Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUINCY HEALTHCARE & SR LIVING	1440 NORTH 10TH STREET , QUINCY, Illinois, 62301

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S0000	Initial Comments Annual Licensure Survey	S0000		07/25/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3)6) 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. 300.1210. General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active	S9999		07/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and provide necessary treatment and services to promote healing and prevent worsening of pressure injuries, assess and document wound conditions, perform weekly wound assessments with measurements, notify the physician of wound progression, administer the correct treatment per the physician's order, and failed to properly apply a wound vacuum for three of four residents (R26, R53 and R62) reviewed for pressure ulcers. These failures resulted in R26, R53 and R62, experiencing deterioration of their pressure injuries without timely or appropriate clinical response. Findings include:	S9999		

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S9999	Continued from page 2 The facility's Pressure Injuries Overview policy dated 3/2020 documents "Pressure ulcers/injuries occur because of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. "Avoidable" means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed: Monitoring or evaluation of the impact of the interventions; or Revision of the interventions as appropriate." 1.) R53's current care plan dated 01/15/25 documents R53 has redness to the coccyx, a stasis ulcer to the left chin, and a scabbed area on the right great toe. Despite this, R53 was assessed as low risk for skin breakdown, and the care plan was not updated to reflect increased risk or wound progression. R53's Physician Orders document a hydrocolloid dressing was ordered on 05/01/25 for coccyx redness. R53's electronic medical record does not contain documentation of weekly skin assessments or measurements to R53's coccyx. R53's Bath Skin Assessment dated 06/15/25 documents "small pinhole open areas" on the coccyx. R53's electronic medical chart does not contain documentation of an assessment to R53's coccyx on or after 6/15/25. R53's Minimum Data Set (MDS) dated 4/23/25 documents R53 is cognitively impaired. On 07/09/25 at 09:28 AM, V4 (Registered Nurse) assessed R53's coccyx as red, macerated, and open, identifying it as a Stage 2 pressure ulcer. V4 stated that weekly wound monitoring was not being conducted and that V6 (Nurse Practitioner) had not been notified. V4 applied an absorbent foam dressing, which was not the dressing ordered by V6. On 07/09/25 at 10:32 AM, V6 confirmed by assessment that R53 had a Stage 2 pressure ulcer and that the incorrect dressing had been applied. V6 stated the wound progression was not reported, and that V6 was unaware of the development of the Stage 2 ulcer. V6	S9999		

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S9999	Continued from page 3 added that weekly monitoring and provider notification should have occurred, and that V6's office had no documentation of the ulcer. On 7/9/25 at 1:00 PM, V3 (Infection Preventionist) stated V3 was not aware of R53's Stage two pressure ulcer on her coccyx. V3 stated the staff should have been doing a weekly skin assessment on R53. 2. R62's Current Care Plan, dated 7/9/2025, documents, "I require extensive assistance from 2 staff member to move about in bed, I require assistance with my ADL's (Activities of Daily Living). I am at risk for loss of movement in my joints due to dementia, general weakness." The Facility Wound Log dated 6/5/2025 documents, "(R62) Right Buttock." The Facility Weekly Wound Tracking Log dated 7/8/2025 documents, "(R62) stage four, location, right buttock." On 7/8/25 at 2:15 PM, V10 (Wound Nurse Practitioner) stated "This facility needs lots of training on wound vacuums. The facility should not accept new residents with wound vacuums until they have received training." V10 stated "Two residents seen today for wound services both have had their wound vacuums applied incorrectly, which then caused worsening of the wounds and further skin breakdown." V10 stated that the foam which was to be inserted in the wound bed was touching healthy skin, this caused the peri wound to worsen and be macerated. V10 further stated "(R62's) wound looks worse than last week because the foam to R62's wound bed was touching the peri wound and the outer skin, the foam has caused the skin surrounding the wound bed to become macerated." On 7/8/25 at 2:25 PM V3 (Infection Preventionist) stated "There was no drape applied to R62's skin surrounding her wound bed and the foam which was inserted in the wound bed was touching healthy skin and caused the skin surrounding the wound bed to be redder and more excoriated." V3 stated "The wound vacuum was not applied per the physician's order which caused the wound to worsen." On 7/9/2025 V3 (Infection Preventionist) stated "Weekly skin assessments, documenting wound conditions and	S9999		

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S9999	Continued from page 4 measurements, and notifying the physician of wound progression was not done or documentation was not found prior to June of 2025 for R62." 3. R26's Current Care Plan, dated 7/9/2025, documents, "I am at high risk for skin breakdown. I require limited/extensive assistance from one staff member/ two staff members to move about in bed." The Facility Wound Log dated 6/5/2025 documents, "(R26) left lateral leg, right lateral leg, left medial leg, right medial leg, right upper buttock, intragluteal left middle, right buttock." On 7/9/2025 V3 (Infection Preventionist) stated "Weekly skin assessments, documenting wound conditions and measurements, and notifying the physician of wound progression was not done or documentation was not found prior to June of 2025 for R26." (B)	S9999		