Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016794	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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 Complaints: 2047324/IL126842 2046667/IL126081 2046519/IL125909 2046523/IL125913 2043508/IL122663 2048424/IL128041	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c)2)3) 300.1210d)5) 300.1220)b)2)3) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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S9999	Continued From page 2	S9999		

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:

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

2) All treatments and procedures shall be administered as ordered by the physician.

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.

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:

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,

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S9999	Continued From page 3	S9999		

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:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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 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 Regulations were not met as evidenced by:

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S9999	Continued From page 4 Based on observation, record review and interview, 1) the facility failed to timely obtain pressure ulcer treatment orders from a physician, perform routine skin assessments, routinely monitor and assess pressure ulcers, and develop pressure ulcer prevention interventions for seven of eight residents reviewed (R4, R5, R7, R11, R12, R3, R9) for pressure ulcers. 2) The facility failed to notify the physician of pressure ulcers either identified upon admission, at onset or with progression, for five of eight residents (R4, R5, R3, R9, R12) reviewed for pressure ulcers. 3) The facility failed to develop policies related to wound management, notify the physician of pressure ulcers, neglected to provide pressure ulcer treatment in accordance with physician's orders, and routinely monitor/assess/treat pressure ulcers in accordance with professional standards, for two of eight residents reviewed (R4, R5) for pressure ulcers. These failures resulted R4 and R5, both admitted pressure ulcers on the coccyx, going without physicain's ordered treatments and progressing to a Stage 4 infected wounds requiring debridement. These failures resulted in R4 developing a Stage 4 pressure ulcer on the coccyx, which became infected, led to sepsis and R4's subsequent death on 8/22/20; R5 developing a Stage 4 pressure ulcer on the coccyx, which became infected and required hospitalization; R7 developing a deep tissue injury to the calf after staff failed to routinely assess R7's skin while using a leg immobilizer, prolonging his admission; R11 developing a Stage 3 pressure ulcer on the right heel and a Stage 2 pressure ulcer on the left heel; R9 having a Stage 2 coccyx wound that progressed to a Stage 3; and R12 having a pressure ulcer on the Right Ischium that	S9999		

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S9999	Continued From page 5	S9999		

Continued From page 5

progressed from a Stage 2 pressure ulcer to a Stage 3 pressure ulcer.

Findings include:

The facility failed to ensure R4 received timely and appropriate treatment of a Unstageable Pressure Ulcer that was identified upon admission, then failed to routinely monitor that wound and provide appropriate treatment when the wound progressed to a Stage 4 pressure ulcer. R4's pressure ulcer became infected, which led to sepsis. R4 expired on 8/22/20, due to sepsis from the infected coccyx wound.

The facility policy, titled "Pressure Injury Prevention (no date)," documents, "Purpose: To prevent avoidable pressure injuries. Procedure: 1. personal care associates to inspect skin daily during care. Pay particular attention to bony prominence's. Report new skin irregularities to the nurse via a STOP and Watch. 2. Keep the skin clean and dry. Cleanse the skin with mild soap and water or a facility approved perineal cleanser after each incontinent episode and at routine intervals. Avoid very hot water. 3. Apply moisturizers to keep skin subtle. Apply moisturizers after bathing, thus reducing dryness. 4. Protect the skin from exposure to excessive moisture with a barrier product in order to reduce the risk of pressure damage. 5. Avoid massage over bony prominence's and reddened areas. 6. Avoid friction and shearing by using proper positioning, transferring and turning techniques. 7. Avoid positioning the guest directly onto medical devices, such as tubes, drainage systems or other foreign objects. 8. Do not leave guests on the bedpan longer than necessary. 9. Encourage adequate intake of calories and fluids.

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S9999	Continued From page 6 10. Reposition guests frequently or as often as they will allow. 11. Utilize positioning devices to keep bony prominence's from direct contact with one another. Discourage use of ring or donut shaped devices. The edges of these devices create areas of high pressure that may damage tissue. 12. Float heels as guest will allow. Synthetic sheepskin pads, cutout ring, or donut-type devices should not be used to elevate heels as these products have been shown to have limitations. When floating heels, ensure that the heels are free of the surface of the bed. 13. Avoid positioning directly on the trochanter. 14. Use lifting devices to move guests in bed whenever possible. 15. Maintain the head of the bed at the lowest degree of elevation possible (consistent with the guest's medical condition). 16. Apply pressure-redistributing mattresses to the guest beds and wheelchairs as guest allows. 17. Keep linens as wrinkle free as possible." The facility policy, titled "Notification and Significant Change of Condition Policy (no date)," documents, "Purpose: To ensure that the facility immediately informs the guest; consult with the guest's physician; and notify, consistent with his or her authority, the guest representative when there is: An accident or incident involving the guest which results in injury and has the potential for requiring physician intervention; A significant change in the guest's physical, mental, or psychosocial status (Deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications); Life threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a pressure injury, onset or recurrent periods of delirium, symptoms of a urinary tract infection, or onset of depression; A need to alter treatment significantly or	S9999		

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S9999	Continued From page 7	S9999		

commence a new form of treatment to deal with a problem." The policy later documents, "The physician will be contacted immediately for any emergencies regardless of the time of day. Non-emergency notifications may be made the next morning during normal business hours if the situation occurs on the late evening or night shift. This applies to any day of the week, including holidays. If the physician cannot immediately be reached in an emergency, the Medical Director will be contacted. If that physician cannot be reached, the Director of Nursing or the Charge Nurse can make arrangements for Transportation to the Emergency Department. In a non-emergency situation, the physician will be called unless he/she has left an alternate name to call. If after two attempts, if there is no response to the calls, the Medical Director will be contacted. Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the physician."

The facility's Abuse Prevention Program (2/07/17), defines Neglect as, "the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish. Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness."

On 10/20/20, at 3:30 pm, V2 (Director of Nursing) stated the facility does not have any written policies or procedures related to the management of pressure ulcers/wounds once they develop, but they do have the expectation that staff will do daily skin checks, assess and measure any pressure ulcer on a weekly basis, document

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S9999	Continued From page 8	S9999		

those findings, notify the physician of any observed changes and implement appropriate interventions to prevent pressure ulcers from worsening or new ones developing.

