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
	IL6010052	A. BUILDING: _____ B. WING _____	R 02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE OF LAKE COUNTY	850 E US HIGHWAY 45 MUNDELEIN, IL 60060

(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 First revisit to Annual Survey of 1/29/2024	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations 300.610a) 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 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}		

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{S9999}	Continued From page 1 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 Requirementsa were NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to identify a resident's (R113) pressure injury prior to the injury becoming unstageable. The facility failed to implement pressure injury interventions which resulted in R113 not being repositioned in bed and developing two (2) new pressure injuries. These failures apply to 2 of 3 residents (R113, R96) reviewed for pressure injuries in the sample of 13. The findings include: 1. R113's current care plan showed R113 was cognitively impaired related to his diagnosis of dementia. R113 was dependent on 1-2 staff for transferring, incontinence care, and bed mobility. R113 was incontinent of bowel. R113 was at risk for pressure injuries as his care plan showed he	{S9999}		

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was re-admitted to the facility, on 12/11/23, with a pressure injury to his right buttock/sacral area. The plan showed, "Encourage/assist resident with turning and repositioning every 2-3 hours... Use pillow/cushion between bony prominence's...Monitor skin when providing cares, notify nurse of any changes in skin appearance... " The plan showed R113 became hospice on 2/17/24.

R113's Wound Assessment Report dated 2/21/24 showed R113 had a Stage 3 pressure injury to his right buttock/sacral area measuring 8.5 centimeters (cm) x 5.0 cm x 4.5 cm. The report also showed, on 2/7/24, a new, facility-acquired, Stage 3 pressure injury was found on R113's left heel, measuring 2.5 cm x 4.0 cm x 0.1 cm. The report showed no documentation of any pressure injuries to R113's left buttock or scalp/head area.

On 2/26/24 at 10:30 AM, R113 was asleep in bed, lying on his back. Two (2), linear, purplish-red bruises, in a V-like formation, were noted to R113's scalp, directly behind his right ear. At 10:32 AM, V5 Certified Nursing Assistant (CNA) entered R113's room. R113 stated to this surveyor, "Did you see the right side of his head? He's got marks on his head. He didn't have them last week when I took care of him. When I came in earlier this morning, to help with his wound care, he was lying on his right side. You could tell he'd been lying like that (on his right side) for awhile because the skin on the right side of his body, like his right hip, was hard." When V5 was asked how often R113 was to be repositioned in bed, V5 stated, "He's supposed to be repositioned every 2-3 hours. I didn't work this weekend but we don't have enough staff to get things done so I'm not sure how often it got done (this weekend)." At 10:36 AM, V4 Wound Nurse

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entered R113's room. V4 stated to this surveyor, "I already did wound care on him today. We found two, new pressure injuries on him this morning. He has a new, unstageable pressure injury to his left buttock. He has a new DTI (deep tissue injury) to the right side of his head. When I saw him on Friday (2/23/24), he didn't have these two wounds. He only had the one on his sacrum/right buttock, that we have been treating. No one reported these new wounds to me. I happened to find them when I was doing wound care today. I looked at his progress notes from over the weekend. I don't see any documentation of any new skin issues." Dressings were intact to R113's sacral wound and left buttock wound. V4 Wound Nurse showed this surveyor a picture of R113's left buttock wound that he had taken that morning. The picture showed a large, black-purple wound to R113's left buttock with a large open area noted to the center of the wound. V4 stated, "(R113) just turned hospice a couple of weeks ago. This really isn't a wound that would develop, to this extent, overnight. It measures about 7.0 cm x 6.5 cm x 0.1. It's dark blackish in color." V4 stated R113's new wounds to the right side of his head were caused by pressure to that area.

On 2/26/24 at 11:34 AM, R113 remained asleep in bed, lying flat on his back. The right side of R113's head laid against a pillow.

On 2/26/24 at 12:32 PM, R113 was asleep in bed, lying on his back.

On 2/26/24 at 1:35 PM, R113 remained in the same position in bed; asleep, lying flat on his back.

