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S 000	Initial Comments Annual Health with Complaint#1821497/IL100844 Statement of LicensureViolations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210c) 300.1210d)5) 300.1220b)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. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.
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

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 the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

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S9999	Continued From page 2 resident. These requirements were not met as evidenced by: Based on observation, record review and interview, the facility failed to follow policy and procedure related to altered skin integrity, including the development and implementation of pressure ulcer prevention interventions, follow physician ordered treatment/interventions, and the monitoring and assessment of wounds, for five of six residents reviewed (R66, R77, R94, R102 and R34) for skin breakdown, in a sample of 22. These failures resulted in R66 developing a Stage IV Pressure Ulcer on the coccyx, measuring 4.5 cm (centimeters) x 3.5 cm x 3.0 cm, which resulted in the placement of a wound vacuum dressing. Findings Include: The facility's Skin/Pressure Ulcer Policy last revised 6/26/17 documents the following: "Policy: It is the policy to assess all residents for alteration in skin integrity, injury or factors that place them at risk for developing pressure ulcers. Skin assessment must be completed upon admission and as outlined below. 3. A licensed nurse will complete a Braden Scale on the day of admission, weekly for 4 weeks, then quarterly or as needed relating to a change in a resident's status. Additional risk factors are included on the pressure ulcer prevention plan. 6. When risks are identified as identified on the Braden Scale, prevention measures are implemented to eliminate or reduce risk for pressure ulcer	S9999		

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development. All patients will be turned and repositioned at a minimum of every two hours, however, the frequency may be more or less depending on patient's risk factors and mobility. These are included in the resident's plan of care and are evaluated quarterly and as indicated with a change in status."

1. R66's electronic medical record documents R66 was admitted to the facility on 10/17/17.

R66's electronic Admission Observation dated 10/17/17 at 6:27 PM documents the following under the section titled skin: Dermatitis. R66's interim care plan dated 10/17/17 documents the following: skin, left great 2nd and 3rd toe; Coccyx, Dermatitis, no interventions were implemented to prevent further breakdown or deterioration. R66's Braden Scale for Predicting Pressure Sore Risk dated 10/17/17 documents R66 is at high risk for developing pressure sores. R66's Braden Scale for Predicting Pressure Sore Risk dated 11/5/17 and 11/11/17 document R66 is at high risk of developing pressure sores. These same forms have a section titled: "pressure ulcer risk prevention plan, goal, interventions and summary." These sections contain boxes to check for indicated treatments and goals, but no areas were checked and failed to advise staff on interventions to utilize to prevent further skin breakdown for R66.

R66's Wound Care Specialist Initial Evaluation form dated 10/18/17 does not contain any notes regarding R66's coccyx. On 10/25/17 R66's Wound Care Specialist Evaluation document the following: "unstageable (due to necrosis) coccyx-Initial evaluation." This same form did not include any measurements of R66's coccyx wound. R66's Wound Care Specialist Evaluation

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dated 11/8/17 documents the following: Unstageable (due to necrosis) Coccyx, wound size 6cm (centimeters) wide x 7.5 cm long x not measurable deep. This form documents 10% thick adherent necrotic tissue (eschar) and 90%thick adherent devitalized necrotic tissue. R66's Wound Care Specialist Evaluations dated 11/15/17, 11/22/17, 11/29/17, 12/7/17 all document the coccyx wound had improved. The evaluation dated 12/7/17 documents the following: "pressure wound coccyx 3.5 cm x 3.5 cm x Not measurable with moderate serous exudate and 40% thick adherent devitalized necrotic tissue. R66's Wound Care Specialist Evaluation dated 12/14/17 documents the following: Stage 3 pressure wound of coccyx measuring 6.5 cm x 5cm x not measurable, wound progress: deteriorated. The facility was unable to provide Wound Care Specialist Evaluations for R66 between the dates of 12/14/17 and 1/3/18.