On 10/22/20, at 2:29 pm, V14 (Certified Wound Specialist/Nurse Practitioner) stated the facility has an ongoing problem with the management of pressure ulcers and wounds. V14 stated the facility does not have a definitive "wound protocol", and no one is developing a treatment plan for the residents who have pressure ulcers present on admission. V14 stated she has seen wound dressings on residents that have not been changed for three days. V14 stated patients are "leaving this facility worse than when they came in." V14 stated she is often not notified of wounds that staff find when residents are admitted and/or if wounds progress. V14 stated she has come into the facility to assess residents and will find they have a treatment on their wound that is three days old, when it should be changed every day. V14 stated that a simple protocol for nursing staff to follow for wound management would be beneficial, because wounds are not always being monitored on a weekly basis, which is a standard of care, and basic pressure reduction interventions are not always being implemented for residents in a timely manner. V14 stated she has seen treatments on residents that are not treatments that she or the Medical Director would have ordered, as they are not within the parameters of the standard of practice for wound care.

On 10/22/20 at 10:03 am, V3 (Wound Nurse/Registered Nurse) stated he started in that position late July 2020. V3 stated the previous Wound Nurse had already left when he started,

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S9999	Continued From page 9	S9999		

so he was given instruction by V2 (Director of Nursing). V3 stated he was told by V2 that wounds needed to be assessed weekly and within 24 hours of a residents admission and guided him on the computer program, but "the remainder was trial and error." V3 stated that the facility did not have any written protocols for wound management, so he went forward with his position based on his experience working in a burn center. V3 stated if a resident is admitted with a Stage 1 or Stage 2 pressure ulcer, they will initiate a foam dressing and repositioning without a physician's order, but the facility does not require a physician's order for that treatment. V3 indicated they "would not contact the physician for treatment orders unless the wound is not going in a positive direction. There is no set guidance. We often don't call the physician (for orders) until the wound is a Stage 3." V3 confirmed that there is no written standing orders by a physician for wound care that the facility utilizes. V3 did not have an explanation as to why R4's coccyx wound did not have a documented assessment for 19 days, and concluded that the standard of practice for wound assessments would be to measure them weekly (ideally on the same day of the week).

1. The electronic medical record documents R4 was admitted to the facility on 7/24/20, following surgical repair of a Right Femur Fracture, for inpatient Physical and Occupational Therapy, and planned to discharge back to home. Nursing Notes, dated 7/25/20 at 4:11 am, document R4 had a "pressure ulcer measuring 4.0 cm x 3.3 cm on her coccyx." R4's admission physician orders for 7/24/20, do not include treatment orders for for a pressure ulcer on the coccyx or evidence that the physician was notified R4 had a pressure ulcer upon admission.

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S9999	Continued From page 10	S9999		

A Plan of Care, dated 7/24/20, documents R4 was determined to be "Very high risk for skin breakdown (related to) impaired mobility, occasional incontinence. Admitted with pressure wound to coccyx, (right) leg surgical wound and (bilateral upper extremity) bruising." A Braden Scale for Prediction of Pressure Sore Risk, dated 7/25/20, documents R4 was determined to be at "moderate risk" for the development of pressure ulcers, and instructs staff to do the following interventions: conduct a Braden risk assessment upon admission and weekly for four weeks, observe during care for any signs of breakdown, pressure reducing mattress on bed, pressure reducing wheelchair cushion when in wheelchair, preventative skin care as indicated, and treatment as ordered to the right lower extremity surgical wound. The initial Plan of Care for R4 does not instruct staff to turn and reposition R4, off-load pressure to the coccyx, or administer a treatment to the coccyx wound. An Admission Nursing Assessment, dated 7/25/20, documents R4 has an "unstageable" pressure ulcer with scant serosanguinous drainage.

A Treatment Administration Record (TAR) for July 2020, documents the facility obtained an order to treat R4's coccyx wound on 7/28/20, four days after the wound was first noted to be present. The July 2020 TAR documents staff started treating R4's coccyx wound by covering it with a comfort foam dressing, which was to be changed every other day. On 7/28/20, R4's Plan of Care was updated with the intervention of "treatments as ordered to coccyx," but still failed to indicate R4 needed staff to off-load pressure to the coccyx area or turn and reposition. A 7/30/20 Minimum Data Set assessment, documents R4 needs the physical assistance of 1-2 staff for bed mobility

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S9999	Continued From page 11	S9999		

and transfers. The electronic medical record documents R4's weight had decreased from her admission weight of 105.6 pounds, down to 100.6 pounds on 8/04/20, and then decreased again on 8/12/20 to 98.8 pounds.

The Progress Notes document R4 did not have another wound assessment until 8/12/20, nineteen days after the initial wound assessment of 7/25/20. The 8/12/20 Progress Note documents R4's coccyx wound as being a Stage III the "medial coccyx" and measuring 5 cm x 2 cm (no depth measured), and the presence of a new Stage II pressure ulcer on the right medial buttock, measuring 1 cm x 1.5 cm. On 8/13/20, a Physician's Orders document R4's treatment changed to "clean wounds and apply comfort foam border dressing to wounds on buttocks" every other day.

On 10/22/20 at 10:03 am, when V3 was questioned regarding R4's treatment orders for the coccyx wound not changing between 7/25/20 and 8/12/20, after the wound had progressed and an additional wound developed, V3 indicated he had implemented that treatment order and didn't call the physician. V3 did state he referred R4 to the wound clinic for evaluation, which she did go to on 8/17/20.

