STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	C 07/18/2018

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CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

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S 000	Initial Comments Complaint #: 1844538/IL104111	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)5) 300.1220b)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
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,

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S9999	Continued From page 2 discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met evidenced by: Based on record review and interview, the facility failed to identify, assess, prevent, evaluate, monitor and treat pressure sores for 1 of 3 residents (R2) reviewed for pressure ulcers in the sample of 4 resulting in R2 being hospitalized for cellulitis infection of buttocks, debridement to sacrum decubitus, entering into hospice then passing away. Findings include: 1. R2 was admitted 03/07/16 with diagnosis of osteoarthritis, hemorrhoids, anemia, essential hypertension, hyperlipidemia, Vitamin D deficiency, abnormalities of gait and mobility, dementia without behavioral disturbances, glaucoma, insomnia and constipation. R2's Minimum Data Set (MDS) dated 04/10/18 documents a BIMS (Brief interview for mental status) of 14 is cognitively intact and requires supervision and assistance of one staff member for transferring. Skin conditions; a zero was entered for unhealed pressure ulcer(s). Braden	S9999		

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scale dated 05/07/18 scores a total of 19 at risk is 15-18.

Nursing Note dated 05/07/18 at 4:10am. Note Text: (R2) returned from (local hospital) ER with new orders no weight bearing to left leg, until she can stand without knee giving out. Knee immobilizer as needed to stabilize gait, F/U (follow up) with Dr. in 3 days, will have day shift F/U with appt., (R2) in bed. +LPP. No c/o (complaint of) pain, call light in reach, safety reminders given, will monitor.
Nursing Note dated 05/07/18 at 8:42 pm. Note Text: In bed resting throughout this shift. Voiced no c/o pain, Meds given per orders & fluids @ bedside. ADL's (Active Daily Living) done as needed, brace to left leg in place. Appetite is good. Neuro-checks ongoing & WNL, (within normal limits). Able to make needs known, V/S, (Vital Signs) stable 127/74, 97.2, 18, 68, will continue to monitor.
Nursing Note dated 05/08/18 at 2:30 pm. Note Text: T 98.8, P 20, R 80, BP 134/82, Resting in bed with long leg splint in place to left leg, toes warm and movable. Appetite good, continent of b/b, (bowel and bladder), has voiced no complaints.
Nursing Note dated 05/08/18 at 9:42 pm. Note Text: resident continues on follow up r/t, (related to), fall and right leg non weight bearing. Resident vital signs wnl, Perrl, able to voice all needs appetite good, po (by mouth), fluids encouraged and taken well. Rested in bed all shift, able to turn self, call bell in reach, preventative skin care cont. (continued), apt. will be called in am by day nurse, as she stated at shift change R/T left knee, which remain swollen.

Nursing notes dated 05/24/18 at 0:30 am.
Incident Note: CNA (certified nursing assistant)

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reported to this nurse of (R2) having a skin tear, to inner aspect of right heel. (R2) unable to tell staff how she sustained skin tear. Cleansed with would cleanser and applied steri-strips and covered with dry dressing. POA and (R2's Physician), (V11) to be notified by Day shift nurse. V/S are as follows: T 98.6, P 68, R 20, B/P 120/64, will continue to monitor.
Nursing Note dated 05/24/18 at 1:37 pm. Note Text: POA (Power of Attorney) notified of skin tear incident.
Nursing Note dated 05/27/18 at 2:10pm. Note Text: Upon assessment, noted right heel wound was a popped blister, now appearing as a DTI (deep tissue injury). Is partially intact, with discoloration under the skin. Also noted a superficial, 2(stage 2) to her right back of heel. Noted a 4cm by 2cm unstageable wound to her coccyx. Call placed to V11's, Nurse Practitioner (V16). New orders received, and discussed with DON. PCE (Potential Compensable Event) for areas done, Family and MD aware.
Nurses Note dated 05/28/18 at 6:43 pm. (R2) continues on PCE, r/t wound to coccyx and left heel resident has been running temps throughout this shift, unable to get below 99. Labs due in the am, no s/s acute distress noted preventative skin care continued.
Nursing Note dated 05/30/18 at 1:18pm. Note Text: resident notes change in condition (V11) notified regarding labs results displays s/s lethargic rec'd order to transfer to Local hospital ER for an evaluation and treatment, family notified.
Nursing Note dated 05/30/18 at 6:26pm. Note Text: attempted to call Local ER, regarding resident's condition, resident was admitted, unable to give diagnosis at this time, but resident will possibly have back surgery.
Nursing Note dated 05/31/18 at 4:35 am. Note

