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	IL6000939	A. BUILDING: _____ B. WING _____	07/19/2023

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FLANAGAN REHABILITATION & HCC	201 EAST FALCON HIGHWAY FLANAGAN, IL 61740

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999	Attachment A Statement of Licensure Violation	

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S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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	S9999		

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S9999	Continued From page 2 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 are not meet as evidence by: A. Based on observation, interview and record review, the facility failed to assess a surgical wound weekly, complete dressing changes as ordered to prevent a surgical wound from deteriorating, failed to notify the physician/wound practitioner of the wound decline and failed to implement nutritional interventions for wound healing for one of one residents (R32) reviewed for surgical wounds on the sample list of 17. This failure resulted in delayed wound healing and R32's surgical wound increasing in size. B. Based on observation, interview and record review, the facility failed to prevent the development of a deep tissue injury pressure wound, failed to notify the physician and/or wound practitioner of a newly developed deep tissue injury and obtain treatment orders and document the deep tissue injury for one of two residents (R32) reviewed for pressure injuries on the sample list of 17. This failure resulted in R32 developing a new deep tissue injury to the plantar surface of the right foot. Findings Include: R32's Skin Risk Assessment dated 5/30/23 and 6/15/23 both document R32 is at risk for skin breakdown. On 7/16/23 at 8:45 AM, R32 stated R32 has a foot wound on R32's right foot caused by a screw	S9999		

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S9999	Continued From page 3 that R32 stepped on at R32's house. R32 explained R32 had surgery for it, but the doctor "went too deep" and caused more issues. R32 stated "it was making great progress healing then stopped." R32's Dietitian Review dated 6/26/23 documents this is an admission assessment for R32, who was admitted to the facility on 5/25/23. This Review documents a nutritional recommendation for 30 ml (milliliters) of liquid protein daily for 21 days for wound healing. R32's Dietary Note dated 7/14/23 by V11 RD (Registered Dietician) documents R32's surgical wounds are deteriorating and again recommended 30 ml of liquid protein daily for 21 days for wound healing. R32's Progress Notes document the following: 5/31/23 - Surgical wound. Skin issue location: Right plantar foot - 1 cm (centimeter) by 1.8 cm by 1.5 cm. Wound bed with Granulation tissue. Wound exudate: Serosanguineous. Peri wound condition: WNL (within normal limits). 6/7/23 - Skin Issue: Surgical wound. Skin issue location: Right plantar foot - 1 cm by 1.8 cm by 1.2 cm. Wound bed with Granulation tissue. Wound exudate: None. Peri wound condition: WNL. 6/14/23 - Skin Issue: Surgical wound. Skin issue location: Right plantar foot - 1 cm by 1.5 cm by 0.8 cm. Wound bed with Granulation tissue. Wound exudate: None. Peri wound condition: Maceration. 6/21/23 - Skin Issue: Surgical wound. Skin issue	S9999		

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S9999	Continued From page 4 location: Right plantar foot - 0.9 cm by 0.8 cm by 0.4 cm. Wound bed with Slough. Wound exudate: None. Peri wound condition: Maceration. 6/28/23 - Skin Issue: Surgical wound. Skin issue location: Right plantar foot - 1.2 cm by 0.8 Depth by 0.4 cm Wound bed with Slough. Wound exudate: None. Peri wound condition: Maceration. 7/12/23 - Skin Issue: Surgical wound. Skin issue location: Right plantar foot - 1.8 cm by 2 cm by 0.4 cm. Wound bed with Granulation tissue. Wound exudate: None. Peri wound condition: Maceration. There is no wound measurements for 7/5/23 in R32's medical record. R32's June 2023 Physician Orders do not document an order for liquid protein as recommended by V11. R32's July 2023 Physician Orders document an order for the Right plantar foot wound: cleanse with NS (Normal Saline), pat dry, apply skin prep to periwound, lightly pack with Calcium Alginate AG (cut to fit to wound bed), cover with island dressing, change daily until resolved but there is no order for nutritional interventions for wound healing as recommended by V11. R32's June 2023 TAR (Treatment Administration Record) does not document that R32's surgical wound treatment was completed as ordered on the 23rd, 27th, 28th, and the 30th. R32's July 2023 TAR does not document that R32's surgical wound treatment was completed as ordered on the 1st, 3rd, 4th, 5th and 10th.	S9999		