On 8/17/20, a Wound Care History and Physical by V14 (Certified Wound Specialist/Nurse Practitioner), documents the following: "The patient is an 86-year-old female that was referred to the Wound Center from the Bridge Care Suites. I was notified approximately one week ago that the patient had a wound 'that might need to be seen.' I had the (facility) refer her to the wound clinic at that time. She has been at the Bridge since approximately the beginning of

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S9999	Continued From page 12 August after a hip fracture. She has a past medical history of Atrial fibrillation, is on Eliquis, (Deep Vein Thrombosis), Hypertension. I did speak to her son, who is her Power of Attorney, over the phone quite extensively about her history. She currently lives alone. However, at discharge he plans to have her live with him. I have also suggested that (extended care facility) placement would be appropriate. She does need 24 hour care. When the patient presented today, there is just a foam border dressing covering her wound and that was it. She is in a wheelchair with a cushion that was flat. She has Left Buttock Stage II pressure ulcer that was debrided using a scalpel. Her coccyx wound is very extensive and has large amounts of slough. I am able to feel the bone with palpation, as well. The Bridge is unable to tell me if she came with this wound or how long it has been there. I have been seeing her under Medical Directorship for rehabilitation related to her recent hip fracture. I was informed of this wound one week ago on August 10, 2020. The wound was debrided of some slough using a scalpel. The wound is going to require multiple debridements." The Wound Care History and Physical documents R4's coccyx wound as a Stage 4 Pressure Ulcer, measuring (length) 5.2 cm, (width) 3.0 cm and (depth) 3.2 cm, with purulent, yellow drainage, large amount of necrosis, and bone exposed. The Wound Care History and Physical documents R4's Left Buttock Stage II Pressure Ulcer as (length) 3.0 cm by (width) 0.5 cm by (depth) 0.1 cm. The Wound Care History and Physical documents, "Impression and Plan: I would like her to get and x-ray of the sacral and coccyx area to rule out any osseous destruction. The wound should be cleaned twice daily with soap and water and Dakin's moistened gauze packed into the wound, then covered with a foam border dressing.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 13	S9999		

Xeroform should be applied to the left buttocks pressure ulcer. She needs to get a offloading cushion for her wheelchair. She should only be up for meals. She should be turned and repositioned every 1 hour from side to side. Will add Med Pass (nutritional supplement) 90 cc (three) times per day for extra protein supplement for wound healing."

R4's Plan of Care related to skin impairment was still not updated with any new pressure ulcer prevention interventions, and remained the same plan of care that was developed for R4 upon admission.

The Treatment Administration Record (TAR) for August 2020, documents the nursing staff performed the treatment to R4's coccyx wound on 8/18/20, in the morning and in the afternoon, as ordered by V14 the day prior. The August 2020 TAR documents the treatment to R4's coccyx wound was only performed in the morning on 8/19/20, and not in the afternoon, due to the Dakin's solution being unavailable. The August 2020 TAR, documents on 8/21/20, R4 developed pain in the coccyx area that she rated a "5" on a scale of 1-10. All previous pain assessments in the August 2020 TAR document R4's pain level at a "0" on a scale of 1-10. The electronic medical record fails to document that staff notified the physician on 8/21/20 of R4's sudden onset of coccyx pain.

On 10/22/20 at 2:29 pm, V14 (Certified Wound Specialist/Nurse Practitioner) stated she would expect staff to contact herself or the Medical Director if a resident experiences a sudden onset of pain/increased pain in a wound.

The August 2020 TAR documents on 8/22/20 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ____ B. WING ____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

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S9999	Continued From page 14	S9999		

R4 had increased pain, rated at a "7" on a scale of 1-10. Progress Notes, dated 8/22/20 at 10:50 am, document R4 was "complaining of severe discomfort to back and to coccyx. Order received for Tylenol 650 mg (milligrams) q (every) 6 (hours)." The Progress Notes then document at 11:51 am, R4 was complaining of nausea and abdominal discomfort, with Zofran 4 mg every four hours being ordered. At 12:30 pm, the Progress Notes document, "Note (V4's) mental and physical condition had declined. (V4) is unable to answer simple yes and no questions, (V4) is awake but will not respond to name. (V4) is unable to talk to Son, via telephone. (V4) drank one Ensure for breakfast, refused (morning) meal. Spoke with (V4's) Son who would like his Mother sent to (Hospital) for evaluation. (V14) contacted and order received to send to (Hospital) for evaluation." Progress Notes document at 12:50 pm on 8/22/20, V4 was transported via ambulance to the Hospital.

Hospital Emergency Department records, dated 8/22/20, document V4 arrived with agonal breathing, no blood pressure or pulse and CPR (Cardiopulmonary Recusitation) was initiated, as R4 was a Full Code. Hospital Emergency Records document CPR was unsuccessful and V4 was pronounced dead at 2:10 pm.

R4's Death Certificate documents the following under cause of death: 1. Bacterial Sepsis with Enterococcus Faecium and Escherichia Coli, 2. Sacral Decubitus Ulcer and Cystitis, 3. Fracture of the Hip due to a fall. Additionally, the Death Certificate documents "Neglect" as a "significant condition contributing" to R4's death.

A Medical Pathology Report, by V21 (Medical Doctor/Pathologist), dated 9/18/20, documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 15 "After consideration of the circumstances surrounding (R4's) death, review of available medical history and records, and after the postmortem examination with ancillary studies, the death of this 86 year old female (V4), is Bacterial Sepsis with Enterococcus Faecium and Escherichia Coli in the blood, due to a sacral decubitus ulcer with enteric bacterial odor and cystitis with microscopic pyelonephritis, and fracture of the hip due to a fall with surgical repair. A significant factor in her death based upon the coroner investigation information and the autopsy findings is neglect." On 10/26/20 at 2:00 pm, V31 (Registered Nurse) stated she could easily recall R4 because of her coccyx wound, stating it was "very sizable, you could put your fist in it" and described it as having an odor with a lot of slough (dead tissue). V31 stated the morning of 8/22/20, it was not passed on to her from the night shift nurse that R4 had complaints of increased pain in the coccyx wound. V31 stated R4 was alert when she came on shift the morning of 8/22/20, but "not as alert as in the days prior." V31 stated R4 had complained that morning of increased pain in her coccyx and nausea, so she did call the physician to request an order for Tylenol and Zofran, which she did administer to R4. V31 stated, mid morning R4's Son called to talk with her and V31 gave R4 the phone. V31 stated she received a phone call at the nurses station from R4's Son, who was concerned because R4 was "not making any sense." V31 stated she went to check on R4, who she described as "very slow to respond." V31 did not do any kind of nursing assessment on R4 at that time, but called R4's Son back and asked him what he wanted her to do with R4. V31 stated she gave R4's Son the option of her trying to manage R4 at the facility by increasing	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 16	S9999		

her fluids or sending R4 to the Emergency Room. V31 stated R4's Son requested she send R4 to the Emergency Room.