R66's progress notes dated 12/24/17 at 1:39 AM document the following: Dressing changed on coccyx area, old dressing soaked in dark black drainage. Two large holes noted in coccyx area with noticeable odor present, Area's of breakdown black inside and appears to becoming larger from yesterdays site. R66's progress notes dated 12/24/17 document, "left side of mouth has red line running down to chin from laying on that side."

A Wound Care Specialist Evaluation dated 1/4/18 documents R66 has a Stage 3 pressure wound on the coccyx measuring 6.5 cm x 4.5 cm x not measurable, due to necrotic tissue/eschar and describes the wound as "deteriorated." This record also documents R66's wound was cultured on 12/28/17 and was found to be infected with

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"Clostridium Ramosum, Bacteroided Thetaiotamicron." R66's Wound Care Specialist Evaluations documented improvement in the wound from 1/4/18-1/25/18, with the coccyx wound measuring 5.5 cm x 5 cm x 3 cm at that time; however, on 2/01/18 R66's Wound Care Specialist Evaluation form documents the coccyx wound as deteriorated and measuring 6 cm x 4.2 cm x 3 cm, with undermining of 8 cm at 12 o clock. R66's wound care evaluation dated 2/22/18 documented the coccyx wound measured 5.5 cm x 4 cm x 2.5 cm with undermining at 6 cm at 12 o clock. A Physician's order dated 2/23/18 instructs staff to start R66 with a "negative pressure (wound vacuum) TID (three times daily)." The most current Wound Care Specialist Evaluation, dated 3/05/18, document R66's has a Stage 4 pressure wound on the coccyx, measuring 4.5 cm x 3.5 cm x 3 cm.

On 3/5/18 at 2:25 pm, V5 (family member) stated when R66 was admitted to the facility R66's coccyx area was red, but not open. V5 stated that (V5) is at the facility everyday and R66 is supposed to be repositioned every two hours but V5 is not sure staff are doing it. V5 stated in R66's room has a turn and reposition log book and it is often blank or not filled in.

On 3/8/18 at 12:34PM V8 LPN (Licensed Practical Nurse) stated she was the staff member assigned to "round" with the wound physician at the time R66's wound developed. V8 was unable to identify what interventions were put in place to prevent R66's pressure ulcers. R66 stated the wound doctor was on vacation and did not see R66 from 12/15/17- 1/3/18. V8 stated the floor nurses should document would measurements if the doctor does not come. Upon review of all Progress Notes dates 12/14/18 through 1/3/18

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S9999	Continued From page 6 there was no documentation of wound measurements. R66's care plan dated 11/9/18 documents the following: (R66) has a pressure ulcer over his coccyx, unstageable with eschar. This same care plan documents R66's care plan had not been reviewed or revised with new goals or interventions after 12/29/17. R66's Turn Schedule for Every 2 Hours forms, located at the bedside, were reviewed from 1/10/18 through 3/6/18. These forms have multiple 2 hour turns not initialed as completed. On 1/12/18 the turn schedule form indicating R66 was turned every 2 hours was initialed at midnight and 2 a.m., those are the only 2 documented turns on 1/12/18. On 1/16/18 R66's Turn Schedule form documented R66 was on his left side at 4 a.m. and not turned again until 4 p.m. The only documentation of R66 being turned on 1/18/18 was to his right side at 9:30 AM. R66's turn schedule documents R66 was turned on 1/19/18 at 11AM and then not again until 1/20/18 at 2AM. R66's turn schedule documents R66 was turned on 1/26/18 at 2PM on R66's right side and not positioned again until 1/27/18 to R66's right side. R66 was turned to his right side at 10AM on 1/28/18 and not turned again until 4PM. On 2/1/18 R66 was turned on his left side at 10AM and then not turned again until 4 PM when R66 was in his chair. This same form documents R66 was not turned from 4 AM until 2:30PM. R66's turn schedule form documents the following: 2/3/18 turned at 1PM and then not again until 10:30PM; 2/9/18 turned at 2PM and then not turned again until midnight on 2/10/18; 2/16/18 R66 was positioned at noon and then not repositioned again until 6PM. R66's tuning schedule documents on 2/18/18 R66 was	S9999		

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repositioned at 4AM, 4:30PM, 6:30PM and 9:15 pm; 2/22/18 repositioned at 4:30PM and not repositioned again until 2/23/18 at 6AM; no documentation of turning and repositioning on 2/27/18; 3/3/18 contains no documentation of repositioning; and 3/6/18 the form was blank indicating R66 had not been repositioned every two hours.

