

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003420	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2014
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE REHAB & HC	STREET ADDRESS, CITY, STATE, ZIP CODE 5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Based on observation, interview, and record review, the facility failed to monitor and implement interventions to promote the healing of pressure ulcers and prevent development of new pressure ulcers for two residents (R8 and R17) reviewed for pressure ulcers. This failure resulted in R17 developing two Stage II pressure ulcers, one of which worsened from a Stage II to a Stage IV, and R8 developing an avoidable Stage II pressure ulcer.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. R17's medical record documents R17's current diagnoses of Osteoporosis, Congestive Heart Failure, Hypertension, and Depression. R17's MDS (Minimum Data Set) Assessment, dated 6/11/14, documents R17 requires extensive assist of two for bed mobility and extensive assist of one for transfers and ADL's (Activities of Daily Living). R17's Braden Skin Assessment, dated 5/14/14, documents a Braden score of 16 (high risk). <p>On 7-14-14 at 2:15 pm, during wound care R17 was observed with a large area to the left and right coccyx approximately 10 cm x 10 cm, grayish in color with a thick flap of skin and obvious tunneling. The area to the coccyx had a strong odor and there was a small open area to both R17's right and left heels.</p> <p>A facility Pressure Ulcer Report, dated 6/3/14, documents a facility-acquired Stage II pressure ulcer to R17's left and right coccyx. According to the report, the wound was first observed on 5/28/14 measuring 4.0 cm x 5.0 cm. A facility Pressure Ulcer Report, dated 6/29/14, documents R17's wound to the coccyx measured 8.0 m x 9.0 cm, Stage II. The report also documents a newly acquired Stage II pressure</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>ulcer to R17's left heel, along with a stage II pressure ulcer to the right heel, which was present upon admission.</p> <p>The facility's Pressure Sore Prevention guidelines Policy dated 11/12, documents, "To provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale. Intervention: Turning and positioning may be more often than every two hours for high risk if indicated. Special Mattress with specification of type of mattress on the care plan, and Care Plan Entry: Skin risk and appropriate interventions are to be placed on the Care Plan. If despite interventions a Pressure ulcer develops, the care plan must reflect updated interventions for healing of ulcers and additional interventions for further prevention of pressure ulcers."</p> <p>The facility's Decubitus Care/Pressure Areas Policy dated 05/07 documents under Procedure: " 1) Upon notification of skin breakdown, a Newly Acquired Skin Condition report will be completed and forwarded to the Director of Nurses. 3) Completed all areas of the TAR (Treatment Administration Record) i) document size, stage, site, depth, drainage, color, odor, and treatment. 5) Documentation of the pressure area must occur upon identification and at least once each week on the TAR. The assessment must include: i) Characteristic, treatment and response to treatment. 6) Reevaluate the treatment for response at least every two to four weeks. Most pressure areas will respond to treatment in this amount time. If no improvement is seen in this time frame, contact the physician for a new treatment order. 8) Initiate problem on care plan.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>R17's Plan of Care dated 6/3/14, failed to document the development of pressure ulcers and implement interventions to prevent R17's coccyx wound from worsening.</p> <p>R17's medical record does not document any changes in the characteristics or the treatment to R17's coccyx from the date it was acquired at a Stage II and now at a Stage IV.</p> <p>On 7-15-14 at 12:11 pm, E4 (CPC/Care Plan Coordinator) stated, "(E3) normally puts wounds on the care plan along with new interventions. (E3) did not realize they were not on for R17 until now."</p> <p>On 7-15-14 at 12:20 pm, E2(DON/Director of Nursing) during interview verified no documentation has been done regarding pressure ulcers in the nursing notes or R17's medical record. E2 also verified the physician should be notified in two weeks if there is no improvement in any wounds, and the care plans for R17 should have addressed the pressure wounds and new interventions. E2 stated, "R17's coccyx pressure wound worsened since there were no interventions in place and the facility can not produce a turning and positioning log.</p> <p>On 7/15/14 at 8:45 am, R17 was sitting in the wheelchair in R17's room, leaning to the left side. No one entered R17's room until 9:30 am at which time R17 was pushed to therapy. R17 was still observed leaning to the left side in the wheelchair while in therapy, only swinging his legs in therapy. R17 was then pushed to the dining room, still leaning to the left side. At 1:00 pm that day, R17 was pushed to R17's room and left in the wheelchair still leaning to the left side.</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>On 7/15/14 at 1:50 pm, R9 and R10 both R17's (CNA's/Certified Nursing Assistants) verified they did not put R17 to bed, toilet or reposition R17 and verified R17 had been in the wheelchair the entire shift.</p> <p>On 7-15-14 at 2:15 pm, E5 (Medical Director) verified R17's wound to the coccyx has worsened from a Stage II to a Stage IV, and R17 also has Stage II pressure ulcers to both heels. E5 also verified if interventions were put in place the wounds could have been avoided and not progressed to a worse stage.</p> <p>2. R8's Treatment Administration Record, dated 07/01/14-07/31/14, indicates a four centimeter by one centimeter by 0.8 centimeter wound to coccyx.</p> <p>On 07/15/14 at 10:50 am, E8, Licensed Practical Nurse (LPN), performed wound care to R8's coccyx wound and observed a new pressure ulcer one by one centimeter in diameter on labia. Area is open and red with a small amount of bloody drainage.</p> <p>On 07/15/14 at 10:50 am, E8 verified that R8 did not have the wound on the labia yesterday. E8 also verified that this wound is a Stage II.</p> <p>(B)</p>	S9999		