On 10/19/20, V34 (Family/Power of Attorney) stated on the morning of 8/22/20, he called the facility to speak to R4. V34 stated he "knew immediately something was wrong with her (R4)" and described hearing R4 "moaning and screaming" on the phone. V34 stated R4 sounded like she was in distress and was not making any sense, so he hung up and called the nurses station. V34 stated the nurse he spoke with told him R4 was just dehydrated and that she would try to get fluids into R4, but he asked they send R4 to the hospital. V34 stated R4 died either on the way to the hospital or as soon as she arrived. V34 stated he was in shock, as they had been planning on R4 discharging to his home. V34 stated he was unaware of how severe R4's coccyx wound had become, until he received a call from V14 on 8/17/20, and V14 told him she was "mortified at the condition my Mom was in."

On 10/22/20 at 2:29 pm, V14 (Certified Wound Specialist/Nurse Practitioner) stated she did see R4 as a patient during her admission to the facility, as she is practicing under the facility's Medical Director. V14 stated she saw R4 on a frequent basis, because the staff felt R4 was declining, but staff did not inform her of R4's coccyx wound until approximately one week before V14 saw R4 as a patient at the Wound Clinic. At that time, staff had simply requested a referral to the Wound Clinic and no treatment orders, making her assume appropriate wound care orders were already in place. V14 stated when she did see R4 at the facility, she was always sitting up in her wheelchair. According to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 17 V14, when she saw R4 at the wound clinic, she first noted R4 was "very thin and frail" and was sitting on a "flat cushion" in her wheelchair, not a pressure reduction cushion. V14 stated she was "mortified" when she first saw R4's coccyx wound, as it had "obvious tunneling to the bone," and stated the wound was "nasty, nasty." V14 stated the foam dressing that was in place when R4 presented to the Wound Clinic was not an appropriate treatment for that size/extent of a wound. V14 stated when she removed the foam dressing, the wound "stunk" and had "copious amounts of drainage." V14 stated that the treatment of the foam dressing that was initiated on 7/28/20, was not ordered by her or the Medical Director and must have just been initiated by the facility's Wound Nurse. V14 stated the treatment started on 7/28/20 (foam dressing changed every two days) would not have been an appropriate treatment for what was described as an "unstageable" and "draining" wound. V14 also stated R4's weight loss was not addressed timely, as V14 was who initiated the nutritional supplement order on 8/17/20, which was two weeks after the significant weight loss occurred. V14 concluded that the facility should have obtained a treatment order for R4's coccyx wound on the day she was admitted (7/24/20), implemented a turning and repositioning program, assessed the wound on a weekly basis, and utilized a actual pressure reduction cushion in her wheelchair. V14 stated, if the facility had implemented all of the basics of wound management upon R4's admission, they could have prevented R4's wound from developing into a Stage 4, along with the development of the Stage 2 on the buttock. According to V14, if the facility did not follow the instructions she provided on 8/17/20 regarding wound care and the need to change R4's coccyx dressing twice per day, it	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 18	S9999		

Continued From page 18

could lead to the wound getting infected because R4's wound had significant drainage. V14 indicated, had she or the Medical Director been notified of R4's wounds, they could have ordered appropriate treatments and possibly prevented the wound's progression.

On 10/22/20 at 2:29 pm, V14 (Nurse Practitioner/Certified Wound Care Specialist) stated if a resident has a pressure ulcer or deep tissue injury upon admission to the facility and does not have treatment orders, or if a wound deteriorates, the Physician or herself should be notified for appropriate wound care orders.

On 10/20/20 at 12:51 pm, V15 (Coroner) stated he observed R4 in the Emergency Room shortly after she expired on 8/22/20. V15 stated "(R4) was in bad shape, enough for me to recommend an autopsy by (V21)." V15 stated that it was he and V21's opinion that poor/lack of wound care led to R4's bacterial sepsis and the deterioration of R4's wound was something that could have been avoided with proper treatment.

2. The electronic medical record documents R5 was admitted to the facility on 7/22/20 for Physical and Occupational Therapy following surgical repair of a left femur fracture. The 7/22/20 admission Progress Note, simply documents R5's buttocks as "red" and identifies a surgical incision. A Plan of Care, developed 7/22/20, documents R5 as "very high risk for skin breakdown (related to history) of pressure wound (right) buttocks, Stage 2 pressure wound (left) buttock and coccyx, impaired mobility, occasional bladder incontinence." On 7/23/20, Progress Notes document R5 has a Stage 2 pressure ulcer on medial left buttock, measuring 2.0 x 3.0 cm, and described as open with bright red scant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 19	S9999		

drainage, and Stage 2 pressure ulcer on the medial coccyx, measuring 1.0 x 0.5 cm, described as open and bright red, with both being covered by a foam dressing. R5's 7/22/20 admission physician's orders do not include treatment orders for either pressure ulcer on R5's buttocks and there is no documentation in the electronic medical record that the physician was aware of the pressure ulcers.

On 7/30/20, Progress Notes documents R5's buttock wounds had progress to a 5.0 x 2.0 cm unstageable pressure ulcer on the right medial buttock and a 2.0 x 1.0 Stage 3 pressure ulcer on the medial buttock, with V3 (Wound Nurse) documenting the wounds were covered with foam dressing. V3 also documented the skin surrounding both pressure ulcers as being red, so zinc cream was applied to the area. There is no documentation that V3 notified R5's physician that the wounds progressed, on 7/30/20. R5's Plan of Care was updated on 7/30/20, documenting R5 now had a "unstageable" right buttocks pressure ulcer and a "Stage 4" pressure ulcer to the "medial buttock" with the added intervention of "encourage/assist to turn/reposition frequently."

