STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003503	A. BUILDING: _____ B. WING _____	C 09/14/2023

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BRIA OF GENEVA	1101 EAST STATE STREET GENEVA, IL 60134

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S 000	Initial Comments Complaint Investigation 2377379/IL164054	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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) 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: 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 Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to implement specific	S9999		

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S9999	Continued From page 2	S9999		

interventions to prevent pressure ulcers from developing to a resident assessed as high risk. This applies to one of three residents (R1) reviewed for pressure ulcers.

The findings include:

The EMR (Electronic Medical Record) showed that R1, an 86-year-old with diagnoses that include but not limited to diabetes mellitus type 2, dementia, hypertension, Alzheimer's disease, cerebral infarction, hyperlipidemia, hyperkalemia, lack of coordination, weakness, kidney failure, metabolic encephalopathy, obesity, psychotic, mood and anxiety disturbance, and cognitive communication deficit. R1 was admitted to the facility on 7/18/2023.

The MDS (Minimum Data Set) dated 7/25/2023 showed that R1 was severely impaired, required extensive to total assistance with ADLs (Activities of Daily Living) such as transfer, bed mobility, hygiene and eating. The MDS also showed that R1 had functional impairment of range of motion on one side of the body of the upper extremity and both sides of the lower extremities. The assessment showed that R1 had no pressure ulcers, no DTI (deep tissue injuries) that were pressure related, no open lesions, diabetic ulcers or any kind of ulcers or tissue injuries of the feet.

The initial nursing assessment dated 7/19/2023 showed that R1 was free of skin alteration and had no pressure ulcers.

On 9/11/2023 at 2:00 P.M. the Braden Scale skin assessments and current care plan was reviewed with V3 (Director of Nursing) and V4 (Licensed Practical Nurse/Wound Care Nurse). V3 and V4 stated that the Braden Assessment of 7/18/2023

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with a score of 17 (at risk for pressure ulcer development) was not accurate. V3 and V4, said that if the Braden Assessment was done correctly, the score should be 11 and that would place R1 as high risk of developing pressure ulcer. The Braden Scale dated 7/26/2023 showed that R1 had a score of 11. The current care plan initiated on 7/19/2023 showed that there were no specific interventions to prevent R1 from development of pressure ulcer. The care plan was discussed with V3 and V4. Both have confirmed that there were no specific interventions to prevent R1 from development of pressure ulcer. In fact, they both said that heel protectors were only applied on 9/5/2023 when R1's daughter had discovered the unstageable pressure ulcer to R1's both heels on 9/5/2023. The care plan was updated on 9/7/2023 for R1 to always have the heel protectors after the discovery of the unstageable pressure ulcer of both heels. V4 said that on 9/5/2023, R1's daughter had complained regarding a skin tear to R1's right lower leg. V4 added that due R1's daughter complaint, V4 did skin assessment on same day with R1's daughter at bedside and V3. Both V3 and V4 said that they assessed R1's heels as "black discoloration to both heels which were unstageable pressure ulcer. (V7/Nurse Practitioner) came to see the wounds and categorized it as DTI (deep tissue injury). Both heels were covered with black discolored skin and was unknown what was building inside the wound."

The skin /wound assessment shows the wound measurement as follows:
The 9/5/2023 wound measurement of the left heel was 6.76 cm. on the affected surface area; length was 3.78 cm x 2.72 cm. in width. The right heel measurement was 2.69 cm on affected

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S9999	Continued From page 4 surface area; length was 2.54 cm. x 1.4 cm. in width. The 9/8/2023 wound measurement basement of the left heel was 7.2 cm, on the affected surface area; length was 3.64 cm. x 2.71 cm in width. The right heel measurement was 12.06 cm on the affected surface area; length was 5.45 cm x 2.98 cm. in width. The 9/12/2023, the left heel measurement was 22.5 cm in affected surface area, length was 6.7 cm.: x 4.7 in width. The right heel measurement was 19.4 cm in affected surface area, length was 6.0 cm. x 5.5 cm. The measurements from 9/5/223 through 9/12/2023 showed an increased in size for the unstageable pressure ulcers. The progress notes dated 9/7/2023 showed that R1 was sent to the hospital at 1:30 P.M. for evaluation of stroke. R1 returned to the facility on same day at 10:48 P.M. The hospital ER (Emergency Room) record showed that R1's daughter had expressed concern regarding R1's "lesions on feet. Does have what appears to be an eschar (dead tissue) are thick callus over the lateral aspect of the right heel and less so to the plantar aspect of the left heel. These do appear to be pressure related." The ER record documents that the clinical impression of the heels was "pressure injury of the skin feet, with unspecified stage of injury stage." On 9/11/2023 at 11:45 A.M., R1 was observed sitting in her reclining wheelchair. R1 was in the dining room. R1 was confused and was not conversant. R1's skin was checked with the assistance from V4, V5 (LPN/License Practical	S9999		