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S9999	Continued From page 5 Text: Call placed to Local hospital inquiring on (R2's) condition. Was informed resident was admitted with dx: cellulitis, (Location not given). Meds and bed placed on 10 day hold, personal belongings remain at facility. Hospital notes dated 05/30/18; Reason for visit Altered level of consciousness, Skin-color normal, dry warm, decubitus (large ulcerated area to sacrum with surrounding erythema, induration, color, also left anterior ankle with redness, color) ulcers (to heels bilaterally). Site of cellulitis; buttocks Right lateral ankle stage 1 pressure ulcer Left lateral ankle stage 1 pressure ulcer Left heel stage 1 pressure ulcer Coccyx wound Eschar (black tissue), red, slough (yellow, tan) drainage moderate, drainage color brown, un-approximated, odor yes, measurements 8cmx4cmx0.02cm unstageable pressure injury, photos taken yes. Left Achilles area red, scabbed, slough (yellow, tan), wound measurements 4cmx2cmx0.01cm unstageable, photos taken yes. Right heel red, un-approximated wound measurements 7cmx6cmx0.02cm, photos taken yes. MD orders dated, 05/07/18; knee immobilizer as needed to stabilize gait. DO NOT walk, until you can stand without knee giving out MD orders dated 05/09/18; skin checks every shift. MD order dated 05/24/18; Monitor, steri-strips to skin tear of inner aspect of right heel. Cover with protective dressing and change daily and PRN. D/C (Discontinue) when healed MD order dated 05/27/18; extra thin Duoderm to open area on resident right back of heel, change every 3 days and PRN and SWM to evaluate and	S9999		

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treat wounds to right heel, left heel, and coccyx. MD order 05/28/18; Santyl to wound on coccyx, after cleansing with NS, (Normal Saline). Apply Santyl to wound bed, cover with dry dressing daily and PRN.

Quality Assurance/Improvement Weekly Pressure Wound status report dated 05/22/18 and 05/29/18 documents R2 having a unstageable pressure wound to coccyx.

On 07/17/18 at 12:30 pm, V11 (R2's Medical Doctor) MD stated, "I was surprised, I did not know they were this significant." (R2's) wounds. "I don't think I saw her." "I would have to check with my office to look at messages," "I've been at the facility and I would have thought staff would have informed me." "Normally, "yes" I would have expected staff to have identified a pressure ulcer before it becomes unstageable." "I don't think adequate assessments or skin checks were being done." "(R2) sat in wheelchair all the time everyday all day." "R2's wounds were infected R2 was septic when she arrived at hospital." "R2 had bedside debridement of sacrum."

On 07/18/18 at 11:15am V9 Director of Nursing (DON) stated, "Yes, I would expect staff to identify and assess a pressure ulcer before it becomes unstageable." R2 didn't walk after receiving the immobilizer she was in bed or a wheelchair."

Facility's policy and procedure titled Wound Assessment dated 08/11 documents in part; Systematic, consistent, and accurate wound assessment is completed to determine response to nursing/medical care and treatment. A complete wound assessment will be completed at least weekly by a licensed nurse for all wounds, ulcers, and impairments in the skin integrity.

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S9999	Continued From page 7 Facility's policy and procedure titled Wound Management dated 11/10 documents in part; the facility will perform continuous monitoring of resident's skin in accordance with the skin assessment policy and procedure. The physician, resident and/or the resident's legal representative will be notified of all newly developed wounds or whatever a wound demonstrates a significant change in status that dictates a change in how the wound is treated. Facility's policy and procedure titled Skin Assessment dated 03/11/15 documents in part; Routine skin assessments are completed in an effort to detect changes in skin integrity and ensure prompt treatment of identified problems. The resident's physician and responsible party will be notified of any skin breakdown or abnormalities not previously recognized. Facility's policy and procedure titled Pressure Ulcer Risk Assessment and Prevention dated 11/10 documents in part; Prevention of skin breakdown is the responsibility of all direct caregivers. Monitor skin daily for changes. Inspection should include all bony prominence's; feet, heels, hips, coccyx, spine and ischium. Facility's policy and procedure titled Wound Care Protocols dated 10/10 documents in part; the following treatment protocols are recommendations, which may be passed on to the physician. Some ulcers/wounds may require additional consultations for proper treatment. Orders may deviate from these protocols at the discretion of the physician and the needs of the resident. The physician or practitioner should be notified of all wounds that present with signs and/or symptoms of infection so that appropriate	S9999		

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S9999	Continued From page 8 orders can be obtained.sed on (B)	S9999		