On 8/05/20, Progress Notes document V26 (Licensed Practical Nurse) contacted V3 over concerns about R5's pressure ulcers and V3 advised her to continue to apply zinc to the areas and cover them with a foam dressing until he could see the wounds 8/06/20. There is no documented evidence that V3 assessed R5 on 8/06/20.

On 8/07/20, the Treatment Administration Record (TAR), identifies the first scheduled wound care for R5's pressure ulcers, 17 days after the

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
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 20 wounds were first identified upon admission. The August 2020 TAR instructs staff to "cleanse (R5's) bottom and apply foam dressing daily"; however, there is no corresponding Physician's Order for that treatment. Progress Notes on 8/07/20 document V17 (Licensed Practical Nurse) attempted to contact V27 (Primary Care Physician) regarding R5's pressure ulcers and to request a referral to the Wound Clinic, but did not receive a return call. There is no documented evidence that the facility attempted to contact the Medical Director or V14 (Nurse Practitioner) when V27 failed to respond to their messages left regarding R5. R5's Progress Notes on 8/10/20, by V3 (Wound Nurse), document, "(Right) medial buttock/ medial buttock expanding/joining stage 3 (pressure ulcer) with areas of eschar, covered with mepilex, physician/ wound consult needed, Blisters has callused on bilateral heels, guest instructed to keep heels off bed, redness surrounding PU on buttocks, zinc paste applied." The following Progress Note, on 8/10/20, documents V17 attempted to contact V27 again regarding R5's pressure ulcers. The next documentation regarding R5's pressure ulcers is a Progress Note dated 8/12/20 by V17, indicating another call was placed to V27 wanting a referral to the Wound Clinic for R5. Progress Notes document on 8/12/20 at 9:27 am, the facility decided to send R5 to the Emergency Room for evaluation of her coccyx wounds, with still no notification to the facility's Medical Director or Nurse Practitioner. Hospital Admission records, dated 8/12/20, document, "71 year old female (R5) brought to the emergency room today from (rehabilitation) center with the complaints of increased lower	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 21	S9999		

back and left hip pain. She has a recent history of left intertrochanteric femur fracture status post ORIF (Open Reduction Internal Fixation) done here in our hospital was discharged to the rehab, now presented with infected sacral decubitus ulcer. Sepsis secondary to infected sacral decubitus ulcer." The Hospital Admission record documents the reason for admission as infected Sacral Decubitus Ulcer with the bone exposed. The Hospital History and Physical documents the sacral wound was debrided by Plastic Surgery and R5 was treated with IV (intravenous) Vancomycin for wound infection. On 8/19/20, a Hospital Physician Progress Note documents R5 was treated with additional IV antibiotics and planned to discharge; however, R5 was going to require an additional six weeks of antibiotic therapy due to "concern for osteomyelitis."

On 10/22/20 at 9:22 am, V17 (Licensed Practical Nurse) stated she was trying to reach V27, who was R5's Primary Care Physician for several days, because she knew R5 needed to be seen by the Wound Clinic for the pressure ulcer on her coccyx. V17 stated the wound was not getting better, but getting worse and in need of treatment. V17 stated the facility can always fall back on their own Medical Director if they are unable to reach a resident's Primary Care Physician and need treatment orders, but V17 stated she did not do so in this situation.

On 10/22/20 at 2:29 pm, V14 (Nurse Practitioner) stated the facility always has the option of reaching out to herself or the Medical Director for orders related to the care of any resident admitted to the facility. V14 stated she nor the Medical Director were ever notified that R5 had a pressure ulcer, let alone that it was progressing to a Stage 4 wound. V14 stated the facility should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	IL6016794		C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 22	S9999		

have obtained appropriate treatment orders for R5's wound at the time of her admission and notified either herself or the Medical Director as soon as the wound started worsening.

On 10/22/20 at 2:29 pm, V14 stated the nursing staff or V3 (Wound Nurse) never contacted her or the Medical Director for any wound care orders or regarding R5's wound deteriorating. V14 stated the staff should be immediately contacting her or the Medical Director if a residents Primary Care Doctor is not responding to their concerns.

3. The electronic medical record document R7 was admitted to the facility on 8/24/20 for inpatient Physical and Occupational therapy following a Left Hip Fracture. Hospital Discharge instructions, dated 8/24/20, document R7 has a left leg immobilizer that he is to wear at all times.

Progress Notes, dated 9/02/20, document "Wound Nurse found DTI (Deep Tissue Injury) on (R7's) posterior left calf from leg brace. (V14-Wound Nurse) assessed area and has ordered mepilex to area and sheepskin in between leg and brace. Removed center metal plate that caused injury and she has ordered to keep brace off while in bed until return call from (Orthopedic Doctor's) office." A Weekly Skin Check, dated 9/02/20, documents R7's Deep Tissue Injury as 6.5 cm x 1.5 cm, and that R7 was referred to the wound clinic.

On 9/16/20, documentation in a Nurse Practitioner Nursing Home Note indicates V14 examined R7 at the facility for a routine visit. The 9/16/20 Nursing Home Note documents, "I'm seeing the patient today for follow-up at the Bridge Care Suites. He had a fall which resulted

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S9999	Continued From page 23	S9999		

in a left distal femur fracture. (R7) is a 77 year old male with past medical history of cardiomyopathy, Atrial fibrillation, hypertension, diabetes. Patient had ORIF of left distal femur on 8/23/20. He was made non-weight bearing and places in a leg immobilizer. The leg immobilizer has since caused a deep tissue injury to his left posterior calf area. The wound is currently unstable. Wound bed does have some loss. Today when I examined, it was very saturated. Surrounding skin shows signs of maceration. Drainage is serosanguinous."

A Wound Clinic note, dated 9/30/20, documents R7's left calf wound measured 6.9 cm x 3.7 cm x 0.7 cm and required a wet to dry dressing with Dakin's solution daily. A subsequent Wound Clinic note, dated 10/12/20, documents R7's left calf wound measured 6.3 cm x 2.7 cm x 1.0 cm and now required a wound vacuum to promote healing.

