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	IL6002869	A. BUILDING: _____ B. WING _____	C 12/07/2022

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CEDAR RIDGE HEALTH & REHAB CTR	ONE PERRYMAN STREET LEBANON, IL 62254

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S 000	Initial Comments Complaint Investigation: 2249472/IL153754	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)5) 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 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide turning and repositioning for pressure relief, failed to ensure no pressure causing items were positioned under resident, and failed to provide treatment for pressure ulcer prevention and treatment for 2 of 3 residents (R1, R3) reviewed for pressure ulcers in the sample of 5. This failure resulted in R3's development of a facility acquired Stage 3 pressure ulcer from oxygen tubing. Findings Include: 1. R3's Face sheet documents admission to facility on 9/1/2022 with diagnosis of Cerebral Infarction due to Occlusion of Right Middle Cerebral Artery, Type 2 Diabetes, Acute Pulmonary Edema, Benign Prostatic, Hyperplasia, Hemiplegia and Hemiparesis.	S9999		

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S9999	Continued From page 2 R3's order sheet dated 9/9/2022 documents Skin inspection/ Nursing weekly assessment on Thursday. R3's admission nursing assessment dated 9/1/2022 documents R3 is unable to move left arm and left leg. Skin assessment is clear with no skin issues. R3's Minimum Data Set (MDS), dated 9/14/2022 documents R3 has no pressure ulcer/injury or dressings on admission. R3 is at risk for developing pressure ulcers, has no unhealed pressures or injuries. R3 has no cognitive deficits. R3 is totally dependent and requires 2-person physical assist for bed mobility. R3's progress notes dated 10/5/2022 at 4:49PM document Skin/Wound Note: Nurse notified of new area to R3's left scapula by therapy and DON (Director of Nursing). R3 appeared to have an open blister measuring 8.5cm (centimeters) X 1.4cm. R3 states he is unsure of how wound had gotten there but stated it has been there for a few days and he has noticed a slight pain in the area while moving. R3 stated that his daughter had come in to visit on 10/3/22 and saw it and took a picture, but it was not reported to staff. Daughter was called and she states that she noticed it 10/3/22 while giving her dad a back massage. Daughter states she did not see wound when she came 9/28/22 to give back massage. V12 (R3's Physician) called and notified. New orders in place, wound consultant referral is being initiated. Staff will continue to monitor. R3's care plan with a revision date of 10/6/2022 documents actual pressure ulcer to left scapula. R3 requires assist with turning and positioning.	S9999		

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S9999	Continued From page 3 Interventions include: (wound consultant) referral, assessment of ulcer, monitor for signs and symptoms of infection, drainage, foul odor, swelling, redness, notify MD (medical doctor) of signs of infection, treatments as ordered, monitor for pain indicators, assess pressure weekly by licensed nurse, notify MD as needed if ulcer fails to show progress in healing R3's Braden Assessment dated 9/29/2022 documents score of 15.0. R3 has potential for impaired skin integrity related to immobility, hemiparesis, CKD (chronic kidney disease), incontinence. Interventions include observe skin integrity, baths/showers per schedule, skin evaluation, turn and reposition. R3's skin care assessment dated 10/8/2022 documents open area to upper mid vertebrae, open. R3's initial wound consultant note dated 10/12/2022 documents initial consult of R3 was noted on 10/5/22 to have an ulcer of his left back, which nursing reports is secondary to his oxygen tubing. Currently treating with Bactroban and collagen. Albumin 3.6, protein 6.4. R3 has history of Type 2 Diabetes and HgA1c 5.1. Wound Ulcer#1: location left back. Pressure ulcer injury stage 3. Size 5cm X 0.5cm X 0.3cm. Treatment: Cleanse with NS (normal saline) or wound cleanser, apply Bactroban and collagen cover with silicone bordered foam change daily and prn. Nursing is repositioning every 2 hours and prn (as needed). R3's Skin and Wound evaluation dated 10/12/2022 documents: Location left scapula, in house acquired, exact date of 10/3/2022. Wound measurements 6.5cm X 7.0cm X 1.4cm. 100% of wound granulated. Wound pink/red ruptured serum filled blister. Moderate exudate,	S9999		

