STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004477	A. BUILDING: _____ B. WING _____	C 12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP SKILLED NSG & REHAB	910 WEST POLK STREET CHARLESTON, IL 61920

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S 000	Initial Comments Annual Licensure & Certification Survey Complaint Investigation 2269419/153712 Complaint Investigation 2269487/153786	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210b) 300.1210d)2) 300.1210d)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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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. These requirements were Not Met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and services to promote healing of pressure sores. The facility failed to transcribe and implement physician orders, failed to implement care plan interventions for pressure sore prevention, and failed to obtain physician orders for skin issues and ensure pressure wound treatments were	S9999		

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S9999	Continued From page 2 being completed as ordered for three of three residents (R29, R56, R259) reviewed for pressure sores in a sample list of 27 residents. The facility failed to promote healing of R259's pressure sore by failing to implement pressure relieving interventions for R259's left foot pressure sore which subsequently progressed from a stage three to a stage four pressure sore. Findings include: 1.) R259's undated Face Sheet documents R259 was admitted to facility on 10/20/22 with medical diagnoses of Anemia in Chronic Kidney Disease, Atrial Fibrillation, Idiopathic Peripheral Autonomic Neuropathy and Osteomyelitis of the Left Foot and Ankle. R259's Electronic Medical Record (EMR) does not document R259 was admitted to the facility with a Left Medial Foot pressure ulcer. R259's Minimum Data Set (MDS) dated 10/27/22 documents R259 as cognitively intact. This same MDS documents R259 as requiring extensive assistance of two people for bed mobility, transfers, dressing and personal hygiene. R259's Initial Wound Evaluation and Summary report dated 10/26/22 documents R259's Left Medial Foot Pressure Ulcer as a Stage 3. R259's Wound Evaluation and Management Summary dated 11/8/22 documents R259's Left Medial Foot Pressure Ulcer as a deteriorated Stage 3 due to larger size. R259's Care Plan dated 11/8/22 documents heel protectors at all times. This same Care Plan documents to float R259's heels. This same care	S9999		

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S9999	Continued From page 3 plan documents an intervention for a pressure redistribution mattress and to assess pressure ulcer weekly by licensed nurse. R259's Wound Evaluation and Management Summary dated 11/16/22 documents R259's Left Medial Foot Stage 4 Pressure Ulcer as deteriorated due to larger size. This same report documents a physician order to cleanse R259's Left Medial Foot Stage 4 Pressure Ulcer and apply Calcium Alginate, absorbent pad and gauze wrap twice daily. This same report documents a physician order for R259 to wear calf high heel protectors at all times. R259's Wound Evaluation and Management Summary dated 11/29/22 documents R259's Left Medial Foot Stage 4 Pressure Ulcer as deteriorated due to larger in size. This same report documents a physician order to cleanse R259's Left Medial Foot Stage 4 Pressure Ulcer and apply Calcium Alginate, absorbent pad and gauze wrap twice daily. This same report documents a physician order for R259 to wear calf high heel protectors at all times. R259's Physician Order Sheet (POS) dated December 1-31,2022 does not document a physician order for R259's Left Medial Foot Stage 4 Pressure Ulcer from 12/2/22-12/8/22. On 12/06/22 at 2:22 PM R259's Left Foot was covered with a white gauze bandage not dated or initialed. R259 was not wearing heel protectors. R259's heels were not floated. R259's bed did not have a low air loss mattress. On 12/07/22 at 2:00 PM, V4 (Licensed Practical Nurse/LPN) completed the dressing change for R259's Left Medial Foot Stage 4 pressure ulcer.	S9999		

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S9999	Continued From page 4	S9999		

R259's wound had a red wound base with approximately 50 percent yellow slough covering base of wound. The peri wound area was dry with moderate dark red color. R259's wound had a previously applied Calcium Alginate dressing well adhered to wound. V4 (LPN) spent several minutes soaking the prior dressing off of R259's wound. R259 showed facial grimacing as V4 LPN was attempting to remove the prior dried on dressing. R259 was not wearing heel protectors. R259's heels were not floated. R259's bed did not have a low air loss mattress.

On 12/8/22 at 10:30 AM, R259 was laying on R259's back in bed with both heels laying directly on the sheets. R259 was not wearing heel protectors. R259's heels were not floated. R259's bed did not have a low air loss mattress.

On 12/9/22 at 10:30 AM, R259 was sitting up in the wheelchair with R259's Left foot on the foot pedal and Right foot resting on the floor. R259 was wearing ankle high heel protectors. R259's Right foot was dark purple colored and Left foot was purple and white colored.