On 10/21/20 at 11:00 am, R7's wound care was completed by V3 (Wound Nurse). V3 removed the old dressing and released the suction from the wound vacuum, making the wound on the left calf fully visible. R7's wound was 5.0 cm by 2 cm and 0.1 cm deep. At that time, V3 stated R7's wound developed "a few days after he was admitted, when (R7's) leg brace was not removed for a few days, per an order."

On 10/22/20 at 3:10 pm, V14 (Nurse Practitioner) stated R7 developed a very large deep tissue injury from his leg immobilizer. V14 stated she observed the wound on 9/02/20 after it was identified. V14 stated she recalled staff at the facility were under the impression that R7's leg could not be taken out of the immobilizer at all, when he was first admitted. V14 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 24	S9999		

hospital discharge orders were not clear in their instruction regarding the immobilizer, but staff should have clarified those orders. V14 stated R7 should have had a skin assessment once per shift during cares, especially if they have a "device" on their body. V14 stated routine skin checks would have caught the deep tissue injury earlier and the wound could have been prevented.

On 10/26/20 at 2:40 pm, V32 (Orthopedic Nurse) stated, even though R7's hospital discharge orders said for R7 to utilize the immobilizer to the left leg at all times, it is assumed staff will be doing skin checks at a minimum of every shift, as that is basic nursing care.

On 10/19/20 at 1:10 pm, R7 was lying in bed with a wound vacuum attached to his left outer calf. R7 stated that he got the wound to his leg shortly after he was admitted to the facility when his leg was in a "brace for a few days straight." On 10/22/20 at 3:15 pm, R7 stated he has pain in his leg, mostly from the constant suction of the wound vacuum. R7 stated the pain and suction often keeps him up at night. R7 stated he tried to go home to his wife once, but had to come back to the facility for care. R7 stated he would have been home a by now, but "the wound has kept me here."

4. The electronic medical record documents R11 was admitted to the facility for Physical and Occupational Therapy following a left femur fracture. The Progress Notes, dated 6/03/20, document upon R11's admission "heels soft placed on pillow off the bed." A Plan of Care dated 6/03/20, documents R11 is at risk for skin breakdown due to impaired mobility and instructs staff to perform preventative skin care as needed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: _____ B. WING _____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 25	S9999		

utilize a pressure reduction wheelchair cushion and mattress, observe during care for signs of breakdown, and conduct weekly Braden Risk skin assessments for the first four weeks.

On 7/06/20, Progress Notes document staff observed a "skin flap" on R11's right heel and nursing staff applied "skin prep" to the area. On 7/08/20, R11's Treatment Administration Record. the following treatments were initiated by V20 (Previous Wound Nurse): 1. Skin Prep to Right Heel twice per day for "popped blister" and 2. Apply foam dressing to Deep Tissue Injury on Left Heel every three days. A Weekly Wound Pressure Injury Report documents R11's Left Heel Wound measured 1.0 cm x 1.0 cm on 7/08/20.

R11's electronic medical record does not contain any documented information regarding either of R11's heel wounds, until 16 days later, on 7/24/20. A Skin Assessment, by V3 (Wound Nurse) documents on 7/24/20 that R11 now has the following: 1. A unstageable wound to the right heel, with heavy purulent drainage, measuring 2.5 cm by 4.0 cm and 2. A Stage 2 Pressure Ulcer to the left heel, measuring 2.5 cm by 4.0 cm. It was not until that time, that pressure reduction interventions for R11's heels were implemented. V3 documented on 7/24/20 in the Progress Notes that R11 needed to be referred to the Wound Clinic, heel cushions were ordered and R11's wound treatment was changed to a daily treatment, rather than every three days.

R11's Plan of Care during his admission from 7/08/20 through 9/01/20 was never updated to identify R11 had skin impairment on the bilateral heels or with pressure ulcer prevention interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ___ B. WING ___	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 26	S9999		

Continued From page 26

On 10/28/20, at 11:45 am, V3 (Wound Nurse) stated when he first observed R11's bilateral heel wounds on 7/24/20, they had progressed to the point that they required a daily wound treatment, due to the amount of drainage from the right heel.

On 10/28/20 at 11:50 am, V2 (Director of Nursing) stated she had no explanation as to why staff failed to complete the necessary skin assessments for R11's bilateral heel wounds on 7/06/20 or the week following.

On 10/22/20 at 3:10 pm, V14 (Nurse Practitioner) stated she observed R11's heel wounds for the first time at the Wound Clinic (on 8/03/20) and R11's heels needed to be debrided. V14 stated she was unaware that R11 had wounds of that nature, as R11 was admitted to the facility with no skin issues. V14 stated that routinely off loading R11's heels, when they were found to be "soft" upon admission, could have prevented the wounds from developing

4. R3's nursing notes dated 2-16-20 document R3 was admitted on 2-15-20 with sepsis, cellulitis, congestive heart failure, diabetes, hypertension and chronic kidney disease with dialysis. R3 was admitted with a 1 x 1 cm open skin area to his left foot on left side and a partially amputated right foot. This note states these wounds need to be evaluated by the wound nurse.

