STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009179	A. BUILDING: _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PAVILION	105 EAST 23RD STREET STERLING, IL 61081

(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 Licensure Post Visit to Annual Survey 6/9/2015 Sterling Pavilion is in compliance with the Plan of Correction for 300.610a, 300.1220 b)3), and 300.3240 a)	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care 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, and prevent new pressure sores from developing. This requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident identified as at risk for pressure did not develop skin breakdown. This failure resulted in R49 developing 2 unstageable pressure ulcers within 4 weeks of admission to the facility.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

This applies to 1 of 3 residents (R49) reviewed for pressure ulcers in the sample of 10.
The findings include:
The hospital discharge summary for R49 dated June 16, 2015 lists R49 ' s diagnoses to include: Weakness, Atria Fibrillation, Urinary Tract Infection and Pneumonia. R49 came to the hospital from an assisted living facility. The Physician Nursing Home Progress Note on June 19, 2015 documents R49 is at the facility for restorative physical and occupational therapy, and R49 might be able to go back to her assisted living center.
The June 16, 2015 admission nursing assessment documents no open areas to the skin and R49 was continent of urine. The initial Comprehensive Assessment for R49 dated June 16, 2015 shows R49 is unable to change position (in bed or chair) by herself. The Braden Scale -for predicting Pressure Sore Risk score for R49 was 13 (moderate risk) on June 23, 2015, June 30, 2015 and July 7, 2015.
The June 16, 2015 physician order sheet shows an order for daily skin checks for R49. The Minimum Data Set (MDS) dated July 14, 2015 documents R49 requires extensive assistance of 2+ persons physical assist for bed mobility, transfer, toileting and personal hygiene. It also documents R49 as frequently incontinent and having 2 unstageable pressure ulcers.
The Treatment Record for July 9, 2015 shows skin was checked and there was no documentation of any redness or open area on R49 ' s skin. On July 10, 2015 the nurses ' note documents 2 unstageable areas were found on R49 ' s left ischium (boney prominence of the lower buttocks). The wound to the lateral side of the ischium measured 1 cm x 0.6 cm and was completely covered with necrotic (black) tissue. The wound to the medial side measured 2.2 cm x

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S9999	Continued From page 2 2.1 cm with approximately 50% black necrotic tissue with 50% beefy red tissue. The Pressure Sore/Wound Admission and Weekly Flow Sheet dated July 15, 2015 documents both of R49 ' s wounds combined into one larger wound measuring 3.0 cm x 2.9cm, unstageable and having 75% yellow slough (moist, stringy, necrotic tissue) and 25% gray slough. On August 8, 2015 at 12:25 PM, E2 (Certified Nursing Assistant-CNA) stated R49 requires extensive assistance for bed mobility, hygiene, toileting and repositioning. E2 also stated R49 used to get up around 7:00 AM but now gets up later and is laid down for naps since she has an open sore. On August 5, 2015 at 12:30 PM, E3 (Wound Nurse) stated chair cushions, repositioning in chair and frequent toileting are interventions that could prevent pressure ulcers. On August 5, 2015 at 1:36 PM, Z1 stated that R49 ' s pressure ulcer would have been identified before becoming unstageable if skin checks were done at least 2 times a week. Z1 stated, with R49 ' s limited co-morbidities, I can ' t think of any reason this pressure ulcer was unavoidable. On August 4, 2015 at 11:45 AM, R49 ' s wound bed was observed to be pink and without drainage, and the approximate size was 2.5cm x 2.5cm. The facility Pressure Ulcer Risk Screening Procedure dated November, 2013 documents pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues. (B)	S9999		

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