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	IL6011340	A. BUILDING: _____ B. WING _____	C 01/19/2023

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S 000	Initial Comments Complaint Investigation: 22410321/IL154785	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1210d)5) 300.1810f)1 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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	S9999		

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S9999	Continued From page 2 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 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. Section 300.1810 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. These requirements were Not Met as evidenced by: Based on interview and record review, the facility failed to assess, monitor, and provide treatment to prevent the development of pressure ulcers for 1 of 4 residents (R2) reviewed for pressure ulcers in the sample of 12. This failure resulted in R2 developing a Stage IV pressure ulcer and being admitted to the hospital with a diagnosis of Osteomyelitis. Findings include:	S9999		

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S9999	Continued From page 3 R2's Face Sheet, undated, documents R2 was admitted to the facility on 11/23/21 and had diagnoses of chronic kidney disease, stage 3, Obstructive and reflux Uropathy, Retention of urine, Type II diabetes Mellitus with diabetic Chronic Kidney disease, Pressure Ulcer of left buttock, stage 3, and need for assistance with personal care. R2's Minimum Data Set (MDS), dated 11/30/22, documents R2 is cognitively intact and requires extensive assistance, 2 plus person physical assist with bed mobility. It also documents R2 is total dependence, 2 plus person physical assist with toilet use and bathing. R2's MDS documents R2 has an indwelling catheter and is always incontinent of bowel. It documents R2 is at risk for developing pressure ulcers/injuries. It further documents R2 has no skin issues. R2's Care Plan, undated, documents Problem start date: 06/01/22, R2 is at risk for pressure ulcers/skin breakdown r/t (related to) incontinence. On 12/30/22, R2's Care Plan was updated and documents 12/14/22, "Excoriation to bilateral buttocks noted, and Triad cream as ordered for protection. Do weekly skin checks, notify family and MD (Medical Doctor) of any new skin issues." On 01/03/23, R2's Care Plan was updated and documents R2 has an unstageable pressure ulcer to his coccyx. R2's Physician's Orders, dated 06/04/22, documents apply Triad Cream to buttocks every shift and PRN (as needed). R2's Progress notes, dated 07/29/2022 at 4:50 PM, documents Resident seen by V19 (Wound Care Physician), the new wound Dr (doctor), for	S9999		

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S9999	Continued From page 4 treatment to the coccyx. The order is for Silvadene, antifungal and Maalox every shift. R2's Initial Wound Evaluation & Management Summary, dated 07/30/22, documents Stage 3 Pressure Wound of the left buttock. R2's Physician's Orders, start date of 08/01/2022, documents "Cleanse with NS (normal saline), apply Silvadene, calcium alginate, collagen powder and a dry dressing to left buttocks once daily for 30 days." R2's Wound Evaluation & Management Summaries, dated 08/19/22 and 8/26/22, documents R2 had a Stage 3 Pressure Wound of the left buttock, which was improving and healed. R2's Electronic Medical Record, had no documentation R2 had any pressure ulcers /injuries from 9/12/22 through 12/8/22. Skin Observation Information in R2's Electronic Medical record, dated 12/08/22 at 12:16 AM, documents excoriated buttocks. There was no documentation in R2's medical record that V8 (Medical Doctor/MD), or V12 (Nurse Practitioner/NP), were notified of R2's excoriated buttocks. R2's Progress Notes, dated 12/14/22 at 12:47 AM, written by V21 (Licensed Practical Nurse/LPN), documents "Night nurse went into resident's room to look at buttocks due to concern noted by hall aide. Nurse examined resident's skin and saw there were 2 prominent areas on both L (Left) & R (Right) buttock that were excoriated. Redness also covered both of resident's buttocks. (Brand type) skin	S9999		

