STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: _____ B. WING _____	09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH HOLLAND MANOR HTH & RHB	2145 EAST 170TH STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Annual Recertification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 300.1220b)3) 300.3240a) 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 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. 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. 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: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in	S9999		

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S9999	Continued From page 2 the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to monitor and assess a resident's skin condition for the development of a pressure ulcer for appropriate treatment and failed to assist a resident with turning or repostioning for one resident (R339) in the sample. This failure resulted in R339 developing an unstageable pressure ulcer wound. Findings include: 09/18/18 11:01 AM R339 said, "I am supposed to be turned every 2 hours; the only time I can remember being turned is when I have a bowel movement. They said I am refusing to be turned and therapy, but I am not." 09/18/18 03:50 PM R339 said, "I have sores on my bottom and I did not have them when I came in here." 09/18/18 03:55 PM V3 (Certified Nurse Aide) said, "I started seeing redness to R339's bottom	S9999		

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S9999	Continued From page 3 about two weeks ago. Now there is skin break down." 09/19/18 10:06 AM V4 (Wound Care Nurse) said R339 had an abrasion on the left buttock that has resolved and now has an unstageable wound to the coccyx measuring 4cm x 11cm. V4 said, "The wounds on R339's bottom could have been avoided if R339 could really fully turn. The staff helps turn and reposition but R339 said it is more comfortable laying on her back." 09/19/18 12:30 PM R339 said, "I have not refused to be turned; it is very painful and I do scream." 09/19/18 03:28 PM V1 (Administrator) stated the Skin Practice Guide Process Flowchart is used as the wound care policy. 09/20/18 09:07 AM V5 (Wound Nurse Practitioner) said, "I am seeing R339 for the first time. I deal with pressure ulcers, any facility acquired wounds, arterial, and venous wounds but I do not see every type of skin impairment. R339 got the left buttocks wound here; it could not have been prevented if R339 was not turning because of the pain. I can't say that the wound was developed over two days. With a deep tissue injury you cannot tell what is under there until the epidermis comes off, then you can stage the wound. That is an unstageable wound." V5 stated to R339, "What you have here is an unstageable pressure ulcer; you are on an air mattress and need to turned more frequently." 09/20/17 09:10 AM during a wound treatment the surveyor observed V4 (Wound Care Nurse) turn R339 to right side. The pressure ulcer had slough (yellow tissue) noted to the bed of wound of	S9999		

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S9999	Continued From page 4 sacral area. 09/20/18 09:48 AM V4 (Wound Care Nurse) said, "No one made me aware of the wound; Tuesday was the first time I saw it. The floor nurse will assess the wound then I come the next day. If the (Certified Nurse Assistant) saw the wound during bedside care they should have notified me. Skin checks are done twice a week on shower days. Initially if the resident does not have any skin issues, the floor nurse will do the skin checks. It would have helped if a pillow were to be used to relieve some of the pressure. The last time the dressing was changed for R339's skin tear was Tuesday and I changed it either Saturday or Sunday. It took four days for me to be notified of the initial left buttocks skin tear." 09/20/18 10:01 AM V9 (Registered Nurse) stated, "Skin assessments are done every shift to make sure there is no broken skin, bruises or abrasions. If there are any skin alterations we call the doctor, they let us know how to treat it and we do a wound care consult. There were no changes on R339 skin last week, except for left buttocks skin tear." 09/20/18 11:13 AM V4 (Wound Care Nurse) said, "I saw the new opening Tuesday because the left buttocks dressing change was due and R339 had an unstageable wound. It can develop fast. I was shocked myself because the last time I saw R339 the wound was not there. Residents can develop pressure wounds if they are not able to turn and reposition. I knew R339 was resistant to turning and repositioning. Certified Nurse Assistants provide daily ADL care and they are expected to do skin checks." 09/20/18 01:16 V6 (Certified Nurse Aide) said, "I	S9999		

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S9999	Continued From page 5	S9999		

was helping V7 (Certified Nurse Assistant) with R339's bed bath on 09/10/18." Both stated that they noticed what looked like a large pink skin tear to R339 coccyx area. "We told V8 (Registered Nurse), who said she would report it to the wound nurse."

09/20/18 V2 (Director of Nursing) stated when a resident is found to have a skin issue it is to be reported to the nurse. The nurse does an assessment, notifies the doctor and the wound care nurse. V2 left a message on V8's (RN) answering service of need to speak with surveyor with no response.

R339's Admission Screen - V3 (nurse) dated 9/1/18 showed there were no noted skin alterations.

R339's Minimum Data Set (MDS) assessment 3.0 Section M - Skin condition dated 09/08/2018 noted Resident has no stage 1 or greater, scar over boney prominence, or a non-removable dressing/device.

R339's care plan dated 9/19/18 reads, Focus: At risk for alteration in skin integrity. Intervention: Observe skin condition with ADL (activities of daily living) care daily; report abnormalities.

R339's Skin worksheet dated 9/10/18, 9/13/18, and 9/17/18 reads: open area noted to sacral area on diagram.

The facility Shower List had R339 scheduled 7am to 3pm on Monday and Thursday.

Electronic treatment administration record (ETAR) dated 9/1/18-9/30/18 reads: R339 Body audit on shower days every day shift every Mon,

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S9999	Continued From page 6 Thu for skin observation, initialed 9/10/18, 9/13/18 and 9/17/18. R339's ETAR dated 9/1/18-9/30/18 also reads: Apply to Lt (left) buttock topically every shift every other day for wound - cleanse with wound cleanser, cover with foam dressing, initialed 9/12/18, 9/14/18 and 9/16/18. R339's Progress note dated 9/10/18 shows V4 documented: Assessed Lt buttock per nurse request. Noted 4.0 x 2.0cm, 100% red, no odor or drainage and intact periwound. R339's Progress note dated 9/15/18 shows V8 documented: Pt has ulcers to both buttock areas. R339's Progress note dated 9/19/18 shows V4 documented: Unstageable wound to more on coccyx area 4.0 x 11.0cm 100% yellow slough, wound edges pink, moist, periwound intact. ETIOLOGY: Pressure. Policy Titled Skin Practice Guide Process Flowchart dated 2013: Diagramed to Assess - Complete skin risk section of admission - Is patient at risk for skin breakdown? - Braden Scale weekly x 3 more times - change in condition - Wound team to evaluate - Is the skin alteration a pressure ulcer? - Initiate skin alteration record - Contact physician for orders Policty Titled Skin practice guide dated 2013: Phase 1: Assess Patient positioning: can assist with reducing the risk for breakdown. The Braden scale is completed for four (4) weeks total (at the time of admission and then weekly for the next three (3) weeks. A weekly skin evaluation is completed by the	S9999		

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S9999	Continued From page 7 licensed nurse for those patients identified as at risk for skin breakdown that do not have a pressure ulcer. Patients admitted with skin alterations or those who develop new alterations are ideally evaluated by a qualified health professional within 24 hours or as soon as practicable, after admission or new skin alteration identified. Nursing assistants perform daily skin observations with routine care. The skin worksheet is completed by the nursing assistant at least two times per week with the patient's bath. Results are submitted to the licensed nurse for review and follow-up as needed. Patients at risk have a head-to-toe skin evaluation weekly by a licensed nurse. If a change in patient condition occurs, such as skin alterations, the licensed nurse notifies the physician, wound team, family or responsible party and documents findings in the clinical record. (B)	S9999		