STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016687	A. BUILDING: _____ B. WING _____	03/07/2018

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HICKORY POINT CHRISTIAN VILLAGE	565 WEST MARION AVENUE FORSYTH, IL 62535

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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)4)A)5) 300.3220f) 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 300.1010 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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:	S9999		

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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:

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.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

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.

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S9999	Continued From page 3 Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These findings were not met as Evidenced by: Based on observation, interview, and record review the facility failed to: ensure a resident was not seated on indwelling catheter tubing, identify the subsequent wound that developed as a pressure ulcer/injury, and ensure a dressing was applied to a pressure ulcer for two of seven residents (R5, R15) reviewed for pressure injury in a sample of 18. These failures resulted in R5 developing an unstageable pressure ulcer with full thickness tissue loss and blackened eschar in the wound bed to the back of R5's right upper thigh. These Rgulations were not be as evidenced by: Findings include: A Skin Management Program policy (undated) gives as its objective," Prevent pressure ulcers development on at risk residents. Identification of newly acquired pressure ulcers." A Pressure Ulcer Prevention policy (undated) states, "A pressure ulcer is defined as any lesion caused by unrelieved pressure that result in damage to underlying tissue. Pressure ulcers may develop from positioning as well as the use of medical devices. Pressure ulcers may develop from the use of nasal tubing, catheters, casts, braces, cervical collars or other medical devices.	S9999		

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Monitor all devices for proper placement to avoid pressure on surrounding tissue. Unstageable (pressure ulcer)-Full thickness tissue loss in which the base of the ulcer is covered by slough and /or eschar (tan, brown or black) in the wound bed." The policy shows common pressure ulcer sites which includes the back of the upper thigh.

A Wound Dressing policy dated 1/16/14 states that the facility's policy is, "To provide an appropriate type of protective wound covering that facilitates the healing process."

1. R5's Minimum Data Set (MDS) assessment dated 12/5/17 documents that R5 is severely cognitively impaired, requires extensive assistance of two people for bed mobility and transfers, has functional limitation in Range of Motion to both lower extremities, and requires extensive assistance for mobility in the wheelchair.

R5's Braden Scale for Predicting Pressure Sore Risk dated 2/13/18 documents R5 is at moderate risk for developing a pressure ulcer.

R5's wound investigation dated 2/21/18 states, "Writer was called to (R5's) room by CNA (Certified Nurse Aide) found an open area to the back of (R5's) leg, CNA stated that the (urinary catheter tubing) was bunched up at the back of (R5's) thigh which may have caused a laceration."

R5's care plan dated 3/17/16 states, "I have an actual skin alteration and potential for impaired skin integrity r/t (related to) dementia, age related fragility, and decreased mobility." R5's care plan also documents that a new intervention was added to the skin integrity plan by V4 (Wound Nurse) on 2/21/18 which instructs, "Staff to

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ensure my (urinary catheter) line is in proper placement, thus preventing skin to (urinary catheter) line contact."

On 3/4/18 at 10:19a.m., V4 (Wound Nurse) stated that R5 does not have a pressure ulcer but instead has an abrasion to the back of R5's upper thigh. V4 stated that R5's wound is being documented on the wound assessment sheet as an abrasion. V4 stated that R5 developed the abrasion after R5 had been sitting on R5's indwelling urinary catheter tubing. V4 stated that she did not not believe the pressure caused from R5 sitting on the catheter tubing would cause a pressure injury.

R5's Wound Assessment dated 2/21/18 documents that a laceration was identified on the back of R5's right upper thigh on that date which measured 1.4cm (centimeters) long x 1.9cm wide.

R5's Wound Assessment dated 2/28/18 documents that R5's laceration had deteriorated and had increased to 2.1cm x 2.0cm wide x 0.1cm deep.

R5's Wound Assessment dated 3/5/18 documents that R5's wound was now being assessed as an Unstageable Pressure Ulcer in which R5's wound bed was obscured and had full-thickness skin and tissue loss measuring 3.4cm long x 2.7cm wide. The Wound Assessment also documents that R5's wound had 30% (percent) of the wound bed covered with eschar (dead tissue).

On 3/5/18 at 3:30p.m., V4 and V5 (Licensed Practical Nurse) entered R5's room to evaluate the abrasion on the back of R5's right upper

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thigh. V4 removed R5's soiled dressing to expose a wound approximately 3.4cm (centimeters) long x 2.7cm wide. The wound was reddened around the edge of the wound bed with a moderate amount of serous drainage. A rectangular area covering the center of the wound was blackened. V4 stated that R5's wound was now considered a pressure ulcer which had deteriorated to an unstageable pressure ulcer because of the dead tissue covering part of the wound.

On 3/6/18 at 2:00p.m., V10 (R5's physician) stated that R5 has very fragile skin that is easily injured. V10 stated that it was unfortunate that R5 developed a wound caused from sitting on R5's catheter tubing. V10 stated that because R5's skin is so fragile, any wound can progress to a much larger wound.

2. R15's Wound Assessment dated 2/26/18 documents R15 developed a Deep Tissue Injury to the left heel which measured 1.9cm (centimeters) long x 2.0cm wide and which had 80% of the wound bed covered with eschar (dead tissue).

R15's physician's orders (POS) dated 2/28/18 documents for R15's wound to be treated by cleansing R15's left heel with wound cleanser before covering the wound with a hydrocolloid dressing which is to be changed every three days.

On 3/5/18 at 9:50a.m., V4 (Wound Nurse) stated that R15's left heel wound is suppose to have a dressing in place which is changed every three days. V4 and V5 (Licensed Practical Nurse) entered R15's room in order to examine R15's left heel wound. R15 was dressed and seated in a

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S9999	Continued From page 7 high backed wheelchair. V4 removed the sock from R15's left foot and noted that R15's dressing was missing from R15's heel. V4 searched in R15's sock and bed linens but could not locate R15's missing dressing that was supposed to be covering R15's left heel. (B)	S9999		