On 3/6/18 at 1:41 p.m. R66's wound vacuum system was changed per V6, RN (Registered Nurse). The surrounding skin was pink with a small white area of tissue at 6 o clock, heavy serous exudate, tunneling at 12 o clock

2. On 3-8-18 at 10:58 am, R34 was up in a wheelchair with canvas shoes to both feet. When R34's sock to the right foot was removed, there was a fingertip sized open wound to the second toe.

R34's Wound Care Specialist Evaluation dated 3-5-18 documents R34's right second toe wound measures 1 x 0.8 x not measurable, is unstageable with necrosis and the wound has deteriorated. This form also documents "unstageable (due to necrosis) of the right, second toe - deteriorated due to patient non-compliant with wound care, will not wear slippers as recommended."

R34's care plan dated 2-17-18 does not contain any interventions related to R34's actual pressure sore, only the potential for a pressure sore. There are no interventions related to R34's refusal to wear an open toed shoe or slippers.

On 03/06/18 at 01:30 PM V8 (Resident Unit Coordinator) stated the following: (R34's) right toe is a pressure ulcer. It developed on 9-22-17.

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An open toe shoe to right foot until healed was ordered. The area is from the canvas shoe rubbing the top of the toe. At that time is measured 1 cm x 0.4 cm, reddened with no depth. The care plan does not include (R34) having a pressure ulcer to right second toe. The care plan should include interventions of a weekly wound assessment, treatments as ordered by the wound physician, monitoring for signs and symptoms of infection, open toe shoe. The wound doctor said it could be a slipper

R34's Braden Scales for Predicting Pressure Sore Risk were completed 3-20-17, 7-25-17 and 12-12-17 scoring R34 as low risk. R34's Braden assessments were not completed quarterly per the facility's policy

3. A Wound Care Specialist Evaluation note, dated 3/05/18, documents R77 currently has an "unstageable (due to necrosis) coccyx wound, etiology: pressure," which measures 2 cm (centimeters) x 2 cm x 4 cm. The current Physician's Order Report (2/08/18 - 3/08/18), instructs R77 to utilize a 2 inch thick cushion when up in the reclining high back wheelchair.

On 3/07/18 9:33 a.m., R77 was taken from the dining room following breakfast by V15 (Certified Nursing Assistant) to her room via a reclining high back wheelchair. At that time, R77 did not have a 2 inch cushion in place in the wheelchair, as ordered by the physician. R77's 2 inch seat cushion was on the floor in R77's room next to the storage closet. V15 (Certified Nursing Assistant) stated R77 did not have any seat cushion in her wheelchair at all that morning and stated she was "agency staff" and "not that familiar with the resident."

03/08/18 8:59 a.m., R77 was again up in her

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reclining high back wheelchair for breakfast with no 2 inch seat cushion in place. R77's seat cushion was on the floor next to the storage closet in R77's room at that time.

On 3/08/18 at 10:21 a.m., V9 (Registered Nurse/Unit Coordinator) stated R77 is to utilize a 2 inch seat cushion when in the wheelchair to alleviate pressure on the coccyx.