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S9999	Continued From page 4 serosanguineous drainage. No odor, no edema. On 12/1/2022 at 11:00AM, V2 (DON), stated "From what I recall, (R3) had developed a blister to back left shoulder blade area. We determined it was from lying on his oxygen tubing." On 12/2/2022 at 10:25AM, V8 (Nurse Practitioner) stated "I think I only saw (R3) a couple of times. He went out to the hospital. (R3) wouldn't have gotten the wound if he hadn't been lying on his oxygen tubing. It was a stage 3 pressure ulcer because of the scaring." On 12/2/2022 at 10:45AM, V9 (Licensed Practical Nurse /LPN), stated "I don't remember (R3). If a resident is on oxygen the CNAs (Certified Nurse Assistants) will move the tubing out of the way when they turn the resident." 2. R1's Face sheet documents an admission date of 7/14/2022 with diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction Affecting Left Dominant Side, Acute Embolism of Deep Veins of Lower Right Extremity, Type 2 Diabetes, Chronic Kidney Disease, Morbid Obesity. R1's care plan updated 7/14/2022 documents actual pressure ulcer to coccyx: Interventions include: ordered treatments, pain meds, turn and reposition every 2 hours, pressure reducing mattress, catheter leg strap, check dressing placement every shift, monitor for signs and symptoms of infection, assess pressure ulcers weekly by licensed nurse, notify MD if ulcers fail to show progress healing, provide offload of pressure site, monitor for incontinence and provide peri care after each incontinent episode,	S9999		

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S9999	Continued From page 5 labs as ordered, encourage fluids, diet as ordered, encouraged to reposition as able. R1's care plan updated 7/14/2022 documents R1 has a self-care deficit related to weakness, hemiparesis, obesity, diabetes, CKD. Interventions include, Bed mobility, 2 persons assist, mechanical lift transfer, assistance with ADLs (activities of daily living), turn and reposition every 2 hours. R1's progress notes dated 7/14/2022 documents: new admission skin assessment: R1 admitted with coccyx wound from hospital. Area assessed. New order received for (wound consultant) to evaluate and treat and (name brand liquid protein supplement) for healing. R1 on LAL (low air loss) mattress. R1 has peg (percutaneous endoscopic gastrostomy) tube, no other skin issues noted. R1's Braden scale assessments dated 7/14/2022 documents on admission R1 has a score of 13.0 moderate risk of pressure ulcer development. R1's Braden scale assessments dated 10/13/2022 documents R1 has score of 12.0 high risk for pressure ulcer development. R1's MDS dated 10/25/2022 documents R1 has no cognitive deficits. R1 requires extensive assist with bed mobility. R1 was admitted to facility with 1 stage 4 pressure ulcer to coccyx. R1's skin inspection assessment dated 11/10/2022 to 11/17/2022 documents new concerns identified. Sacrum stage 4 pressure ulcer left gluteal fold pressure, right lower leg lesion, right antecubital dryness and left antecubital dryness. R1's initial wound consultant notes in facility	S9999		

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S9999	Continued From page 6 dated 7/18/2022 document: Initial consult. Wound/Ulcer #1 Coccyx stage 4 pressure ulcer, measurements 9cm X 14.4cm X 4.5cm. Undermining. Treatments cleanse with NS, apply Santyl then pack with calcium alginate, cover with silicone bordered foam dressing. Change daily and prn. R1's wound consultant notes dated 8/1/2022 documents: Wound/Ulcer #1 measurements 9cm X 14.4cm X 4.1 cm. Undermining. Treatments cleanse with NS, apply Santyl then pack with calcium alginate, cover with silicone bordered foam dressing. Change daily and prn. Wound/Ulcer #2 Left Buttock noted on 8/1/2022. Pressure injury stage 2. Measurements 3cm X 3cm X 0.2cm. Cleanse with NS and apply foam dressing. Change every 3 days and prn. R1's wound consultant notes dated 8/8/2022 documents: R1 readmitted from inpatient hospital stay. Diagnosis sepsis. Readmitted 8/7/2022. Noted to have several new pressure ulcers including mid back, left posterior thigh/gluteal fold. #1 Wound/ulcer Coccyx stage 4 measurements 11cm X 15cm X 6.5cm. Treatment's cleanse with NS, apply Santyl then pack with calcium alginate, cover with silicone bordered foam dressing. Change daily and prn. #2 Wound/ulcer left buttock pressure ulcer stage 2 measurements 2.5cm X 2.5cm X 0.2cm. Cleanse with NS and apply foam dressing. Change every 3 days and prn. #3 Wound/ulcer midback stage 2 measurements 2cm X 0.8cm X 0.2cm. Cleanse with NS and apply foam dressing. Change every 3 days and prn. #4 Wound/ulcer pressure stage 3 Left posterior thigh/gluteal fold. Measurements 5cm X 5cm X 0.3cm. 2 ulcers measured as one. Cleanse with NS and apply foam dressing. Change every 3	S9999		