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S9999	Continued From page 5 protectant/barrier cream, applied and note left for wound nurse. Will continue to update & monitor." On 01/10/23 at 1:58 PM, V21 (LPN) stated she had worked at the facility only one time. She said she remembers R2. V21 said she went in to look at his bottom and noted the top layer to be excoriated. She said she did not see any open areas. V21 stated she put the (Brand type) skin protectant/barrier cream on it to protect it more, and then asked him (R2) if he wanted anything on it to cover it. V21 said R2 said no, he would just have the wound nurse look at it tomorrow (12/15/22). V21 stated she wrote a note on a piece of paper and enclosed it, labeled it as "per wound nurse," and the other nurse told her what door to hang it on. V21 stated she also passed it on in report about R2's buttocks being excoriated. R2's Skin Observation Information in R2's Electronic Medical record, dated 12/14/22 at 10:12 PM, documents R2 had an excoriated buttock. R2's Electronic Medical Record, documents Confidentiality Note, dated 12/15/22 at 7:55 PM, "Attn (Attention) V8 (Medical Doctor), Resident (R2), 4 new open wounds on resident L (Left) R (Right) buttock, 1 coccyx, 1 under right testicle. Applying Triad. Please advise." There was no documentation describing the size or appearance of any of these new pressure ulcers. R2's Fax Response from V12 (NP), dated 12/16/22 at 8:47 AM, documents "Continue with barrier cream to area BID (twice a day) and PRN (as needed) for soiling. Monitor for improvement, if no improvement or any worsening, update provider."	S9999		

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S9999	Continued From page 6 There was no documentation a physician's order was written for the barrier cream, which V12 ordered on 12/16/22. R2's Skin Observation Information in R2's Electronic Medical record, dated 12/21/22 at 2:51 AM, documents (bilateral) buttocks excoriated. There is no documentation of any pressure ulcer to R2's right testicle or any description of R2's skin condition. R2's Skin the Vital Organ Assessment and Documentation Tool, dated 12/27/22, written by V9 (Certified Nurse's Aide/CNA), documents "Open Area". The adjacent body figure has a circle placed around the buttocks. This documentation did not describe the open areas or condition regarding R2's skin or R2's scrotum. On 01/10/23 at 1:15 PM, V9 (CNA) stated she did give R2 a shower on 12/27/22. When question about the shower sheet having documentation stating there was an open area on R2, V9 stated there must have been an open area for her to circle that. She said the whole area was excoriated and he had an open area on his buttocks. V9 said she put on the sheet no new wounds because it was a wound they already knew about. She said she doesn't think she informed the nurse because it was an area they already knew about. V9 stated if it had been something new, she would have put it on the sheet. R2's Skin Observation Information in R2's Electronic Medical record, dated 12/28/22 at 9:20 AM, documents coccyx excoriated. The Observation Information documented that wound physician would be consulted and the area	S9999		

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S9999	Continued From page 7 measured 18.4 centimeters (cm) by (x) 15 cm. This Observation did not include a description of the areas including odor or drainage. There was no documentation regarding any opened pressure ulcer to R2's scrotum. On 01/11/23 at 8:34 AM. V2 (Director of Nursing/DON), stated she would expect the nurses to just document the assessment, and if they see any changes in the resident, to get an order if they didn't already have an order in place. She said if the nurses were to see the wound wasn't improving or was worsening, she would expect the nurses to call the doctor to see if they wanted to change the order and get an order for them to be seen by the wound specialist. V2 said she reads the nurses notes every day, and if she sees something that is off, she will go down and look at that resident, then if she thinks they need it, she will have them on the list to be seen by the wound specialist. V2 stated what had changed from 12/08/22 to 12/28/22 was she believes on the left side of his buttocks he had what looked like an open area and yellow slough on it. She said the order he had in place was triad cream, PRN, and barrier cream. V2 said for a treatment for an open wound, she would have them seen by the wound doctor the next day, and he would give them an order. She said usually Silvadene Cream. V2 said she would expect the CNAs to report any skin issues to the nurses. R2's Skin the Vital Organ Assessment and Documentation Tool, dated 12/28/22, documents red, open. The adjacent body figure on the assessment has a circle placed around the buttocks and documents red, open. This documentation did not describe the open area or condition regarding R2's skin and scrotum.	S9999		

