STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004493	A. BUILDING: _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENVILLE NURSING & REHAB	400 EAST HILLVIEW AVENUE GREENVILLE, IL 62246

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S 000	Initial Comments Complaint Investigation #2143513/IL134120 Complaint Investigation #2143599/IL134245 Complaint Investigation #2143661/IL134317	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210d)5) 300.3240a) 300.1210 General Requirements for Nursing and Personal Care 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) 300.1210d)5) General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 300.3240a) Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) There Regulations are not met as evidenced by: Based on interview, observation, and record reviewed the facility failed to provide pressure relief and apply treatments for pressure ulcer prevention for 3 of of 3 residents (R1, R2, R3) reviewed for pressure ulcers in the sample of 8. This failure resulted in R2 sustaining a deep tissue injury bedpan impression and multiple stage 2 pressure ulcers. Findings include: 1. R2's Braden Risk Assessment, dated 05/13/21, documents R2 as moderate risk for developing pressure ulcers. R2's Minimum Data Set (MDS), dated 04/21/21, documents R2 has moderately impaired cognition, requires extensive assistance with bed mobility, transfer, toilet use, and personal hygiene. It also documents R2 is at risk for developing pressure ulcers. R2's Care Plan for float heels while in bed, dated 4/16/21, documents the intervention to offer to reposition often. There was no other Care Plan or	S9999		

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S9999	Continued From page 2 interventions for pressure ulcer prevention. R2's Care Plan for ADLs (activities of daily living), dated 4/23/21, does not address R2's use of bed pan. R2's Nursing note, dated 05/18/21 at 8:47 PM, documents, "Late Entry for I/R 7:15 am: CNA (Certified Nursing Assistant) came to notify night shift and day shift nurses during change of shift that resident was noted still on bed pan with 1 cm. (centimeter) indention circumference on buttocks and upper legs posterior with bruising to upper creases of bilateral upper legs. Resident is alert and oriented most of the time to use her call light when she needs to use the bedpan and call when she's done, call light was in reach." R2's Progress note, dated 05/20/21 at 11:48 AM, documents, "Safety committee meeting review of incident on 5/18/21. Day shift CNAs found resident on bed pan at shift change and it was noted that she had an indention on backside the circumference of bed pan. Assessment by nurse noted 1 cm circumference on buttocks and upper legs posterior with bruising to upper creases of bilateral upper legs. Video footage of that hall was of poor quality and unable to determine at what time resident was placed on bed pan and by whom. Resident is confused and often asks staff to check if she is on bed pan as she unable to determine that per self. Staff was questioned by DON (Director of Nursing) and none recalled placing her on the bed pan. MD (Medical Doctor) and POA (Power of Attorney) notified of incident. Intervention: Inservice staff related to bed checks, T & P (turning and positioning) schedule and use of 24-hour report sheet to keep track of occurrences that might be forgotten."	S9999		

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S9999	Continued From page 3 R2's Hospital Report, dated 05/20/21, documents left gluteal open area/ bruising (11 cm x 1 cm), right thigh open area/bruising (9 cm x 3 cm), R2's Hospital Record, dated 05/20/21, documents "bedpan impression noted to patient's bottom. Significant bruising seen; 3 open sores noted. MD notified." On 05/26/21 at 4:29 PM, V5, Physician, stated that "In my professional opinion, (R3) lying on a bedpan for a unspecified amount of time would cause the skin to breakdown." On 05/27/21 at 8:55 AM, V2, Director of Nursing stated that (R3) was left on the bedpan but they are not for sure how long. The CNA and Nurse checked on the resident that morning but no one noticed she was lying on a bedpan. "I reviewed the video of that but the quality was too poor to see who placed her on the bedpan and at what time it was." The video does show that (R3) did not use her call light. The nurse was sitting 2 doors down from her room but didn't know she still sitting on the bedpan. "(V10) and I looked at her buttocks later that day and she had no open areas. She (V10) just said to put TAO (triple antibiotic ointment) on it." On 05/27/21 at 9:41 AM, V10, Nurse Practitioner, stated that she was at the facility later in the day of the incident with the bedpan for R2. V10 stated that it looked pretty bad. V10 stated the skin looked shiny like it could break down. V10 stated that sitting on that bedpan for an unknown period of time could definitely cause her skin to break down. The Facility's Prevention of Pressure Ulcers/Injuries policy and procedure, revised July	S9999		