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S9999	Continued From page 5 On 7/17/23 at 1:23 PM, V22 Agency LPN (Licensed Practical Nurse) entered R32's room to provide wound care. R32 was lying in bed with the right foot resting up against the foot board of the bed with a dark brown liquid on the bed sheets under the right foot. Nurse removed the island dressing, which had a moderate amount of brownish drainage, to reveal a large wound with a gray wound bed, macerated white tissue surrounding the open area and dark purple tissue extending past the maceration. V22 removed a thin covering of saturated calcium alginate from the large wound. It was not packed with calcium alginate. V22 measured the surgical wound to the right plantar foot and reported measurements of 1.5 cm by 3.5 cm. V22 did not have supplies at the bedside to measure the depth but stated, "it appears to be about 3/4 of an inch deep." The open area including the maceration measured 3.2 cm by 5 cm and the area including the open, macerated, and DTI (deep tissue injury) appearing area measured 5 cm by 5.7 cm. V22 cleansed the wound with NS, cut calcium alginate to the size of the wound and applied one layer to the wound bed, applied skin protectant to the periwound and covered the wound with a bordered anti-stick dressing. V22 stated V22 last observed R32's wound five days ago and that it has deteriorated since, she then explained the open area is about the same size however five days ago the wound base was pink, instead of the gray in color as it is now and the macerated area was about half the size it is now and the DTI appearing area was not there at that time. As of 7/18/23, R32's Progress Notes do not document the new DTI area or that the physician was notified. R32's July 2023 Physician Orders do not document a treatment for the new DTI area.	S9999		

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S9999	Continued From page 6 On 7/18/23 at 12:08 PM, V7 MDS (Minimum Data Set)/Care Plan Coordinator stated nurses change the dressings and if the wound had deteriorated, they should notify V18 Wound NP (Nurse Practitioner). V7 stated all wounds are to be measured weekly, and pressure should be removed from R32's foot. V7 checked the Progress Notes, Wound Assessments, and Wound Measurement Reports and stated there is no documentation of the changes in R32's wound or that V18 was notified. On 7/18/23 at 3:35 PM, V18 stated with the decline in R32's wound condition, V18 would have expected a phone call and would have probably changed the treatment order for R32 explaining, calcium alginate is the best thing for the wound, but the dressing might need to be more frequent with the amount of drainage R32 now has. V18 also stated R32 pushing R32's foot up against the foot board could most definitely be the cause of the deterioration of the wound. On 7/19/23 at 10:15 AM, V4 Regional Clinical Nurse stated when a resident comes in with wounds or they develop a wound, nursing should notify V5 DM (Dietary Manager) who would then notify V11 RD (Registered Dietitian) for recommendations for wound healing. On 7/19/23 at 10:21 AM, V5 DM stated V5 was made aware of R32's surgical wound at the time of R32's admission and V11 RD was notified also at that time, so V5 isn't sure why it took over a month for R32 to be assessed. On 7/19/23 at 10:25 AM, V1 AIT (Administrator in Training) stated after V11 assesses a resident, those recommendations are sent out to the	S9999		

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physician and when they are returned, they are given to the nurses. Not sure why R32's nutritional recommendations were not implemented.

On 7/19/23 at 10:32 AM, V11 RD stated V11 assessed R32 on 6/26/23 because V11 has 30 days before V11 needs to see new admissions. V11 stated V11 recommended the liquid protein on that day and on again on 7/14/23 due to R32's surgical wound deterioration. V11 stated when a recommendation is made, V11 gives it to V1 AIT (Administrator in Training) and is unsure what V1 does with them. V11 stated protein is needed to build new tissue so not getting the liquid protein could have contributed to the wound not healing. V11 stated, V11 is to be notified of Pressure Ulcers at the time of discovery so nutritional recommendations for wound healing can be given. V11 stated, V11 was notified of R32's surgical wound but not the pressure wound.

On 7/19/23 at 11:45 AM, V21 RN (Registered Nurse) stated V21 was not aware that the RD had ordered R32 nutritional supplements on two separate occasions and stated that R32 has not received the recommended Protein supplement. V21 explained that V24 Regional Nurse "had been handling stuff like that due to the facility not having a DON (Director of Nursing) but that (V24) hasn't been at the facility for sometime due to working at other facility's and now being off work due to an injury." V21 and V18 Wound NP entered R32's room and R32 was lying in bed with bilateral feet pressing up against the foot board. At this time, V18 measured R32's surgical wound at 3.2 cm by 3.3 cm by 0.6 cm and stated the wound continues to deteriorate and get bigger; part of that is due to the macerated skin coming off but explained the pressure from the

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S9999	Continued From page 8 foot board is also contributing to the wound's deterioration and preventing healing of the wound. V18 also stated the recommended liquid protein from V11 would have helped the surgical wound heal but also thinks R32 needs to have laboratory tests done to see if R32 should be being given any additional wound healing supplements like Vitamin D, iron, zinc, etc. V18 removed the dressing to the right foot and stated, "I (V18) see exactly what you {surveyor} were talking about yesterday with the dark spot" (pointing to the area next to the surgical wound). V18 stated, V18 think's "that is definitely a DTI caused from the pressure from the foot board." V18 measured the DTI area only at 2.6 cm by 2.5 cm and stated V18 should have been notified of the new DTI on Monday (2 days prior when it was first observed). The facility Decubitus Care/Pressure Areas Policy dated January 2018 documents it is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcers. Upon notification of skin breakdown, the QA (Quality Assurance) form for Newly Acquired Skin Conditions will be completed and forwarded to the Director of Nursing. The pressure areas will be assessed and documented on the Treatment Administration Record or the Wound Documentation Record. The physician will be notified for treatment orders. Nursing Personnel are to also notify dietary personnel of any pressure areas to seek nutritional support. When a pressure ulcer is identified, additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers.	S9999		

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