On 12/07/22 at 2:10 PM, V4 (Licensed Practical Nurse/LPN) stated prior to changing R259's Left Medial Foot Stage 4 Pressure Ulcer dressing, V12 (Wound Physician) changed R259's Pressure Ulcer dressing orders 12/6/22 but new order has not been entered into Electronic Medical Record (EMR).

On 12/8/22 at 1:00 PM, V2 (Director of Nursing/DON) stated R259 is to be seen weekly by V12 (Wound Physician). V2 stated R259 was not seen by V12 on 11/23/22 due to the holiday. V2 stated "We (facility) did not assess R259's Left Medial Foot Stage 4 Pressure Ulcer that

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S9999	Continued From page 5	S9999		

week. R259 went from 11/16/22-11/29/22 without having (R259's) wound assessed. That is unacceptable. It had gotten worse again on 11/16 so that is even more reason to keep an eye on that wound. I wasn't aware of (V12's) physician order for the calf high heel protectors so that is why R259 has not had them on. If the previous dressing was that difficult to remove, I am sure it had been on for more than one shift. That dressing was most likely put on by V12 on V12's 12/6/22 rounds. That would make the most sense since V12 saw R259 and treated R259's Left Medial Foot wound that day." V2 (DON) stated R259 should have heels floated, calf high heel protectors in place and have a low air loss mattress. V2 stated "Anyone with a Stage 4 pressure ulcer should automatically be on a low air loss mattress. (R259) is on a pressure reducing mattress, but they are not the same. (R259) needs the low air loss mattress. I don't know how we missed that."

On 12/9/22 at 9:30 AM, V13 (Regional Clinical Nurse) confirmed the facility did not enter V12's (Wound Physician) treatment orders for R259's Left Medial Foot wound. V13 stated "There are no orders entered into the Electronic Medical Record (EMR) for R259's Left Medial Foot pressure ulcer from 12/2/22 through 12/9/22. The staff should have entered those orders into the EMR. I do not know why the orders did not get entered but we (facility) will get it taken care of today."

On 12/9/22 at 10:35 AM, R259 stated, "They (staff) just dragged those things (heel protectors) in here this morning. I have not had them since I have been here. I want to go home but first I have to get these sores healed up. I will do what the doctor says so that I can get home." R259

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S9999	Continued From page 6 confirmed R259 had not been offered or given any style of heel protectors, or air mattress since admission. The facility policy titled 'Prevention of Pressure Injuries' revised 1/10/22, documents the following: "Provide a low air loss or other similar surface to those residents who are at high risk according to the Skin Risk Assessment. Low air loss systems will be inflated based on resident's weight, tolerance and functional status with that inflation rate marked on the control unit and checked each shift for correct settings. Residents on low air loss mattresses require the assistance of two staff for repositioning, turning, perineal care, bathing, transfer or other process where the resident may need support. Complete a skin inspection assessment in EMR approximately weekly for the duration of the resident's stay." The undated facility policy titled 'Dressings, Dry/Clean' documents the following: "Preparation: Verify that there is a physician's order for this procedure. Label tape or dressing with date, time and initials." The facility's undated Dressings, Dry/Clean Policy, documents the purpose is to provide for the application of dry, clean dressings. This policy also documents to verify a physician's order for the dressing, check the treatment record, clean the wound, apply the dressing. 2.) R29's Physician Order Sheet (POS), dated 11/2022, documents R29's diagnoses as: Morbid (Severe) Obesity due to excess calories, Excoriation (skin picking) Disorder, and Paresthesia of Skin.	S9999		

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S9999	Continued From page 7 R29's Care Plan dated 12/7/22, documents potential for pressure ulcer development related to history of pressure ulcer, impaired mobility, and morbid obesity. R29's Minimum Data Set (MDS) dated 11/28/22, documents R29 is cognitively intact. R29's Skin & Wound Evaluation V5.0 dated 10/20/22, documents a venous skin issue on the left medial malleolus. R29's Wound Evaluation & Management Summary dated 11/16/22, documents stage 4 pressure wound of the left lateral ankle, dressing treatment plan, Alginate calcium, apply three times per week for 22 days, foam dressing apply three times per week for 22 days, peri wound skin prep apply three times a week for 22 days. R29's Medication Administration Record (MAR) and Treatment Administration Record (TAR) both dated November 2022, have no documented treatment order for R29's left lateral ankle wound since 11/18/22. R29's Progress Notes dated 11/29/22, documents R29 was taken to the Emergency Room. On 12/7/22 at 1:54 PM, V17 (Nurse Practitioner/NP) stated R29 came to the Emergency Room on 11/29/22 and had a dressing on R29's ankle with the date written on the dressing as 11/18/22. On 12/9/22 at 12:31 PM, V1 (Administrator) stated there are no orders documented for treatments for R29's ankle after 11/18/22. On 12/9/22 at 2:48 PM, V15 (Nurse Practitioner/NP) stated the dressing for R29's	S9999		