On 2/26/24 at 12:22 PM, V9 Licensed Practical

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{S9999}	Continued From page 4 Nurse (LPN) stated he cared for R113 on 2/25/24. V9 stated he noticed R113 had "redness to both of his buttocks" while doing cares but he thought the redness to R113's left buttock was from the sacral wound R113 already had. V9 stated he did not notice any wounds or discolorations to R113's head. On 2/26/24 at 12:50 PM, V10 CNA stated she provided cares to R113 on 2/25/24. V10 stated she also noticed redness to R113's left buttock but thought the redness was caused by R113's sacral wound. V10 stated she did not report R113's left buttock redness to a nurse. When asked if she was able to reposition R113, every 2-3 hours, on 2/25/24, V10 stated, "Absolutely not. I haven't been able to get resident showers done let alone repositioning. We don't have enough staff. They decreased the number of CNA's, on our unit, 3-4 weeks ago because of census. (R113) needs two staff to do cares on him. He's completely dependent on us. There isn't enough hours in the day for me to get all of the cares done." On 2/26/24 at 11:55 AM, V8 Wound Physician stated, "I can't say exactly what caused (R113's) new wounds. I haven't seen them yet. (R113's) skin is very fragile and he's immobile. The DTI to his head was most likely caused by him laying on that area for too long. Since I haven't seen the new wound to his left buttock, I can't say how long or how quickly a wound like that could take to develop." V8 stated that even though R113 is hospice, staff should "attempt" to offload areas at risk for pressure as directed per R113's plan of care. On 2/26/24 at 2:24 PM, V4 Wound Nurse stated, "(R113) it totally dependent on staff for cares. For	{S9999}		

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{S9999}	Continued From page 5 sure, he would develop pressure injuries if he is not repositioned frequently. We still need to reposition him every 2-3 hours even though he's hospice." R113's progress notes dated 2/23/24-2/25/24 were reviewed and showed no documentation of any skin changes or new wounds to R113's left buttock or scalp. R113's Wound Assessment Report dated 2/26/24 showed two new pressure injuries were identified on R113. It showed a pressure injury, categorized as a DTI, was found on R113's right scalp/head. R113's scalp injury measured 2.5 cm x 4.0 cm x 0. An unstageable pressure injury was found to R113's left buttock that measured 7.0 cm x 6.5 cm x 0.1 cm. The facility's Skin Policy date May 2023 showed, "If the resident is determined to be at risk or has developed any skin integrity abnormalities, the nurse will implement action according to the specific skin issue identified per protocol including but not limited to: Preventing injury to the resident by maintaining and improving tissue tolerance to pressure in order to prevent injury... The nurse and the Interdisciplinary team will plan and implement preventive care to avoid complications resulting from a resident's inactivity including: Encouraging and assisting the resident to spend time out of bed, except when prohibited by a physician's order. Maintaining proper body position and alignment... If the resident has, on admission, or develops pressure sore(s), he/she will receive necessary and appropriate treatment and services to promote healing, prevent infection and prevent further development of additional skin integrity..."	{S9999}		

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{S9999}	Continued From page 6 2. R96's Minimum Data Set Assessment dated 2/15/24 shows that she is dependent on staff for personal hygiene, needs substantial/maximal assistance for rolling from left to right and is always incontinent of stool. R96's Braden Scale (Prediction of pressure ulcer risk assessment) dated 12/14/23 shows that she is at high risk for developing pressure ulcers. R96's Wound Assessment details report dated 2/7/24 shows that she had a facility acquired stage 3 pressure ulcer on her right inner thigh that healed on 2/7/24. On 2/26/24 at 11:55 AM, R96 was provided incontinence care by V11 (Certified Nursing Assistant). V11 removed an incontinence brief that had a moderate amount of dried stool present. V11 stated,"I think it was from last night." R96 had a large reddened and open area approximately 10 centimeters (cm) by 7 cm on her posterior upper thigh and a red and open area approximately 0.5 cm x 2.5 cm on her right buttock. On 2/26/24 at 11:55 AM, V11 said that she has not been in to provide care to R96 yet since her shift started (7:00 AM). V11 said that the areas on her buttock and thigh are new since the last time that she had provided care to R96. R96 said that she was last changed and repositioned at night time. On 2/26/24 at 2:14 PM, V4 (Wound Nurse) said that the two areas on R96's buttock and thigh are new. V4 said that they are most likely MASD (Moisture Associated Skin Damage) and shearing. V4 said that R96 has a history of pressure ulcers on her thighs and buttocks and	{S9999}		

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{S9999}	Continued From page 7 she just had a pressure ulcer on her right inner thigh that was healed a couple weeks ago V4 said that interventions that are put in place to help prevent pressure ulcers from developing include: repositioning her at least every two hours and keeping her clean and dry by providing incontinence care frequently. V4 said that R96 is incontinent and need to be changed as soon as she has a bowel movement. V4 said that due to R96 having MASD and shearing, it could lead to the development of a pressure ulcer if she is not repositioned and provided incontinence care every 2 hours. R96's Skin Integrity Care Plan shows that she is at risk for alterations in skin integrity related to decreased mobility, bowel incontinence and a history of pressure ulcers. Interventions in place include: Assist to turn and reposition every two hours and as needed, check and change every 2 hours and as needed and keep skin free of moisture; promote clean and dry condition. (B)	{S9999}		