There is no further wound assessments until 2-24-20 when a weekly pressure injury report and weekly skin assessment documents a left foot Stage 1 pressure sore 1 x 1 cm and a right heel DTI (deep tissue injury) measuring 4 x 2.5 cm with a wound bed black and purple.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 27 R3's physician orders do not contain any orders for R3's right heel DTI until 2-25-20 and no orders for R3's Stage 1 left foot pressure ulcer. R3's next weekly skin assessment dated 3-10-20, 15 days later, documents R3 has a right heel DTI with no measurements or assessment. "Blanching redness noted to buttock, cream used." R3's weekly skin assessment dated 3-31-20, 21 days later, documents R3 has a DTI to the right heel that is "unchanged" (no measurements given). "Stage 2 pressure ulcer to coccyx measuring 1 x 2 cm, foam dressing applied, surrounding area is a Stage 1 pressure ulcer." R3's nursing notes dated 4-7-20 document R3 returned from a doctor's appointment with orders for a daily dressing change on an area on R3's spine. There is no wound assessment found for this area. R3's nursing progress notes show no documentation of R3's physician being notified of the open areas to R3's back, penis or newly developed State 2 pressure ulcer. or orders to treat this area. On 10-23-20 at 11:20 am, V28, Nurse Anesthetist stated on 3-29-20, R3 had open pressure ulcers to his buttocks, back and penis. R3's heels were blackened. R3's wounds to the buttock were not dressed. On 10-21-20 at 9:00 am. V2 DON/Director of Nursing verified there was no initial physician's order for treatment and monitoring of R3's right heel DTI nor was the physician notified that R3	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 28	S9999		

developed a Stage 2 pressure ulcer to the coccyx, therefore no treatment was obtained. There is no documentation related to a back wound before 4-7-20 and no documentation at all for an open area to R3's penis.

On 10-21-20 at 2:30 pm, V14 NP (Nurse Practitioner) stated when R3's pressure ulcer advanced from a Stage 1 to a Stage 2, she should have been notified and new orders for treatment obtained. R3's right heel DTI should have been measured weekly and an order obtained for treatment. The supplement Nepro should have been ordered earlier to help with wound healing. V14 had no knowledge of the open area to R3's penis or back.

R3's Braden Sale for Prediction of Pressure Sore Risk dated 2-15-20 notes R3 is at high risk and to initiate pressure reducing devices for bed and wheelchair and initiate a care plan. A repositioning program, pressure ulcer care or dressing were not checked to be initiated at that time. R3's current care plan documents interventions dated 2-15-20 including to observe for breakdown, pressure reducing mattress on bed and cushion in wheelchair, preventative skin care, and Braden assessment. Encourage/assist to turn/reposition frequently was not added until 4-2-20, after R3 coccyx pressure ulcer had progressed to a Stage 2.

R3's RD (Registered Dietician) initial nutritional assessment dated 3-12-20, 26 days after admission, documents R3 weighed 242.6 pounds on admission and has intact skin. R3's nutritional note dated 4-8-20 documents states "continues on a LCS (low concentrated sweet), renal diet. He receives Nepro, carb steady as supplement for healing as he is on dialysis. R3' admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 29	S9999		

weight was 242.6 and his weight on 3-23-20 was 225.2 pounds. In 37 days he had a 17 pound weight loss of 7.5% weight loss. He was admitted with a Stage 1 on his right foot and a DTI on his right heel. On 3-23-20 he had a Stage 1 pressure ulcer to his coccyx and on 3-31-20 he had a Stage 3 to coccyx. The Nepro was added to help with wound heeling."

R3's Physician Order Sheet documents R3's Nepro Card Steady did not start until 4-6-20, two days before discharge.

5. R12's admission nursing note dated 9-4-20 documents R12 was admitted with a right leg fracture, rib fracture, and hypertension. R12's Wound admission note dated 9-4-20 includes a left medial buttock Stage 2 PU (pressure ulcer) measuring 7 x 2.5 cm (centimeter), medial coccyx Stage 2 pressure ulcer measuring 2 cm linear and a right medial buttock Stage 2 PU measuring 7 x 4 cm all covered with Mepilex. R12's physician's order sheet does not contain any treatment orders for these areas.

R12's physician order sheet (POS) documents R12 was admitted on 9-4-20 with a right leg and rib fractures. This POS has no initial wound care orders except to follow hospital discharge orders.

R12's 9-10-20 Weekly wound assessment documents the same information as admission assessment plus redness in high moisture areas of buttock.

R12's 9-15-20 and 9-22-20 Weekly wound assessments document a Stage 2, 2 x 2 cm pressure to the left and right medial buttocks, and a large Stage 1 reddened pressure ulcer to the coccyx buttocks area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 30 R12's 9-29-20 and 10-5-20 Weekly skin assessments documents a Stage 2 medial buttock pressure ulcer 6 x 4 cm covered with mepilex. R12's nursing note dated 10-13-20 document R12 pressure ulcer on buttock has worsened and V14, NP (Nurse Practitioner) was notified. There is no assessment/description of the area given at this time. V14, NP note date 10-14-20 documents "Stage III pressure ulcer to right ischium" Orders left to turn and reposition every 2 hours and Dakin's treatment to the wound once a day or twice a day if large amount of drainage is present. R12's 10-15-20 Weekly skin assessment, 10 days after the last documented skin assessment, documents R12's right medial buttock is now a Stage 3 pressure ulcer measuring 4 x 2 x 2.5 cm and a Stage 2 pressure ulcer to the left buttock measuring 3 x 4 cm. R12's physician's orders do not contain any treatment order for R12's left ischial pressure ulcer until 10-14-20. There is no order for R12's right ischium pressure ulcer until 10-13-20, after R12's pressure ulcer had increased from a Stage 2 to a Stage 3. R12's current care plan dated documents R12 is at very high risk for breakdown related to current pressure wounds to coccyx, right and left buttocks, impaired mobility and occasional bladder incontinence. Interventions developed 9-4-20 include observe for breakdown pressure reducing mattress on bed and cushion in wheelchair, preventative skin care as needed and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 31	S9999		

treatments as ordered. Intervention added on 9-7-20 to encourage/assist with frequent turning schedule. There are no new interventions initiated to care for R12's pressure ulcers and to prevent new or worsening pressure areas.

R12's MDS (Minimum Data Set) dated 9-10-20 documents R12 is alert and oriented and need extensive assistance with bed mobility, turning and repositioning.

On 12-26-20 at 10:30 am, R12 stated for awhile, her pressure ulcers were getting worse from not being turned and repositioned. About two weeks ago, R12 stated the returned from a doctor's visit and sat in the wheelchair for about three hours before someone helped her to bed. R12 stated she is only supposed to be sitting for an hour at a time.

R12's initial RD (Registered Dietician) nutritional assessment is dated 10-4-20, 30 days after admission. R12's next RD note dated 10-21-20 documents R12 has a Stage 2 on her left buttock, coccyx and a Stage 3 on her right buttock. A house supplement twice a day between meals was not added until 10-22-20 per RD recommendation.

