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
	IL6003420	A. BUILDING: _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

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S 000	Initial Comments Complaint Investigation 2422073/IL170560	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)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. 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		

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

Electronically Signed | 04/12/24

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S9999	Continued From page 1 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: 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 interview and record review the facility failed to ensure physician ordered wound treatments and dressing changes were performed as ordered for 1 resident (R1) of 3 residents reviewed for wounds in a sample of 4. This failure resulted in R1 being admitted to the hospital for wound treatments. Findings include: The Nursing Services policy dated 9/27/17 documents, "It is the policy of (the facility) to	S9999		

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assure sufficient qualified nursing staff is available and on duty on a daily basis to provide nursing and related services to attain or maintain each resident highest practical physical, mental and psychosocial well-being based on the comprehensive assessment of the resident and consistent with the resident's preference, needs and choices." 2. "Treatments and procedures ordered by the physician shall be properly administered including enemas, irrigations, catheterizations, applications, application of dressings and/or bandages, diet supervision."

The Decubitus Care/Pressure Areas policy dated 1/2018 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 ulcer." 6) "Reevaluate the treatment for response at least every two (2) to four (4) weeks. Most pressure areas will respond to treatment in this amount of time. If no improvement is seen in this time frame, contact the physician for a new treatment order."

R1's Medical Records documents R1 was admitted to the facility on 8/21/23 with diagnosis Acute Infarction of Spinal Cord (Embolic) (Non embolic), Paraplegia, Monoplegia of Lower Limb Affecting Unspecified Side, Pressure Ulcer of Right Heel (Stage 4), Pressure Ulcer of Left Heel (Unstageable), Pressure Ulcer of Left Ankle (Unstageable), Pressure Ulcer of Other Site (Unstageable, Pressure Ulcer of Left Buttock (Stage 4), Pressure Ulcer of Right Buttock (Stage 4), Neuromuscular Dysfunction of Bladder, and Sepsis.

R1's Minimum Data Set/MDS assessment dated 3/5/24, documents R1 is a paraplegia with

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medically complex conditions. R1 has a BIMs (Brief Interview for Mental Status) of 15 (cognition intact). R1 is dependent for toileting, bed mobility, and most activities of daily living. R1 does not reject care. R1 has one stage 3 pressure ulcer, three stage 4 pressure ulcers, and three unstageable pressure ulcers. R1 did not have any of the wounds when R1 admitted to the facility. R1 has impairment on both sides of his lower extremity. R1 has an indwelling catheter and is always incontinent of bowel.

On 3/18/24 at 10:47 AM, V3 (Ombudsman) stated she had talked to the wound clinic and was told R1's wounds were dirty and smelled horrible.

On 3/18/24 at 11:03 AM, V4 (Ombudsman) stated on 3/15/24 V4 was told by R1 that R1 needed his dressing changed. V4 told a nurse (unknown) R1 wanted his dressing changed. It took over an hour to for the nurse to change R1's dressing. V4 said V4 heard the nurse say how bad it smelled.

On 3/20/24 at 10:53 AM, V5 (Wound Clinic Nurse) stated R1 was not having his wounds dressed as ordered. On 2/22/24 V5 talked to the facility about the dressing the clinic wanted the facility to use for R1's wounds. V5 was told, "That dressing is too expensive, and we will not be getting it." V5 told the facility the clinic would order a less expensive dressing to see if it would work but if it did not work the facility needed to get the (antimicrobial foam) dressing. V5 said when R1 came back to the clinic on 2/29/24 R1's wounds were not getting any better so V15 (Wound Doctor) ordered the (antimicrobial foam) dressing again. A sample of the (antimicrobial foam) dressing was sent with R1 to the facility so the facility could use until the facility could get the dressing ordered. V5 said no one from the facility

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called to say they were not going to order the new dressing. V5 said when R1 returned to the wound clinic on 3/13/24 R1's wounds were much worse. R1's wounds were larger and deteriorating. R1 told V5 the facility ran out the sample dressing and R1 is not sure the facility will get anymore. R1 told V5, V1 (AIT) is trying to get the correct dressing ordered.

On 3/20/24 at 11:00 AM, V15 (Wound Clinic Doctor) stated R1 is alert/oriented and a good historian of his treatments. V15 said, several times R1 has come to the wound clinic from facility with incorrect dressings in place. R1 told V15 the facility has a new administrator (V1) who is working on ordering the correct dressings. R1 told V15 the facility was having staffing issues so sometimes the dressings were not being changed. V15 stated the lack of appropriate dressings being in place has caused R1's wounds to worsen. V15 said on the 3/13/24 visit R1 continued to have the incorrect dressing on, and the wounds were noted to have a foul odor and large amounts of purulent drainage indicating infection. V15 advised R1 he needed to go to the hospital and be seen because V15 felt the wounds were worsening and appeared infected. V15 stated, "I feel (R1's) wounds have worsened as a result of incorrect dressings being in place from the facility. I don't understand why the facility would send (R1) to a wound clinic for an expert opinion and then not follow the treatment orders."

