

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6004303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/19/2022
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HEALTH-PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 21ST STREET PERU, IL 61354
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S 000	Initial Comments  Annual Licensure and Certification.	S 000		
S9999	Final Observations  Annual Licensure and Certification.  Statement of Licensure Violations: 300.610a) 300.1210b) 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	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</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>These regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to identify and assess a pressure ulcer at admission for one of two residents (R42) reviewed for pressure ulcers in the sample of 37. This failure resulted in R42's wound worsening in condition from admit to a Deep Tissue Injury then to a Stage 4 pressure ulcer.</p> <p>Findings include:</p> <p>The facility's Wound and Ulcer Policy, dated 1/10/18, documents, "When a resident is found to have a wound a licensed nurse will complete, either on admission or during their stay, the following: Document assessment of the</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>wound/ulcer in the medical record. Initiate the treatment protocol appropriate for the stage of ulcer or for the wound assessed. Document wound/ulcer treatment provision on the treatment administration record. Notification of the physician, documenting, and initiating ordered treatment. Transcribing, documenting, and initiating written and/or verbal orders of the physician." The policy also documents, "Ulcer treatment protocols: Pressure ulcer-stage 1 Non-blanchable erythema-intact skin with nonblanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. A reddened area should be rechecked after pressure is relieved to see if the area is non-blanchable. Protocol: Implement positioning to relieve/reduce pressure on the affected area (pressure reduction and/or pressure relief measures). Cleanse: Normal saline or wound cleanser. Prep: Apply no sting protectant wipes to surrounding tissue. Let skin protectant dry prior to application of a hydrocolloid or transparent dressing. Treat: If the wound is located on a high friction area: apply Hydrocolloid or transparent film dressing." The policy documents, "Suspected deep tissue injury (DTI): Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful firm, mushy, boggy, warmer or cooler as compared to adjacent tissue."</p> <p>On 05/16/22 at 01:35 PM, R42 was alert sitting up in a chair in his room. R42 stated, "I have an ulcer on my left foot. It's just not getting better, so I'm not able to walk very much. I can't put my shoes on because it hurts too bad. Staff will tell me I need to walk but I can't walk with that on my</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>heel."</p> <p>R42's Clinical Admission Evaluation, dated 2/16/22, documents that upon admission R42 had redness to his bilateral heels.</p> <p>R42's Skilled evaluation, dated 2/21/22 at 9:08 a.m., documents, "Skin location #10: Left heel. Issue type: Pressure ulcer/ injury. Skin tissue: Mushy. Skin tissue: Boggy. Skin tissue: Painful."</p> <p>R42's Skilled Evaluation, dated 2/22/22 at 2:05 a.m., documents, "Skin location #10: Left heel. Issue type: Pressure ulcer/ injury. Skin tissue: Painful. Skin tissue: Mushy. Skin tissue: Boggy."</p> <p>R42's Braden Risk (Risk for Developing Pressure Ulcers) Assessment, dated 2/22/2022, documents that R42 had a score of 17 putting him at risk for developing pressure ulcers.</p> <p>R42's Skilled Evaluation, dated 2/23/22 at 12:39 a.m., documents, "Skin location #10: Left heel. Issue type: Pressure ulcer/ injury. Skin tissue: Painful. Skin tissue: Mushy. Skin tissue: Boggy."</p> <p>R42's Wound Physician Evaluation, dated 2/24/22, documents, "Unstageable DTI of the left heel partial thickness. Wound size: 5.5 cm x 5.5 cm x not measurable.</p> <p>R42's Physician's order's document, dated 2/22/22, documents that an order for skin prep for R42's wound was not obtained until 2/18/22.</p> <p>R42's Current Medical record has no documentation of a wound assessment nor staging of R42's left heel until 2/21/22.</p> <p>R42's Wound Documentation, dated 3/30/22,</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>documents that R42 has a facility acquired Stage 4 pressure ulcer to his left heel that measures 4.5 cm x 4.5 cm that was identified on 2/18/22.</p> <p>R42's wound physician evaluation, dated 5/11/22, documents, "Stage 4 Pressure wound of the left heel full thickness. Wound size 2.5 cm x 3 cm x 0.1 cm. Duration greater than 70 days. Wound Progress: No change."</p> <p>On 05/18/22 at 01:40 PM, R42 had a light pink circular open area with minimal clear drainage on the back of R42's left heel.</p> <p>On 05/19/22 at 09:40 AM, V2 (Director of Nursing) stated, "(R42) did not have a full wound assessment completed prior to 2/21/22. The assessment should have included a description and staging of the wound. The admitting nurse noted that (R42's) heels were both red. However, she did not do an assessment of the wounds or obtain a physician's order. I wish skin prep and heel protectors were started at the time of identifying (R42's) areas on admit. The worsening of the wound was caused by him putting pressure to that area, but there was no redirection to help with that because the wound had not been formally identified and put in (R42's) plan of care."</p> <p>(B)</p>	S9999		