On 10-21-20 at 2:30 pm, V14, Nurse Practitioner stated she should have been notified earlier for care and treatment of R12's pressure areas. V14 stated she was not notified of R12's pressure areas until 10-13-20 when she was notified by the facility to evaluate R12's wounds. R12's right ischium had progressed to a Stage 3 pressure ulcer. V14 stated R12's wound progression may have been prevented if she had been notified earlier for treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 32	S9999		

6. On 10-21-20 at 11:30 am, R9 had a 3.5 cm (centimeter) x 3 cm x 3.75 cm open pressure ulcer to his left buttock. R9 did not have any protection to his heels and did not have his heels floated. On 10-22-20 at 10:00 am, 2:00 pm and 3:10 pm, R9 did not have any heel protection/heels floated.

R9's progress notes document R9 was admitted on 9-1-20 with a fracture of the right hip with "open areas to coccyx, and inner buttocks, with dark area in center small amount of drainage." R9's 9-2-20 weekly skin check noted the following pressure ulcer areas: Unstageable PU (pressure ulcer) medial coccyx, 2.5 cm x 2 cm, dark eschar, 7 x 3 cm open pressure injury area around the unstageable pressure ulcer, covered with mepilex, Stage 2 right medial buttock, .5 x .5 cm, Stage 2 left medial buttock, .5 x .5 cm and Stage 1 right lateral heel, .5 x 2.5 cm. All these wounds were covered with a mepilex (foam) dressing. Interventions documented in the note include R9 having his heels floated, need for a wound consult and inquire about a specialty mattress. R9's physician order sheet contains no orders for treatment of these pressure areas.

R9's physician order sheet shows no physician notification for treatments of these areas upon admission.

Weekly wound assessments notes for 9-11-20 documents measurements remain the same with all the wounds open to air except for the 7 x 3 cm coccyx area which was covered with a mepilex dressing.

R9's weekly wound assessment note dated 9-16-20 documents R9 has an unstageable 7 x 3 cm pressure ulcer to the coccyx area, a Stage 3

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
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 33 to the coccyx area measuring 3 x 3 cm on which a mepilex dressing was applied. A Stage 1 to the right heel remains open to air. Redness noted to R9's medial buttock. Weekly wound assessment note dated 9-21-20 documents R9 has the unstageable 7 x 3 cm medial coccyx wound covered with mepilex and a Stage 1 to the right lateral heel measuring .5 x 2.5 cm open to air. R9's wound clinic note dated 9-21-20, five days after R9's wound progressed from a Stage 2 to a Stage 3, documents R9 has a 4.5 x 5 x 1.6 cm pressure ulcer to the sacrum. New orders received for wet to dry dressing changes two times a day until a wound vac can be placed. Also ordered was a low air loss mattress, up for meals and therapy only, sleep on side, reposition in bed every two hours and every one hour when sitting and a multi-vitamin. R9's weekly wound assessment note dated 9-29-20 documents a wound "vac in place on coccyx" and a "Stage 1 right lateral heel, .5 x .5 cm, mepilex" and redness to medial buttock. There are no measurements available for R9's coccyx wound. R9's weekly skin check dated 10-5-20 documentation is the same as 9-29-20 with no measurement of R9's coccyx wound even though the wound vac was changed at that time. R9's wound clinic note dated 10-12-20 documents R9's sacrum wound as 3.5 x 4 x 1.7 cm. R9's weekly skin note dated 10-16-20 documents R9 has a Stage 3 pressure ulcer to the left	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 34 buttock, 3 x 2 x 2 cm, wound vac changed and a Stage 1 right lateral heel pressure ulcer measuring .5 x .5 cm with mepilex applied. R9's current care plan documents R9 is at high risk for skin breakdown. Intervention developed upon admission of 9-1-20 include: encourage and assist with frequent repositioning-side to side turn, Braden risk assessment upon admit and weekly x 4, observe for signs of breakdown, pressure reducing mattress on bed-low air loss mattress, pressure reducing wheelchair cushion when in wheelchair, preventative skin care and treatment of pressure wounds. R9's nursing notes dated 9-22-20, documents the air loss mattress was not initiated for R9 until 9-22-20. There are no interventions related to protection of R9's heels on R9's care plan. There is no mention of repositioning every one hour when sitting per orders from the wound clinic. There are no new interventions developed to the care plan after admission on 9-1-20, only notations that R9 is going to the wound clinic and the addition of the wound vac. R9's physician's order form contains no orders for treatment of any of R9's pressure ulcers until 9-21-20. Treatment orders are as follows: Right heel Stage 1 pressure ulcer, no treatment order until 9-29-20. There is no documentation that this wound healed. "Wet to dry with normal saline and gauze to sacrum twice a day until wound vac is applied" started 9-21-20 from wound clinic. Wound vac three times a week starting on 9-23-20. On 10-22-20 at 10:00 am, V3, Wound Nurse, stated he was not the one who completed most of R9's wound assessments and could not	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: ________ B. WING ________	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

(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
S9999	Continued From page 35	S9999		

accurately track R9's wounds as the documentation of location is confusing. V3 was unable to determine which of the three wounds noted on admission, Coccyx, right and left buttock, was the same wound now being treated by the wound clinic and when the other wounds healed. V3 stated the present wound is located more on R9's left buttock area. V3 stated there is no consistent documentation regarding location of wound, accurate staging of wounds, weekly measurements of wounds, when a wound is healed and when a new wound found. V3 stated having a facility protocol for wound assessment and treatment would absolutely help with assessment, treatment, prevention and accurate tracking of wounds.

On 10-21-20 at 2:30 pm, V14 NP (Nurse Practitioner/Certified Wound Nurse), stated R9's sacral wound has become much worse. V14 stated she was not notified for a consult until R9's sacral wound worsened to a Stage 3. V14 stated she should have been notified when an unstageable ulcer and pressure ulcers were first found so appropriate treatment could have been provided.

(A)