4. Resident Progress Notes, dated 12/25/17, document R94's coccyx as red with "2 small areas of shearing." There is no documentation at that time that the red area of the coccyx or the two areas of shearing were measured to determine size. Electronic Treatment Administration Records document staff continued to use Calazyme on the coccyx, that had previously been ordered on 9/25/17. Resident Progress Notes document R94's coccyx as being red or having redness on 1/05/18, 1/08/18, 1/09/18, 1/10/18, 1/11/18, 1/14/18, 1/17/18, 1/18/18, 1/19/18, 1/24/18, 1/27/18, 1/28/18, 1/29/18, 1/31/18, 02/01/18, 02/02/18, 2/05/18, 2/07/18, 2/08/18, 2/10/18, 2/14/18, 2/16/18 and 2/20/18. There is no documented evidence that the facility developed or implemented any new interventions related to altered skin integrity on R94's Plan of Care (dated 3/07/18). On 2/13/18, (R94) scored a 12 on her Braden Scale assessment, indicating high risk for pressure ulcers. Resident Progress Notes, dated 2/22/18, document R94's "buttocks has several small areas where skin had been sheared, but at present (R94) has an open area measuring 2 cm (centimeters) x 1 cm x <0.1 cm that appears to be shearing." The Physician's order sheet, dated 2/08/18 - 3/07/18 document no new treatment orders after the open areas were identified on 2/22/18 and there is no documented evidence in

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the electronic medical record that the physician was notified, or that the open areas of shearing were re-measured.

On 3/07/18 at 10:16 a.m., V14 (Certified Nursing Assistant) provided incontinence care to R94, and at that time R94 had multiple small, superficial opened areas on the skin between the lower back and coccyx, and two larger open areas on the coccyx. V14 stated R94's coccyx had looked like that for "several days."

A Faxed Physician's Order, received 3/07/18, documents staff had identified an "open area 1.5 cm by 1 cm to coccyx (due to) shearing" and an order for Duoderm dressing every three days and as needed was received.

On 03/08/18 at 10:21 AM, V9 (Registered Nurse/Unit Coordinator) stated all wounds should be measured upon being identified and once weekly until healed. All new areas of skin breakdown need to be identified in the residents plan of care along with treatment orders and new preventative measures to be implemented. V9 was unable to provide any documented evidence that staff had measured the areas of shearing on R94's buttocks on a weekly basis or that the physician had been notified on 2/22/18 when R94's coccyx redness progressed to an open wound.

5. Resident Progress Notes, dated 2/19/18, document R102 developed "2 open areas noted to (left) and (right) buttocks. Appears to be caused by shearing. (Left) buttock 0.8 cm x 0.3 cm. (Right) buttock 1 cm x 0.5 cm." R102's Resident Progress Notes contain no further documentation regarding the appearance of or additional measurements of R102's buttock

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wounds. The Physician's Order Report (2/08/18 - 3/08/18) ordered staff to clean R102's buttock wounds with wound cleanser and dress with a hydrocolloid dressing every three days. That same Physician's Order Report documents the hydrocolloid dressing order was discontinued on 3/06/18 and a new order for Z-Guard to be applied to the buttocks every shift was given.

A Plan of Care, dated 3/06/18, documents R102 was identified "at risk for impaired skin integrity related to incontinence and dependence of staff to make significant changes in body position," beginning 8/22/16. The Plan of Care further documents R102, "Has a history of pressure injury to right foot. On 2/15/18, (R102) scored 13 on her Braden Scale Assessment, indicating high risk for pressure ulcers." The last intervention documented on the current Plan of Care, related to impaired skin integrity, was on 11/07/18. The Plan of Care fails to identify any new interventions related to impaired skin integrity after the two open areas of shearing on R102's buttocks was identified 2/19/18.

On 3/07/18 at 1:45 p.m., V9 (Certified Nursing Assistant) and V16 (Unit Coordinator/Registered Nurse) provided incontinence care to R102. R102's coccyx/buttocks skin was intact at that time, with some slight redness noted on the coccyx. R102 did not have any evidence of residual Z-Guard (a white zinc based paste) on the buttock or coccyx at that time. Once R102's incontinence care was complete, V9 did not apply Z-Guard to R102's skin and a clean incontinent brief was put on R102. At that time, V9 stated R102 was no longer receiving a treatment to the coccyx, since it was "healed out" the day before

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER VILLAGE	1200 EAST PARTRIDGE METAMORA, IL 61548

(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 12 (B)	S9999		