Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		•				
		IL6005417	B. WING		02/11/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MCLEANSBORO REHAB & HLTH C CTR  405 WEST CARPENTER MCLEANSBORO, IL 62859						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROPROPERTY)	D BE COMPLETE	
S 000	Initial Comments		\$ 000			
	Annual Health Surv	еу				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.1210a) 300.1210d)2)5) 300.3240a)	•				
	Section 300.1210 ( Nursing and Persor	General Requirements for nal Care				
nwe in a positive of the posit	facility, with the part the resident's guard applicable, must de comprehensive care includes measurabl meet the resident's and psychosocial ne resident's comprehe allow the resident to practicable level of provide for discharg restrictive setting be needs. The assess the active participat resident's guardian applicable. (Section d) Pursuant to	sive Resident Care Plan. A ticipation of the resident and lian or representative, as velop and implement a e plan for each resident that e objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ment shall be developed with ion of the resident and the or representative, as a 3-202.2a of the Act) subsection (a), general include, at a minimum, the				
	following and shall the seven-day-a-week to 2) All treats	pe practiced on a 24-hour,		Attachment A Statement of Licensure Violati	ions	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
,		IL6005417	B. WING		02/11/2021			
			DRESS, CITY, S	STATE, ZIP CODE	02/1	1/2021		
MCLEAR	MCLEANSBORO REHAB & HLTH C CTR 405 WEST CARPENTER							
MCLEANSBORO, IL 62859								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FERENCED TO THE APPROPRIATE DATE			
S9999	Continued From pa	ge 1	S9999					
	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  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 300.3240 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 are not met as evidenced by:  Based on observation, interview, and record review the facility failed to provide care to prevent the development and worsening of pressure ulcers for 1 of 2 residents (R7) reviewed for prevention and treatment of pressure ulcers in the sample of 15. This failure resulted in the new development and or worsening of pressure areas to the back, buttocks, heels and axilla's (underarms/armpits) for R7.  Findings include:  The facility's undated Face Sheet of R7's medical record documents that R7 was admitted to the facility on 12/8/20 with diagnoses that include: a closed fracture of the cervical vertebrae T12, dementia, anxiety, Hypertension, chronic							

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_\_ B. WING IL6005417 02/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **405 WEST CARPENTER MCLEANSBORO REHAB & HLTH C CTR** MCLEANSBORO, IL 62859 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 2 Sclerosis), sick sinus syndrome, and acute metabolic encephalopathy. A Nurse's Note dated 12/8/2020 documents R7 was admitted to the facility from the hospital after a fall and fracture of vertebrae, R7 is in a full body brace that is only to be removed during care, and R7 has an order for SSN (Silvadene) 1% cream daily to areas under right and left arms and cover with an island dressings until healed. A December 2020 POS (Physicians Order Sheet) has an order dated 12/11/2020 for a TSLO (Thoracic Lumbar Sacral Orthosis) brace to be worn at all times except for ADL's (Activities of Daily Living). A Nurse's Note dated 12/15/2020 documents an order was received from V9 (Nurse Practitioner) for R7 to only wear the brace when R7 is out of bed. The December 2020 TAR (Treatment Administration Record) and January 2021 TAR does not include the order received on 12/15/2020 to wear the brace only when out of bed. The December TAR documents an order to wear TLSO brace at all times except for ADL'S from 12/11/2020 until R7 was transferred to the hospital on 12/21/2020. The same order is documented again on the December 2020 TAR from 12/26/2020, when R7 returned from the hospital, until 1/31/21. The January 2021 TAR documents the order to wear the TLSO brace at all times except for ADL's from 1/1/2021 until 1/6/21. The December 2020 and January 2021 TAR's include initials on the above dates, indicating R7 continues to wear his brace at all times except for ADL's until 1/6/21. On 2/10/2021, V7 (Registered Nurse) and V11 (Licensed Practical Nurse) said that R7 was admitted to the facility with the brace and it did not fit well. V7 and V11 said that R7 wore the

Illinois Department of Public Health

brace at all times, except for bathing, until an

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Illinois Department of Public Health

AND PLAN OF CORRECTION		IDENTIFICAT	SUPPLIER/CLIA TION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL600541	17	B. WING		02/	11/2021
NAME OF PRO	VIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
				CARPENT	,		
MCLEANSB	ORO REHAB & HL	TH C CTR		SBORO, IL			
(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 (X (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DA		
					DEFICIENCY)		
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I .		the brace wa	s received in				
do ax (ce x 2 bu V7 the to ha ad 12 op tha cm do of wo do tho by cm tha do pre by ulc 2.5 but	Continued From page 3 order to discontinue the brace was received in January.  An admission assessment dated 12/8/20 documents that R7 had open areas to bilateral axilla. The right axilla measuring 1.1cm (centimeter) x 3cm and left axilla measuring 3cm x 2cm. There were no areas documented to the buttocks, back, or heels. On 2/10/21 at 12:25 PM, V7 (Registered Nurse) stated that R7 acquired the wounds from the brace and he did not come to the facility with the wounds. V7 said that R7 had only redness from the brace when he was admitted to the facility. A Nurse's Note dated 12/16/2020 documents that there are 2 small open areas to his bottom noted on right buttock that measure 1 cm x 1/2 cm and 1/2 cm by 1/2 cm. The note also documents that an older bruise, at the point of back brace, in the left lower quad that measured 1. 5 cm by 2 cm. The note also documents a red area to left hip measuring 8 cm x 2 cm. Nurse's Note on 12/16/2020 documents that V10 (Medical Doctor) was notified of wounds and new orders were received. A wound flow sheet document dated 12/31/2020 documents a stage 3 pressure ulcer to the spine thoracic area at the 9th vertebrae measuring 7cm by 2 cm and the right axilla measuring 5cm by 3 cm. There are no other wounds documented on that date. A wound flow sheet dated 2/7/2021 documents the following wounds: a stage 3 pressure ulcer to the left buttocks measuring 3cm by 2.5cm, a stage 2 pressure ulcer to the right buttocks measuring 4cm by 2cm, a stage 2 pressure ulcer to the left heel measuring 1.5cm						

