STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145445	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL	623 HAMACHER STREET WATERLOO, IL 62298

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Subpart U: Validation Survey	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the Facility to provide pressure relieving interventions to prevent the formation of a pressure ulcer for one of six residents (R11) reviewed for pressure ulcers in the sample of 24. Findings include: The Braden Scale For Prediction of Pressure Sore Risk, dated 7/25/2014, documents R11 is at risk for the development of pressure ulcers. The Braden Scale documents R11 is chairfast, non-weight bearing, slightly limited with mobility, requires moderate to maximum assist in moving and requires frequent repositioning with maximum assist. The Weekly Pressure Ulcer Log, dated 7/20/2014 to 7/26/2104 documents R11 has a facility	F 314		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	Continued From page 1 acquired DTI (deep tissue injury) to the left heel, measuring 4.5 cm (centimeter) X 5.5 cm. On 7/29/2104 at 1:30 PM, R11 was in a wheelchair with his feet resting on the foot pedals. A padded board was behind his lower legs. R11 was wearing knee high, elastic compression stockings to both lower extremities, without shoes. On 7/30/2104 at 8:55 AM, R1 was up in his wheelchair wearing the compression stockings to both lower extremities without shoes. R1's heels were resting directly in the 45 degree angle between the foot pedals and the leg board. Pressure relieving boots were on R11's bed. On 7/30/2104 at 10:07, R11 was transferred with a mechanical lift to bed by E5 and E7, Certified Nurses Aides (CNA). At that time, E5 reported R11's feet and heels had no open or red areas. After completion of care, E5 applied the heel protectors to both feet, and reported they are only applied to R11 when in bed. On 7/30/2014 at 12:55 PM, R11 was seated in his wheelchair with the compression stockings to both legs and no shoes. R11 was rubbing his heels up and down against the padded leg board. On 7/30/2014, at 1:10 PM, E6, Licensed Practical Nurse, (LPN) was interviewed about R11's heels. E6 stated, "I'm not sure why (R11) has a pressure ulcer to the heel. The left heel is dark, like a bruise, but not open. The right heel is okay. I did the skin assessment when he was admitted, and his heels were rough, but intact." The Progress Note dated 7/27/2014 at 9:09 PM,	F 314		

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F 314	Continued From page 2	F 314		

documents, in part, "(R11) does complain of pain with (compression stocking) removal noted on left heel. A 4.5 X 5.5 (cm) dark red/purplish soft area to left heel, feet elevated on pillows and heel protectors applied. New orders for (protective barrier wipe) every shift."

R11's Care Plan dated 7/25/2014, documents, in part, "Risk for impaired skin integrity related to weakness and impaired bed mobility", with an approach documented to start 7/25/2014, "Turn and reposition as needed to prevent prolonged pressure over bony prominences." There is no pressure relieving intervention or approach in the Care Plan to address R11's feet until 7/28/2014 with the application of the protective barrier wipe to bilateral heels every shift.

ON 7/31/2014, at 1:30 PM, E2, Director of Nursing (DON) was interviewed about R11's unstageable DTI to the left heel. E2 reported R11 did not have the DTI on admission, and had only been wearing the heel protectors while in bed. E2 reported (R11) puts pressure on his heels while in the wheelchair.

The Facility's policy and procedure, dated 1/2010, documents in part, "Intact, healthy skin is the body's first line of defense. It is the policy of this facility to monitor the skin integrity for signs of injury and irritation. In addition to ongoing assessment of the skin, the facility will implement measures to protect the resident's skin integrity and prevent skin breakdown."