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S9999	Continued From page 8 R2's Progress Notes, dated 12/29/22 at 9:45 AM, written by V15, (Licensed Practical Nurse/LPN), documents "CNA reported res (resident) has large open area to coccyx. Upon assessment, unstageable pressure ulcer noted to coccyx. Whole area measures 14.5cm (centimeter) x 11.2cm x 0.1cm. Center covered with yellow/tan slough and measures 3.5cm x 5.7cm x UTD (Unstageable). Scant amount of serous drainage from area. Cleansed with NS (Normal Saline). Unable to apply dressing r/t (related to) location and proximity to anus. Silvadene and collagen powder mixed and applied to open area. DON (Director of Nursing) aware and reports res (resident) is to be seen by (Wound consultant company) specialist tomorrow. Fax sent to V8's (Medical doctor) office re (regarding): area and (Wound Consultant Company) referral." R2's Physician's Orders, dated 12/29/22, documents Barrier Cream to buttocks BID (twice a day) for soiling. R2's Progress Notes, dated 12/29/2022 at 2:24 PM, document "POA (Power of Attorney), V6, here and looked at res wound. Indwelling catheter draining cloudy amber urine. Output of 900cc (cubic centimeters) at this time. (Indwelling) Catheter provided. Noted posterior penile shaft is split from chronic catheter. POA requested res be sent to Local Hospital ED (Emergency Department) for eval/tx (evaluation/treatment)." On 01/09/23 at 12:27 PM, V15 (LPN) said it started with R2 not being out of bed for breakfast. She stated she asked the CNA (V16) why R2 was still in bed. V15 said V16 told her R2 was only to be up out of bed for one meal because he had a wound on his bottom, and he chose lunch. V15 stated she asked V16 if they were doing any kind	S9999		

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of treatment for him because she didn't have a treatment ordered. She said V16 told her they were putting barrier cream on his bottom. V15 stated she wanted to look at R2's bottom, so she asked V16 to help her. V15 stated she went and got R2's medications ready and came back to R2's room. V16 was busy with someone else at this time so V15 said she gave R2 his medications, and after that, she helped R2 to turn on his side. V16 stated R2 was soiled, so she went and got V16 to help, and they cleaned R2 up. V15 stated "I was so angry at what I saw." V15 stated the wound had an appearance of a butterfly shape and deep purple in color. She said the CNA told her it had been red for a couple of weeks before this. V15 stated the center was yellow/tan in color with what appeared to slough/eschar. V15 stated there was open tissue around it, and it went down further on his right side, down towards his scrotum. V15 stated V16 said she worked on Sunday (12/25/22) and that was what R2's bottom looked like on Sunday.

On 01/03/23 at 10:31 AM, V6 (R2's POA) stated when R2 was admitted to the facility he did not have any pressure ulcers. She said R2 has been at the facility for a while (over a year). V6 said the facility called her about 2 to 3 weeks ago and told her R2 had 2 red areas noted to his bottom. V6 stated the nurse told her they were going to put some cream on the areas and keep him in bed longer and on his sides to keep him off his bottom a little more. V6 said last Wednesday, 12/28/22, R2 called her and said his butt hurt really bad. V6 stated she told R2 she would be up to see him the next day (which was Thursday 12/29/22) and she would look at it. She stated the nurse (V15) told her when she got to the facility R2's bottom was really bad. She said when she saw it, she couldn't believe it. V6 said no one at the facility