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Nurse) and V6 (CNA/Certified Nurse Assistant). R1 was transferred via the mechanical transfer lift device. It was noted healed scars noted on the sacrum, right below knee and perineal area was clean and no altered skin. The right mid leg was with an open wound. V4 said it was a skin tear that R1 had acquired when R1 was out from the facility to the hospital on 9/7/2023. There was a gauze dressing to the right mid leg. The dressing was intact, and a date labeled 9/11/2023. The skin tear measured 2.7 in length x 0.9 cm in width and 0.1 cm in depth. R1 was also noted with black discoloration that covered entire areas of both heels. The blackened area looked rubbery and shiny looking. V4 said that these blackened discolorations were DTI due to pressure related injuries.

The Nurse Practitioner progress notes dated 9/5/2023 documented by V7(Nurse Practitioner) showed that she examined R1 and called the wound on the heels as unstageable DTI. The notes also showed for a wound physician specialist to check R1 "ASAP" (as soon as possible) whether in -house or outside the facility."

On 9/11/2023 at 3:15 P.M., V7 stated that on 9/5/2023, V7 was called to check R1's blackened/discolored skin of both heels. V7 said she documented the discolored heels as "deep tissue injury because of injuries of the tissues. I don't know about wounds, not my specialty, so I refer (R1) to wound physician specialist ASAP to determine what was building inside the unstageable tissue injuries on both heels. Since there was no certainty on what was going on inside the tissue injury that was covered with blackened discoloration. V7 stated I want the wound clinic /wound doctor to see (R1) ASAP

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whether outside wound clinic or in house wound doctor specialist. Obviously if the wound clinic cannot see (R1) till 9/22/2023, this is far way out of range for R1 to be seen, the tissue injuries must be evaluated and treated ASAP."

On 9/12/2023 at 10:00 A.M., V3 said that the in-house wound physician specialist (V9) was not available on 9/5/2023 and therefore R1 was not seen. However, V3 said V9 will evaluate R1 today (9/12/2023.).

On 9/12/2023 at 9:30 A.M., V8 (R1's Attending Physician) said that he is not involved with R1's wound management and care since it was not his specialty, and it was up for the wound care team to take of R1's wounds.

On 9/12/2023 at 2:46 P.M., V10 (CNA/Certified Nurse Assistant) said that she took care of R1 several times since R1 was admitted to the facility. V10 said that it was only a week ago sometimes around 9/5-7/2023 when staff had been applying the heel protectors to R1's heels.

On 9/12/2023 at 2:47 P.M., V11 said that she had helped during R1's transfers using the mechanical transfer lift device. V11 said that she did not know or had seen R1 with heel protectors on.

The wound physician specialist (V9) had documentation dated 9/12/2023 that showed the wound assessment were as follows:
-right heel categorized as DTI and etiology was pressure injury; measurement of affected area was area of 55.16 cm; length was 5.8 cm x 5.7 cm in width and an unstageable deepness.
-left heel measure categorized as DTI and etiology was pressure injury; measurement of

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S9999	Continued From page 7 affected area was area of 19.95 cm; length was 3.5 cm. x 5.7 cm. in width and an unstageable deepness. On 9/12/2023 at 2:15 P.M., V9 stated that R1 was a high risk for development of pressure ulcer and preventative measures and interventions were a must to be implemented to prevent pressure ulcers from developing. V9 added that he examined R1 on 9/12/2023 and that R1 had an unstageable pressure ulcer to both heels. V9 added that the reason of the DTI was related to pressure related injuries. V9 added that since R1 was highly dependent from staff's assistance for offloading from pressure that would cause pressure ulcers. V9 added that prevention for heel pressure ulcer would include using foam boot protector to offload pressure from the heels. The facility's policy for "Skin Care Prevention" dated 1/2023 showed that all residents will receive appropriate care to decrease the risk of skin breakdown. The policy also showed that ...." 1. The Nursing Department will review all new admissions/readmissions to put a plan in place for prevention based on the resident's activity level, comorbidities, mental status, risk assessment ...2. Dependent residents will be assessed during care for any changes in skin condition including redness (non-blanching erythema), and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider ...6. Unless contraindicated, elevate heels off bed surface and avoid skin-to-skin contact. The facility's policy for "Skin Management; Pressure Injury Treatment /General Wound Treatment dated 1/2023 "1. Implement prevention protocol according to resident needs."	S9999		

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