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S9999	Continued From page 4 2017 documents under Mobility/Repositioning "2. At least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more. 3. At least every 2 hours, reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort." 2. On 05/26/2021 at 2:10 PM, V6, Certified Nurse Assistant (CNA) and V7, CNA, laid R1 down in bed, after performing incontinent care, no barrier cream was applied and R1 was positioned on her back in bed. R1's heels were not floated at that time. R1's positioning schedule was hanging on the wall next to the bed. R1's positioning schedule, not dated, documents that R1 should have been placed on her left side at 2:00 PM. R1's Care Plan, dated 11/23/2021, documents, "Repositioning Schedule 11/23/2020 Active Nursing, Nursing Assistant." R1's Care Plan, dated 04/22/2021, documents, "FLOAT HEELS WHILE IN BED 4/22/2021 Active Nursing, Nursing Assistant. INCONTINENCE CARE, APPLY BARRIER CREAM 4/22/2021 Active Nursing Assistant." R1's Braden Assessment, dated 05/13/2021, documents that she was a high risk for developing pressure ulcers. R1's MDS, dated 05/20/2021, documents that her cognition is severely impaired and that she	S9999		

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S9999	Continued From page 5 requires extensive assistance from staff for personal hygiene and that she is always incontinent of bowel and bladder. R1's Physician Order Sheet, dated 05/2021, documents diagnoses of Cerebral Infarction and Contracture of Left Elbow. On 05/26/21 at 2:00 PM, V6, CNA, and V7, CNA, performed incontinent care for R1 and did not apply barrier cream on R1 after care. On 05/26/2021 at 2:30 PM, V6, CNA, stated that R1 was to be turned and repositioned every 2 hours and the nurse puts cream on her bottom because of her skin breakdown. On 05/27/2021 at 9:35 am, V8, CNA, stated that after she is finished with incontinent care for R1 then she applies barrier cream. 3. On 05/26/2021, R3 was observed lying on her left side in bed from 1:30 PM until 3:45 PM without the benefit of repositioning based on 15 minute or less observation intervals. R1 did not have any supportive device or pillows to assist with positioning during that observation time. A turning and repositioning schedule was on R1's closet door. R3's Repositioning Schedule, not dated, documents that at 12:00 PM to 2:00 PM, R3 should have been positioned on her back. R3's Care Plan, dated 11/29/2021, documents, "Repositioning Schedule 11/29/2020 Active Nursing, Nursing Assistant." It continues, "Provide pillows or other supportive/protective devices to assist with positioning 11/29/2020 Active Nursing, Nursing Assistant."	S9999		

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S9999	Continued From page 6 R3's Braden Assessment, dated 05/13/2021, documents that R3 was a very high risk for developing pressure ulcers. R3's Face sheet, dated 05/27/2021, documents diagnoses of Alzheimer's, Dementia and Hypertension. On 05/26/2021 at 2:35 PM, V7, CNA, stated that residents are turned and repositioned every 2 hours, if she sees an open area then she would tell the nurse. V7, continued to state that skin checks are done at PM and 9 am and that they are charted. On 05/27/2021 at 9:35 AM. V8, Licensed Practical Nurse (LPN), stated that CNA's can apply the barrier cream to residents but not the medicated kind. The facility's Repositioning policy and procedure, dated 05/2013, documents, "1. A turning/repositioning program includes a continuous consistent program for changing the residents position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated." It continues, "3. Residents who are in bed should be on at least every two hour (q2 hour) repositioning schedule." It continues to document, "7. Avoid placing resident on the greater trochanter for more than momentary placement." (B)	S9999		