On 3/18/24 at 11:24 AM, V1 (Administrator in Training) stated R1 is in the hospital, and it has something to do with his wounds.

On 3/20/24 at 11:28 AM, V16 (Regional Director of Operations) was asked why R1 was not getting the dressing to his wounds as V15 (Wound

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S9999	Continued From page 5 Doctor) ordered. V16 stated, "The ball got dropped." On 3/19/24 at 12:30 PM, R1 stated the facility is not doing his dressing changes like they are supposed to do them. R1 must ask to have the dressings changed and if the nurses are busy the dressings are not changed. They are not using the right kind of dressing and it has caused R1's wounds to get worse. On 3/20/24 at 11:18 AM, V1 (Administrator in Training) stated whoever the nurse was working when R1 came back from the wound clinic should have put the new orders in. V19 (Previous Director of Nursing) was monitoring wounds and orders but V19 is no longer at the facility. On 3/20/24 at 11:30 am V17 (Licensed Practical Nurse) stated she has worked in facility for four days. V17 has observed V6 (RN) do R1s dressing change while she was in training. V17 stated V6 read the treatment came up on TAR and V6 packed the wound on R1's ischium with gauze which was soaked in solution she could not remember name of. V17 was asked if she had ever seen the (antimicrobial foam) dressing used on R1's ischium and V17 stated, "I have not seen kind of dressing here." R1's Physician Order for bilateral ischial wounds dated 2/8/24 at 4:49 PM, documents to cleanse with normal saline solution, pat dry. Apply (antimicrobial foam dressing), apply (non-adherent dressing) and cover with an abdominal pad. Cover with (clear adhesive to hold dressing in place). Change daily and as needed. R1's Nursing Note written by V19 (Previous	S9999		

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Director of Nursing) dated 2/9/24 at 11:47 AM, documents, "(R1) came back with orders are not able to attend. May continue with (topical antiseptic) solution until next visit."

R1's Nursing Note written by V19 dated 2/16/24 at 3:17 PM, documents, "New orders processed and reviewed. Call placed to wound clinic. (Antimicrobial foam dressing) is unavailable at this time as well as (biodegradable gel dressing). Orders received to continue with (topical antiseptic) at 0.5 % (percent) as well instead of 0.25%. Will continue with daily treatments." R1 agrees with current treatment plan.

R1's Wound Note dated 2/22/24 documents, "(R1) did not have correct dressing on both ischial sites or on lower legs upon arrival today. Facility did not have any (antimicrobial foam dressing) on those sites today. Leg dressings were dated 2/18/24 when they should be changed daily. Poor prognosis for healing especially with additional factors of non-adherence to wound center orders."

R1's Wound Clinic note dated 2/29/24 documents R1 is alert and oriented to person, place, and time. "(R1) did not have correct dressing on both ischial sites or on lower legs upon arrival today. Facility did not have any (antimicrobial foam) dressing on those sites today. (R1) advised correct dressings were not on his wounds today. (R1) states the facility has a new administrator will order the correct dressings. R1 advised regarding healing. Poor prognosis for healing especially with additional factor of nonadherence to wound center orders."

R1's Wound Orders dated 2/29/24 to bilateral ischial areas documents to pack wounds with

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S9999	Continued From page 7 (absorbent topical dressing), cover with (antimicrobial foam dressing), cover with (nonadherent dressing) and abdominal pad, and secure with (surgical tape). R1's Treatment Administration Record/TAR dated 3/1 - 3/31/24 documents, "bilateral ischium-(povidone iodine) to base. Apply (topical antiseptic) solution 0.5% (percent) cover with ABD (Abdominal) pad and secure with (surgical tape). The last treatment documented was on 3/17/24. The TAR was not signed the ischium treatments were done on 3/4, 3/7, 3/8, 3/12, 3/15, and 3/16/24. (There was not an order to pack wounds with absorbent topical dressing), cover with (antimicrobial foam dressing), cover with (nonadherent dressing) and abdominal pad, and secure with (surgical tape) on the TAR) R1's Wound Clinic Note dated 3/13/24 documents, "Left Ischial- Pressure ulcer stage 4 -base with pale granulation tissue. Moderate amount of yellow gray sloth at the base. Large foul-smelling drainage." Right Ischial -Pressure ulcer stage 4 - base with red granulation tissue at the base. Small amount of yellow sloth at the base. Small amount of exposed tendon and bone at the base. Moderate foul-smelling drainage." "Large amounts of foul-smelling drainage from both hip sites noted today. (R1) states the facility ran out of the (antimicrobial foam) dressing "a few days ago." Per RN, (R1) only had gauze packed into hip wounds. No (povidone iodine) dressing on lower extremities noted on arrival per RN. Unfortunately, wound center orders do not seem to be followed at the facility limiting options for healing. (R1) also has refused to consider negative pressure therapy in the past. (R1) has worsening infections of both hips." "(R1) advised to immediately present to the nearest emergency	S9999		