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S9999	Continued From page 8 ankle should have been changed three times a week according to the wound doctor's orders, and there are no orders for R29's dressing changes since 11/18/22. V15 stated there is no excuse for these bandages not being changed. 3.) R56's undated Face Sheet, documents R56's diagnoses as: Chronic Kidney Disease, Peripheral Vascular Disease (PVD), Kidney Transplant Status, Infection of Amputation Stump right lower extremity, Acquired Absence of Right Leg Below the Knee, and Absence of Left Leg Below the Knee. R56's Care Plan dated 12/5/22, has no documentation of pressure areas on the stump of the right leg. R56's MDS dated 11/22/22, documents R56 is moderately impaired cognition, has medically complex conditions including Coronary Artery Disease (CAD), Heart Failure, Renal Insufficiency, Rhabdomyolysis, Occlusion and Stenosis of Left Carotid Artery. This same MDS documents R56 requires extensive assistance for bed mobility, dressing, and toilet use. Also, the MDS documents R56 has functional limitation in range of motion due to lower extremity impairment on both sides and uses a wheelchair and limb prosthesis. R56's Progress Notes, dated 11/21/22, document R56 returning to the facility with right area on right stump. R56's November 2022 POS has no orders for treatment for R56's right stump area, and there is no treatment documented for R56's right stump on the November 2022 Treatment Administration Record. The Hospital Note dated 11/27/22 documents	S9999		

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S9999	Continued From page 9 R56 was admitted to the hospital on 12/27/22. The Hospital Note dated 11/28/22 documents R56 has a pressure sore to the right residual limb measuring eight centimeters by six centimeters with sanguineous drainage. R56's Discharge Summary, dated 12/1/22, documents a primary discharge diagnosis as Infected Right Stump with Osteomyelitis. This same summary documents findings as changes of below the knee amputation, edema and bone marrow edema enhancement of the distal most tibia and fibula consistent with osteomyelitis, overlying soft tissue edema and enhancement consistent with cellulitis. The summary documents there is skin ulceration. On 12/9/22 at 2:03 PM, V2 (Director of Nursing/DON) stated "we don't have documents or orders for R56's stump treatment" only orders from 12/1/22, when R56 returned from the hospital. (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and	S9999		

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S9999	Continued From page 10 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 and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were Not Met as evidenced by:	S9999		

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S9999	Continued From page 11 Based on observation, interview and record review, the facility failed to supervise and implement fall interventions for a resident (R45) resulting in a fall with major injury. The facility also failed to maintain safe positioning of a resident's (R10) wheelchair during transfer. This failure affects two residents (R45, R10) of seven residents reviewed for accidents in a sample list of 27 residents. R45 sustained contusions (bruises) and a scalp laceration requiring 12 sutures from an unsupervised fall at the facility. Findings include: 1.) R45's undated Face Sheet documents medical diagnoses of Dementia without Behavioral Disturbance, Metabolic Encephalopathy and History of Falling. R45's Minimum Data Set (MDS) dated 11/29/22 documents R45 is moderately cognitively impaired. This same MDS documents R45 requires extensive assistance of two people for bed mobility, transfers, dressing and toileting. R45's Fall Risk Assessment dated 11/6/22 documents R45 as a high fall risk. R45's Care Plan intervention dated 7/13/22 documents keep personal belongings within reach. R45's Nurse Progress Note dated 11/13/22 at 11:24 AM documents, "R45 observed on the floor bleeding from the head. R45 stated that R45 was sitting on the bed and leaned over and fell. Per R45's roommate (R42), R45 was sleeping on the side of bed and fell over. Emergency services were called immediately. Noted laceration on top of scalp and abrasion. Pressure applied to stop the bleeding. Emergency services arrived and R45 sent to emergency room."	S9999		

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R45's Emergency Room Discharge Instructions, dated 11/13/22, documents R45's diagnoses as: Fall, Head Injury, Contusion of Right Eye, Scalp Laceration and Shoulder Contusion.

R45's Fall Investigation dated 11/13/22 documents "R45 observed on floor with bleeding from scalp. Upon entering room, R45 sitting with back against the bed, legs extended." This same report documents R45 stated 'was sitting on bed, leaned over to grab something and fell over hitting head'. This same report documents injury type: laceration to top of scalp. This same report documents R45 has intermittent confusion at times and was sent to emergency room for evaluation and treatment. This same report documents R45 obtained 12 sutures to top of head from a fall.

On 12/6/22 at 12:30 PM, R45 sitting on side of R45's bed looking down at box of tissues sitting on floor. R45 had facial bruising on forehead and under both eyes that was gray and yellow colored.