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S9999	Continued From page 7 days and prn. R1's wound consultant notes 9/28/2022. R1 readmitted to facility on 9/27/2022. Wound/Ulcer #1 Coccyx measurement 9cm X 12cm X 3.5cm. No change in treatment. Wound/ulcer #2 left buttock measurements 0.2cm X 0.2cm X 0.2cm. No change in treatment. Wound/ulcer #3 left abdomen found on 9/27/2022. Measurements 0.5cm X 2cm X 0.2cm. Cleanse with NS, apply silicone bordered foam change every 3 days and prn. Wound/ulcer #4 left posterior thigh/gluteal fold. 1.5cm X 2cm X 0.3cm. Debridement completed. Treatment cleanse with NS apply Santyl, cover with foam, change daily. R1's wound consultant notes dated 11/30/2022 document Wound #1 Coccyx measurements 7cm X 8cm X 1.8cm with undermining. No change in treatment. Improving. Wound #2 Right lower leg measurements 2cm X 1.6cm X 0.3cm. No change in treatment, stable. Wound #4 left posterior thigh/gluteal fold measurements 0.3cm X 0.5cm X 0.3cm. No change in treatments. Improved. R1's 10/2022 Treatment Administration Record does not document treatments being completed on 10/21, 10/22, 10/25, and 10/28. R1's 11/2022 Treatment Administration Record does not document treatments completed on 11/12, 11/16, 11/17, 11/19, 11/20, 11/21, 11/22, 11/23, 11/24, 11/25, 11/27, and 11/30/22. On 12/2/2022 at 9:50AM, V1 (Administrator) stated "(R1) refuses to eat and refuses to be repositioned. I was just in there this morning and tried to get her to eat and she would not. We try to educate her on needing to stay off her back, but she is noncompliant."	S9999		

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S9999	Continued From page 8 On 12/2/2022 at 10:45AM, V9 (LPN) stated "(R1) usually just wants left alone. She likes best to be on her back." On 12/1/2022 at 12:40PM, V5 (CNA) stated, "We reposition (R1) every 30-45 minutes. She doesn't like to be on her back. She tells us what she wants." On 12/1/2022, R1 remained lying in bed on her back without benefit of repositioning from 12:40 PM until 3:49 PM based on 15 minutes or less observation intervals. The positioning wedge remained on floor and no heel floats were in room. R1's heels remaining directly on bed. On 12/1/2022 at 12:40 PM, V4 (LPN) completed wound care to R1. Wound care completed per orders.V5 and V6 (CNAs) assisted V4 with R1's wound care. R1 was not turned and repositioned following wound care. Facility policy with a revision date of 1/10/2022 states "Prevention of Pressure Injuries. The objective is to establish a protocol for identifying and managing risks and prevention of the resident's skin integrity as well as healing any existing injuries to skin integrity or other skin conditions. Reposition all residents with or at risk of pressure injures on an individualized schedule, as determined by the interdisciplinary team. Choose a frequency for repositioning that is based on the resident's risk factors, other interventions in place, and current practice guidelines. Provide support devices an assistance as needed to provide safety and facilitate independent function." "B"	S9999		

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