Illinois Department of Public Health

PRINTED: 03/16/2021

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ B. WING IL6005417 02/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **405 WEST CARPENTER** MCLEANSBORO REHAB & HLTH C CTR MCLEANSBORO, IL 62859 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 On 2/10/2021 at 11:24 am and 12:30 PM, dressing changes and treatment completed by V7 (Registered Nurse) and V11 (Licensed Practical Nurse) was observed to the wounds on the lower back, right and left buttocks, and right axilla. There are no orders noted on the TAR (Treatment Administration Record) or POS (Prescription Order Sheets) for the wounds to left heel or left axilla. The wound bed to the wound on the back has tunneling with white edges at the perimeter of the open area and appeared to be 8cm x 5cm and 1 cm deep. The wound to the buttocks area is approximately 7cm x 5cm and 1cm deep to the left side and 10cm x 5cm and 1cm deep to the right side. The skin surrounding the wound to the buttocks area appears purple. There is some black tissue noted to the edge of the wound on the right and a small amount of bleeding noted to the wound on the left. The left axilla has an area of redness approximately 4cm x 2cm. There is approximately a 1cm linear opening noted to the center of the wound. A Nurse's Note by V7 dated 12/15/2020 documents an order was received from V13 (Nurse Practitioner) to contact the orthopedic clinic of skin issues related to the TLSO brace. V7 documents that the orthopedic clinic would be contacted in the morning when the clinic was open, A Nurse's Note dated 12/16/2020 at 1:30 PM documents that an attempt was made to contact the Orthopedic Clinic to obtain information about the brace. There are no notes documenting that the orthopedic clinic was contacted about the skin issues related to the brace as ordered per V13 on 12/15/2020. A Nurse's Note dated 12/16/2020 documents that an order was received to refer R7 to a different

Illinois Department of Public Health

orthopedic clinic related to the family's request. A Nurse's Note dated 1/4/2021 documents that R7

PRINTED: 03/16/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING IL6005417 02/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **405 WEST CARPENTER** MCLEANSBORO REHAB & HLTH C CTR MCLEANSBORO, IL 62859 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG DEFICIENCY**) S9999 i Continued From page 5 \$9999 was transferred via ambulance for an appointment at a local orthopedic clinic. The Nurse's Note form 1/4/2021, POS entry dated 1/4/21, and the January 2021 TAR document an order to only wear the TLSO brace when R7 is doing physical therapy, R7 should not wear the brace in bed, and wash R7's back and axilla areas daily with Hibiclens solution, dry, apply antifungal powder and cover with white t-shirt. R7's care plan (dated 1/27/2021), lists a problem of wounds related to the back brace to right armpit, buttocks, and midback. The goal listed is for R7 is to demonstrate healing of the wounds. There are no care plan entries upon admission

on 12/8/2020 to identify R7's risk for skin breakdown or documented measures to prevent skin breakdown. There are no care plan entries prior to 1/27/2021 identifying wounds with interventions for prevention or treatment of skin breakdown.

A form titled "Braden Scale for Predicting Pressure Ulcer Risk" was completed on 12/8/2020. R7 received a score of 12 indicating that R7 is at high risk for skin breakdown. A Skin Treatment Review was completed on 12/8/2020, 12/26/2020, and 12/31/2020. The Skin Treatment Review documents "N", or NO, for turning and positioning program and the use of elbow/ heel protectors. On 2/10/2021, V7 states that R7 is completely dependent for bed mobility and transfers. MDS (Minimum Data Set) assessments dated 12/15/2020, 12/21/2020, and 1/2/2021 document that R7 requires total dependence with full staff performance for bed mobility and transfers. On 2/9/2021 at 1:23 PM, R7 is observed lying in bed with heels resting on the bed. R7 was not wearing heel protectors. The heel protectors were noted sitting in a chair in

Illinois Department of Public Health

PRINTED: 03/16/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING \_ IL6005417 02/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **405 WEST CARPENTER** MCLEANSBORO REHAB & HLTH C CTR MCLEANSBORO, IL 62859 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 6 S9999 R7's room. On 2/10/2021 at 11:24 AM and 12:30 PM, R7 was observed not wearing heel protectors while lying in bed. (B)

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