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S9999	Continued From page 10 had called her to inform her that the areas to R2's bottom had gotten worse. V6 said she talked with the DON (V2) and the DON told her (V6) that she worked the on the floor the previous Saturday to help out and she had seen R2's bottom. V6 said V2 stated she was going to have R2 seen by wound care the following day (which was Friday). V6 stated she told V2 that it would almost be a week since this was noticed, and he should have had something done sooner. V6 said that was when she told the facility she wanted R2 to be sent out to the hospital to be evaluated and treated. V6 said that R2 was admitted to the hospital, and he has an admitting diagnosis of Osteomyelitis. The Facility's Wound Summary Report dated 12/24/22 at 3:32 PM, documents R2 has excoriation to his sacrum (bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis), with the current size of 14.5cm x 11.2cm and with the healing status of declining. The Facility's Wound Summary Report, dated 12/29/22 at 9:01 AM, documents that R2 has an unspecified ulcer to his sacrum with a current size of 14.4cm x 11.2cm and a healing status of declining. R2's Hospital Emergency Department records, dated 12/29/22 at 4:23 PM, documents "Musculoskeletal: Comments: Large area of red excoriated skin throughout perineum, buttocks and lower scrotum- very weepy with clear drainage- appears bad candida rash that the skin appears wet and saturated and sloughing off- at lower sacrum/coccyx there is a 4cm circular ulcer with purulent drainage."	S9999		

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S9999	Continued From page 11 R2's Hospital Emergency Department records, dated 12/29/22 at 19:38 (7:38 PM), documents CT scan (Computed Tomography Scan) with contrast, Clinical impression: Acute Osteomyelitis (inflammation or swelling in the bone) of coccyx, sacral decubitus ulcer, stage IV (4), and candida skin infection. Npiap.com (National Pressure Injury Advisory Panel) documents a stage 4 Pressure Injury as "full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining, and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." R2's Hospital Emergency Department records, dated 12/29/22 at 11:17 PM, documents Assessment/Plan: Principle Problem: Acute Osteomyelitis of coccyx Acutely infected chronic sacral decubitus ulcer Plan: -general surgery consult - hold Eliquis as per surgeon for likely OR (Operating Room) in the upcoming days - IV (Intravenous) ABX (Antibiotics) - DVT (Deep Vein Thrombosis) prophylaxis Lovenox for now then switch back to Eliquis when okay with surgeon. Estimated LOS (length of stay) > (greater than) 2 midnights. MDM (medical decision making) complexity: High. On 01/04/23 at 10:32 AM, V5 (Emergency Department Registered Nurse/ED RN), stated R2	S9999		

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presented to their facility with wound infection and red area to buttocks. V5 said upon her assessment it was noted R2 had a significant area to his sacral area with green/yellow drainage noted. She said they did tests, and it showed the area to have Osteomyelitis. V5 stated R2 also had a pressure ulcer to his scrotal area. V5 stated, to her knowledge R2 did not have an order in place for the area to his bottom. V5 said R2 was admitted to the hospital with a diagnosis of Osteomyelitis.

On 01/05/23 at 12:40 PM, R2 stated he was not turned and repositioned every 2 hours while he was in bed, and he wasn't repositioned while he was up in his wheelchair. R2 said he would have let the staff turn and reposition him in bed and his chair at any time, and he stated he never refused to let them turn or reposition him. R2 stated he did not have any skin issues when he first arrived at the facility. R2 stated he started having issues about 6 months ago, and he let them know when he first started having the issues. R2 stated the facility didn't look at his bottom every day. He said they would put the cream on his bottom every time he went to the bathroom (was dirty), but they didn't do anything else for it. R2 stated he didn't know if the CNA's told the nurses about his bottom being sore.

On 01/04/23 at 1:40 PM, V7 (Registered Nurse/RN) stated she took care of R2 a couple of times since she started working at the facility. She said the first time she saw R2's buttocks, they were red and excoriated, and she felt like part of the wound was a little darker. V7 said they were applying cream to R2's buttocks at that time.