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S9999	Continued From page 8 room." R1's Wound Clinic Measurements dated 3/13/24, documents the left ischial wound edges are open. The wound bed "granulating, moist, slough, purple." Large amount of drainage. Drainage characteristics/odor "serous, creamy, purulent, yellow, malodorous." Wound length 4.6 cm/centimeters, wound width 5 cm, wound surface 23 square cm, tunneling depth 6.5 cm, undermining 6.2 cm. (Compared to) R1's Wound Clinic Measurements dated 12/21/23, documents the left ischial wound bed "red, slough." Moderate amount of drainage. Drainage characteristics/odor "serosanguineous." Wound length 4.5 cm/centimeters, wound width 4.5 cm, wound surface 20.25 square cm, no tunneling depth or undermining. R1's Wound Clinic Measurements dated 3/13/24, documents the right ischial wound edges are open. The wound bed "moist, slough." Large amount of drainage. Drainage characteristics/odor "malodorous, purulent, yellow, serous." Wound length 4.1 cm/centimeters, wound width 6.5 cm, wound depth 6.5 cm, wound surface 20.5 square cm, undermining 7 cm. (Compared to) R1's Wound Clinic Measurements dated 12/21/23, documents the right ischial wound edges are open. The wound bed "red, slough." Moderate amount of drainage. Drainage characteristics/odor "serosanguineous." Wound length 5 cm/centimeters, wound width 5 cm, wound depth 5.5 cm, wound surface 20.5 square cm, undermining 7 cm, no tunneling depth, or undermining. R1's Nursing Note dated 3/13/24 at 12:46 PM, documents R1 returned from the wound clinic	S9999		

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S9999	Continued From page 9 visit at 12:30 PM. R1 stated, "They want to add me to go to the hospital again for follow up." R1's Nursing Note dated 3/16/24 at 2:36 AM, documents R1 requested wound care be done on his buttock. More yellow exudates on the right wound, the left wound has reddened pinkish walls. "There was not a strong smell from the wound as compared from before. (R1) Expresses plans of going to the Hospital today." R1's Hospital Record dated 3/18/24 documents R1 presents to the hospital for a wound check. "Worsening buttock wound with purulent discharge." History "(R1) is an unfortunate 54-year-old male with past medical history significant for history of paraplegia with a history of chronic and multiple wounds including history of osteomyelitis with frequent admissions to the hospital. (R1) has been in a nursing home but apparently the correct wound dressing has not been applied and when the patient was last seen in the wound clinic on the 13th of this month (R1) had the wrong dressing on and was recommended to be hospitalized but at point of time (R1) would refuse." R1 was seen in the emergency room and his sacral and buttocks Decubitus appear to be worse with some purulent drainage and tunneling as well. Assessment and Plan "Probable Sepsis. Secondary to infected unstageable sacral/buttocks decub (Decubitus ulcer)." R1's Nursing Note (Late entry) dated 3/20/24 at 8:02 PM written by V29 (Registered Nurse), documents, "In report from AM (morning) nurse (V6/Registered Nurse) said the doctor had wanted (R1) to return to the hospital due to increased size of (R1's) ischium wounds. (V6) said administration was aware of this situation.	S9999		

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S9999	Continued From page 10 (V25/Agency Coordinator) and (V28/Regional Nurse) we're in the Director of Nursing office and we're aware of the situation as well. I (V29) had asked if administration needed called-but since the doctor had wanted (R1) to go to the hospital per (V6) it was assumed administration knew (R1) was going. (R1) had finally agreed to go to the hospital. (R1's) packing gauze length was increased 8 (eight) inches to each ischium wound to a total length used of approximate 21 inches length of each packing gauze. The ischium wounds also had increased tunneling and increased dark yellow exudate per (V6) in report. (R1) was aware his wounds may be getting bigger and (R1) wanted them treated before they had gotten worse." (R1 was sent to the hospital on 3/17/24). (A)	S9999		