PRINTED: 12/20/2023
FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008056	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE HC OF EAST PEORIA	500 CENTENNIAL DRIVE EAST PEORIA, IL 61611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)5) 300.1220b)3) 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. 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.	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

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These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to develop and implement pressure relieving interventions to prevent the development of pressure ulcers for one of one resident (R12) reviewed for facility acquired pressure ulcers in the sample of 40. These failures resulted in R12 developing stage two pressure ulcers to the left and right heel.

Findings include:

The facility's Wound Prevention, Identification, and Treatment Policy revised 2/21 documents, "Purpose: To provide guidelines that will assist nursing staff in prevention, identification, and appropriate treatment of wounds. Policy: Prevention program will be utilized for all residents who have been identified of being at risk for developing wounds. The facility will initiate an aggressive treatment program for those residents who have pressure ulcers. Procedure: 1. All residents will have a Pressure Ulcer Risk Assessment completed upon admission, then weekly for four weeks, then quarterly."

The facility's Wound Treatment Policy dated 4/2023 documents, "General: The following treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used. However, the facility recognizes that the selection of treatment protocols is individualized based in the resident condition and health care Provider practice patterns. Therefore, these are only

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S9999	Continued From page 3 guidelines and not all-inclusive. An order is required for all treatment orders. Guidelines: Implement prevention protocol according to resident needs. Activity: Turn at lease every two hours, reposition in chair, provide appropriate pressure redistribution devices, teach resident to weight shift if appropriate, ensure proper body alignment. Mobility: Turn every two hours, reposition in chair every two hours, provide appropriate pressure reducing devices. Treatment Guidelines for State 2 pressure injuries: Turn and reposition every 2 hours and as needed. Consider pressure redistribution devices for bed and/or chair." The facility's Skin and Wound Management Guidelines Policy dated 4/2023 documents, "General: To provide guidance on the prevention, identification, and management of alterations in skin integrity. Policy: Prevention measures will be utilized for all residents who have been identified of being at risk for developing wounds. Nursing Management and/or Wound Care Nurse: 10. During rounds, ensure residents are positioned correctly and heels are off loaded." R12's Current Face Sheet documents R12 was admitted to the facility on 7-21-23. This same form documents R12 has diagnoses of, but not limited to, Demyelinating Disease of Central Nervous System, Hemiplegia unspecified affecting right dominant side, Hereditary and Idiopathic Neuropathy, and Cerebrovascular Disease. R12's Nursing Admission/Readmission Assessment dated 7-21-23 documents R12's skin is intact. R12's Braden Scale for Predicting Pressure Sore	S9999		

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Risk dated 7-21-23 documents, "4. Mobility: very limited. - Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. 6. Friction and Shear: problem- requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent reposition and maximum assistance. Spasticity, contractures, or agitation leads to constant friction." This same assessment documents R12 has a score of 16 (high risk for developing pressure sores).

R12's Baseline Care Plan dated 7-21-23 documents R12 does not have any skin integrity issues however, this care plan does not include any interventions to prevent pressure ulcers even though the Initial admission Braden/Skin Assessment documents R12 is at risk for pressure ulcers.

R12's MDS (Minimum Data Set) Assessment dated 7-27-23 documents R12 has a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact.) This same assessment documents R12 requires extensive assistance with two staff members for bed mobility, transfers, and toileting and is at risk for developing pressure ulcers/injuries.

R12's current POS (Physician Order Sheet) dated 9-11-23 documents an order for (heel protectors) to be worn while in bed and resident may take off if desired every shift for wound.

R12's Plan of Care dated 8-10-23 documents R12 has potential for pressure ulcer injury related to immobility, pain, requires assist with mobility, and bowel incontinence. Interventions document

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to follow facility policies/protocols for the prevention/treatment of skin breakdown. There are no individualized specific interventions documented to prevent pressure ulcers from developing for R12. This same Plan of Care documents a revision on 9-11-23 (after two pressure ulcers were already identified) of a new intervention for (heel protectors) to be worn while in bed may take off if R12 desires. This Plan of Care does not include any other offloading of heels if heel protectors are not used.

R12's Nursing Progress Note dated 9-10-23 documents, "Bilateral heels noted with discoloration, light-dark brownish color. Skin prep bilateral heels. Notified wound nurse. Applied heel boot protectors to feet. Resident denies any pain to heels."

R12's Physician Order on 9-10-23 documents, "skin prep bilateral heels every shift."

R12's Wound Assessment Details Report dated 9-11-23 signed by V10 (Wound Nurse) documents R12 has a facility acquired pressure ulcer to left and right heel.

R12's Initial Wound Evaluation and Management Summary dated 9-12-23 and signed by V20 (Wound Physician) documents R12 presents with wounds on R12's left heel and right heel. A stage two pressure wound of the left heel partial thickness. Wound size 3 x 2 x Not measurable cm (centimeters). This same Wound Evaluation documents a stage two pressure wound to the right heel partial thickness. Wound size 1.7 x 2 x Not measurable cm.

On 10-18-23 at 1:45 PM V10 was preparing treatments for R12's left and right heel. R12's left

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heel had a dime sized round pink area with a scant amount of yellowish/pinkish drainage. R12's right heel had an approximate 0.5 cm round dry area with no drainage visible. V10 stated there was no pillow offloading R12 heels when he entered R12's room, so he placed one there. R12 at this time told V10 staff never place a pillow under her heals. V10 verified R12's heels should be always offloaded.

On 10-18-23 at 9:15 AM R12 was lying in bed alert and oriented. R12 did not have heel protectors on at this time and R12's heels were not elevated on pillows. R12's heels were resting directly on the bed. R12 stated her wounds to her bilateral heels were caused by lying in bed and staff not coming in to turn and reposition her. She stated, "I do refuse at times to wear (heal protectors) because my feet get hot, but I want my heels elevated on a pillow, but staff never do it."

On 10-18-23 at 10:25 am R12 was in the main dining room in R12's wheelchair sitting at the table. R12 had socks on with no shoes or heel protectors and her feet were resting on the floor.

On 10-18-23 at 9:20 am V10 (Wound Nurse) verified R12 developed pressure ulcers to R12's left and right heels due to no pressure relieving interventions being in place prior to development.
(B)