On 01/04/23 at 2:10 PM, V9 (Certified Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011340	A. BUILDING: _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVISTON COUNTRYSIDE MANOR	450 WEST 1ST STREET AVISTON, IL 62216

(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
S9999	Continued From page 13 Assistant/CNA) said the last time she seen R2's buttocks they were red and looked like some of the skin was peeling off. V9 said they were putting cream on his bottom. On 01/09/23 at 10:30 AM, V9 (CNA) stated she doesn't remember R2 having any open areas on his bottom, but she does remember a little bleeding when they had to clean him up. V9 stated she remembers R2 was sitting in his wheelchair, and she was pushing him out to the dining room, and R2 complained his bottom hurt. V9 stated she doesn't remember what day this was on, but it was recent. She said she doesn't think she reported it to the nurse because the nurses already knew about R2's bottom being sore. On 01/12/23 at 12:55 PM, V23 (Certified Nursing Assistant/CNA) said it was a time between 12/05/22 to 12/16/22 when R2's bottom opened up. She said she was the one that found it and she reported it to V13 (LPN). V23 stated when it first opened, it just looked like the first layer of skin had come off. She said V13 reported it to the doctor, and then she went on vacation and no one else did anything. She said it got worse about a week before he got sent out. She stated she had worked Christmas day, and when questioned if his bottom looked the same as the day he was sent to the hospital, V23, stated, "I believe so, yes." On 01/05/23 at 11:03 AM, V12 (Nurse Practitioner/NP), stated she received a fax on 12/15/22 in the evening or the early morning of 12/16/22 from the facility stating R2 had an open area on his scrotum, and excoriation and open area to his buttocks. V12 said the fax documented the nurse had applied cream to R2's	S9999		

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S9999	Continued From page 14 buttocks. V12 said she sent an order back to the facility, stating continue with barrier cream to area BID and PRN for soiling. Monitor for improvement, if no improvement or any worsening, update provider. V12 stated that she was never notified of any changes in R2's condition. She said she even came and saw R2 on 12/19/22 and no one mentioned anything to her about R2's condition. V12 stated if someone would have notified her of R2's buttocks had gotten worse, she would have ordered a consult with wound care. When V12 was questioned, could the outcome for R2 been different if she (V12) had been notified in R2's change of condition? V12, stated, "Potentially." On 01/12/23 at 2:55 PM, V19 (Wound Care Doctor) stated his methodology when it comes to assessing skin/wound issues of any kind would be where is the wound located, how long has the wound been there, the story behind the wound (he stated it will differ from patient to patient), he stated a good history will help the treatment plan, size of the wound, any odor, and is there any drainage. V19 stated if someone is excoriated, it doesn't change to a pressure ulcer overnight. V19 said if it is from moisture, it will usually have multiple spots, will be bright red, will sometimes bleed, and it will take a while for it to break down to a mild ulcer. V19 said they will use barrier cream, repositioning, and nutrition. V19 stated R2's condition could have potentially had a different outcome if the facility would have contacted him (V19), and it (wound) had been treated sooner. V19 stated he had treated him (R2) once and healed him. The Facility's Wound Management Program, revised date 02/26/2021, documents "Policy it is the policy of (Corporation) to manage resident	S9999		

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S9999	Continued From page 15 skin integrity through prevention, assessment, and implementation and evaluation of interventions. Procedure 1. The facility is provided with Wound care Protocols. There are to be utilized to assist in the care and treatment of wounds." It further documents "Physician orders should be obtained and followed for each resident." The policy further documents "3. Residents identified at risk on the Braden scale will have this addressed on their care plan and will have interventions put in place for preventative measure. Identifier will be assigned to resident room nameplate for risk assessment score. High risk or with a wound identified will have skin checks daily." It also documents "c. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it, Skin Tear Protocol (NUR1225) or New Skin Condition Protocol (NUR1230). Assessments for EHR (Electronic Health Record) are assigned." It further documents "f. The nurse will measure the area; call physician to obtain appropriate treatment order, call the guardian/family member to inform him/her, document the area on the T.A.R. (treatment administration record), and initiate the treatment." It also documents "15. Physician and guardian/family member are called after the weekly Wound Committee meeting with an update of the current wound condition. These calls are documented in the nursing notes." (A)	S9999		