2/22 documents to apply a skin protectant to bilateral heels as preventative. R2's Physician Order dated 3/18/22 and discontinued on 4/29/22 documents R2 is nonweight bearing to the right leg and to keep the splint dry and intact. There is no documentation that this splint is not to be removed. R2's Physician Order dated 4/27/22 documents to apply pressure relieving boots when in bed.	S9999		

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S9999	Continued From page 3 R2's April 2022 Medication and Treatment Administration Record documents R2's weekly skin assessments were completed by V11 Registered Nurse (RN). There is no documentation that R2's skin integrity under the right leg splint was assessed, or that R2's order for a skin protectant to bilateral heels was reinstated after R2 returned from the hospital on 3/9/22. R2's Skin Integrity Event dated 4/27/22 documents R2's right heel unstageable pressure ulcer ("Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar") measured 3 centimeters (cm) long by 3 cm wide with no measurable depth. The wound bed had necrotic eschar (dead tissue). R2's Initial Wound Evaluation & Management Summary dated 5/11/22 by V10 Wound Physician documents R2's unstageable (due to necrosis) full thickness pressure ulcer of the right heel measured 2 cm by 1.8 cm and the wound was 100 % covered by black necrotic tissue. R2's wound was due to R2's "cast." R2's Nursing Notes dated 6/19/22 at 11:30 PM document an unidentified CNA reported R2 had a dime sized open area to R2's left gluteal. There is no documentation of wound measurements/characteristics and that R2's Physician (V9) was notified of R2's buttock wound until two days later on 6/21/22. R2's Skin Integrity Event dated 6/21/22 documents R2's right inner buttock pressure ulcer measured 3 cm by 3 cm and does not identify the stage of R2's ulcer. R2's Wound Management Detail Report documents on 6/29/22: R2's right heel	S9999		

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S9999	Continued From page 4	S9999		

unstageable pressure ulcer measured 1 cm by 1 cm and contained necrotic tissue. R2's right buttock stage 2 pressure ulcer measured 3 cm by 3 cm.

On 7/5/22 at 9:27 AM and at 11:25 AM R2 was sitting in a wheelchair in R2's room. On 7/5/22 at 11:25 AM R2 stated R2 has asked staff 3-4 times this morning to change R2's incontinence brief. R2 stated staff have not come to assist R2 yet. On 7/5/22 at 12:34 PM R2 was sitting in a wheelchair eating lunch in R2's room. On 7/5/22 at 12:46 PM V5 and V6 Certified Nursing Assistants (CNAs) pushed a full mechanical lift out of R2's room. R2 was lying in bed and R2's pressure relieving boots were in the chair. V6 stated: R2 was just laid down but was not provided incontinence care yet. V6 was going to lay down all of the residents who use full mechanical lifts, and then would return to change R2.

On 7/5/22 at 1:04 PM V6 provided incontinence care for R2. R2 was lying in bed and was not wearing pressure relieving boots. R2's heels were lying directly on R2's mattress. R2 had a small red wound to the right buttock. R2's brief was wet with a moderate amount of urine and small amount of bowel movement. V6 left R2's room and did not float R2's heels or apply the pressure relieving boots. V6 stated: R2 was laid down to be changed around 9:00 AM, and then gotten back up into the wheelchair. R2 has been up in the wheelchair since around 6:30 AM - 7:00 AM. V6 had left the facility around 9:00 AM and returned at 11:15 AM. V5 and V7 CNA covered V6's assigned residents while V6 was gone. On 7/5/22 at 1:18 PM V6 stated R2 does not wear pressure relieving boots during the day. R2 refuses to wear the boots at times, and we put a pillow under R2's

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S9999	Continued From page 5 feet. R2 is repositioned every 2 hours when in bed. On 7/5/22 at 1:27 PM V5 and V7 CNAs stated they did not provide any cares for R2 while V6 was out of the facility. On 7/5/22 at 1:34 PM R2 was lying in bed and was not wearing pressure relieving boots. R2's heels were lying directly on the mattress. V3 RN removed R2's right sock. R2's wound to the right posterior ankle/heel was red with a dark tissue to the center of the wound. V3 stated R2's heel wound developed from wearing an air cast that was discovered when R2's cast was discontinued, and R2's cast was not one that facility staff removed. At 1:40 PM V3 stated R2 is supposed to have pressure relieving boots on when in bed, and V3 will apply them. V3 applied R2's boots, and R2 was cooperative. V3 stated R2 usually stays up in the morning, is laid down after lunch, and stays in bed for supper. On 7/6/22 at 10:30 AM V11 RN stated I (V11) do not remember removing (R2's) right lower extremity splint during skin assessments completed in April. On 7/5/22 at 4:05 PM V2 Director of Nursing stated R2's right heel pressure ulcer was identified on 4/27/22 and was an unstageable pressure ulcer. On 7/6/22 at 8:41 AM V2 Director of Nursing stated R2 readmitted in March 2022 from the hospital with a splint to the right lower leg and orders to keep the splint dry and intact. It was a splint with (hook and loop) closure that was removable. The nurses should have removed it during skin assessments. There should be an order to check CMS (circulation motion sensation) to the right leg while wearing the splint	S9999		

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S9999	Continued From page 6 and documented on the MAR (Medication Administration Record). On 7/6/22 at 8:50 AM V2 stated residents should be offered toileting/changing and repositioning every 2 to 3 hours. R2 has a preference to stay up in the wheelchair during the day, and this should be documented on R2's care plan. On 7/6/22 at 9:45 AM V2 stated nurses should document in a nursing note physician notification and any treatment orders when a pressure ulcer is identified. On 7/6/22 at 10:35 AM V2 stated per V10's notes R2's heel wound was caused from the splint. V2 confirmed R2's right leg splint covered the leg and did not extend to the foot, and R2's wound was located at the base of the ankle/posterior heel aligning with the base of the splint. V2 confirmed there was no documentation that R2's buttock wound was reported to V9 Physician on 6/19/22. On 7/6/22 at 10:52 AM V9 Physician stated, "My understanding is that R2's right heel wound was caused by the cast." The facility's Pressure Injury Prevention and Treatment Protocol dated as revised July 2016 documents: "Incontinent residents will be taken to the bathroom at least every two hours if able or according to their individualized toileting plan. If residents are incontinent, perineal care will be given and the resident will be dried." "When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: A. Assess the pressure injury for location, size (measure length x width x depth), wound bed, drainage (amount, color, type), odor, tunneling, undermining or sinus tract, wound edges/surrounding tissue and pain at site. B. Determine the injury's current stage of development:" "C. Notify the physician of above	S9999		

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S9999	Continued From page 7 assessment and obtain orders for treatment of pressure injury." "For those residents that cannot reposition themselves, transfer self out of bed or cannot turn and position themselves in bed, staff will be responsible for." This policy documents predisposing risk factors for pressure ulcers includes casts. (B)	S9999		