On 12/7/22 at 1:00 PM, R45 sitting on side of bed with no shoes or socks on feet. R45 did not have a bedside table in the room. R45's personal belongings were placed in an open closet and in a chair sitting next to the bed.

On 12/7/22 at 2:20 PM, V7 (Certified Nurse Aide/CNA) stated R45 falls frequently. V7 stated, "Sometimes R45 knows what is going on but most of the time (R45) needs a lot of supervision and reminders to not fall."

On 12/8/22 at 10:00 AM, V2 (Director of Nursing/ DON) stated, "We (facility) are really unsure how

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S9999	Continued From page 13 R45 fell. R45'snfall on 11/13/22 was unwitnessed by staff. R45's roommate (R42) stated (R45) was sitting on the side of (R45's) bed, fell asleep and then fell over hitting his head. R45 told us (facility) that he was sitting on the side of his bed, leaned over to pick something up off of the floor and fell over. Either way, R45 ended up with 12 sutures in R45's head. This fall could have been prevented if the staff were watching (R45) closer. We (facility) should have seen that R45 was either falling asleep on the side of the bed which is dangerous or that R45 should have had all the personal items within (R45's) reach. We (facility) do not know when the last time (R45) was checked on prior to the fall. (R45) has had a ton of falls, so we (facility) need to be watching R45 like a hawk." On 12/9/22 at 11:00 AM, V6 (Licensed Practical Nurse/LPN) stated "I was R45's nurse the day he fell and got stitches in his head. R45 is supposed to have all of his belongings within reach, and he did not because he does not have a bedside table. R45 did reside on another hall and had a bedside table but for whatever reason R45's bedside table did not get transferred over here with him. R45's orientation is come and go. Some days (R45) is sharp and other days he needs a lot of supervision. I had several other very ill residents that day and was not able to keep close supervision of R45 like he needs. The staff are very good, but they (CNA's) were busy helping me with the other ill residents when this happened." 2.) R10's undated Face Sheet documents medical diagnoses of Emphysema, Dysphagia, Vascular Dementia, Restless Leg Syndrome and Chronic Pain.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004477	A. BUILDING: _____ B. WING _____	C 12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP SKILLED NSG & REHAB	910 WEST POLK STREET CHARLESTON, IL 61920

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S9999	Continued From page 14 R10's Minimum Data Set (MDS) dated 12/1/22 documents R10 is moderately cognitively impaired. This same MDS documents R10 requires extensive assistance of one person for transfers, bed mobility and personal hygiene. R10's Care Plan dated 10/27/22 documents a bruise to Left Lower Extremity with intervention to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. This same care plan documents an intervention to keep environment clutter free. R10's Facility Incident Investigation dated 10/27/22 documents, "V16 (Certified Nurse Aide/CNA) reported to nurse that R10's wheelchair fell over and hit R10's left lower extremity. Noted bruise to area. (R10) stated 'the wheelchair fell on my leg when I was sitting in recliner.' This same report documents "root cause: R10 was putting recliner footrest down and hit the wheelchair, which tipped and fell on R10's feet. Intervention: encourage (R10) not to leave wheelchair next to the recliner." R10's Nurse Progress Noted dated 10/28/22 at 2:02 PM, documents "V15 (Nurse Practitioner/NP) came to see R10 regarding wheelchair bumping R10's leg when it fell over and bruise to Left Lower Extremity (LLE). New order received to obtain Left Ankle X-Ray complete." On 12/7/22 at 11:30 AM, R10 stated "That girl V16 (Certified Nurse Aide/CNA) was trying to help me get out of my recliner. V16 did not watch where my wheelchair was. V16 just came in and pushed my recliner footrest down and it made the wheelchair fall on my legs. It hurt a bit and left a	S9999		

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S9999	Continued From page 15 small bruise. V16 should have been more careful." On 12/8/22 at 10:30 AM, V6 (LPN) stated "R10 was sitting in R10's recliner when the (V16) Certified Nurse Aide (CNA) pushed down on the footrest of R10's recliner chair. This made the wheelchair tip over onto V16 and R10' legs and feet. The handle of the wheelchair is what hit R10's legs and feet. There was a bruise on R10's left lower leg. V16 should have been more careful and made sure the wheelchair was out of the way so R10 would not have gotten hurt." On 12/8/22 at 2:30 PM, V2 (DON) stated that R10 did not push down her own footrest as the fall investigation documents. V2 stated, "V16 (CNA) actually pushed down the footrest, not (R10). The fall investigation report should have been modified. V16 should have made sure to move the wheelchair out of the way of the footrest. That would have solved the problem. Instead, R10 ended up with a bruise because V16 did not think ahead and try to protect the resident." (B)	S9999		