| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145239 | A. Building<br>B. Wing | 03/21/2024 |

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| Cornerstone Rehab & Hc | 5533 North Galena Road<br>Peoria Heights, IL 61614 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875<br><br>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.<br><br>Findings include:<br><br>The Nursing Services policy dated 9/27/17 documents, It is the policy of (the facility) to 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.<br><br>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.<br><br>R1's Medical Records documents R1 was admitted to the facility on [DATE] 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.<br><br>R1's Minimum Data Set/MDS assessment dated [DATE], documents R1 is a paraplegia with 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.<br><br>(continued on next page) |

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.

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

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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 Doctor) ordered. V16 stated, The ball got dropped.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>R1's Nursing Note written by V19 (Previous 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.<br><br>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.<br><br>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.<br><br>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.<br><br>R1's Wound Orders dated 2/29/24 to bilateral ischial areas documents to pack wounds with (absorbent topical dressing), cover with (antimicrobial foam dressing), cover with (nonadherent dressing) and abdominal pad, and secure with (surgical tape).<br><br>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)<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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 room .<br><br>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.<br><br>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.<br><br>R1's Nursing Note dated 3/13/24 at 12:46 PM, documents R1 returned from the wound clinic visit at 12:30 PM. R1 stated, They want to add me to go to the hospital again for follow up.<br><br>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.<br><br>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 [AGE] 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).<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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. (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). |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875<br><br>Based on interview and record review, the facility failed to provide incontinent care for 4 residents (R1, R2, R3, R4) reviewed for incontinent care in a sample of four.<br><br>Findings Include:<br><br>The Perennial Cleansing policy dated 12/2017 documents, To eliminate odor; to prevent irritation or infection and to enhance residents' self-esteem.<br><br>The Certified Nurse's Aide policy not dated documents the CNA job summary, Working under the direction of the staff nurses, the Certified Nurse's Aide (CNA) provides personal care and assistance to residents to assure their safety and comfort. Carries out basic hygiene measures including but not limited to the following: grooming, shaving, applying makeup, oral hygiene/dental care, cuts/cleans nails, fingers and toes, foot care, skin care, bathing/showering and cleaning incontinent residence.<br><br>On 3/18/24 at 10:47 AM, V3 (Ombudsman) stated that on 3/4/24, R3 called at 8:00 AM and said he was wet and had not been changed since night shift. V3 called V4 (Ombudsman) and asked V4 to go to the facility to check on the residents. Around 9:30 AM, R3 called V3 again and said R3 still had not been changed. V3 called the facility and told the facility receptionist V3 was not going to hang up until someone went to change R3. There was only one CNA for the whole building on day shift and management was working the floor. V3 has talked to management many times and they keeps making promises of what the facility is going to do but it is not getting done.<br><br>On 3/18/24 at 11:03 AM, V4 (Ombudsman) stated on 3/4/24 she got a call from V3 (Ombudsman) asking V4 to go to the facility to check on the residents. V3 had got a call from R3 stating he was incontinent and needed changed. R3 had the call light on when V4 got to R3's room at 9:30 AM. R3 said the light had been on for a long time, and he had not been changed since the night shift left. V4 went to R1's room which had the call light on. R1 wanted to have a nurse look at his dressing. While V4 was talking to R1 she noticed R2 (R1's roommate) was wet. R2's (disposable brief) was engorged with urine. R2 said he would like to be changed but no one had come to answer the call light and change him. R2 said R2 hated to complain because he did not want to make anyone mad at him. V4 walked the halls looking for a nurse to look at R1's dressing and a CNA to change R2 and R3. V4 found a CNA (unknown) making a bed and asked her to help R2 and R3. The CNA had an attitude and acted like making the bed was more important than changing the residents. It was 10:30 AM before R3 got changed. V4 found V1 (AIT) working the floor as a CNA. V4 stated, I walked the halls and there was only one CNA I could find. I know it was at least 30 minutes after I got to the facility before R2 was changed. I have no idea how long R2 had been waiting. V4 told V1 of her concerns about the care of the residents.<br><br>On 3/19/24 at 1:00 PM, V11 (CNA) stated, We come to work in the morning and residents are soaked or soiled and we have to change them.<br><br>On 3/19/24 at 1:30 PM, V10 (CNA) stated, Residents are not being toileted and changed.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. R1's Medical Records documents R1 was admitted to the facility on [DATE] with a diagnosis which includes 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<br><br>R1's Minimum Data Set/MDS assessment dated [DATE], documents R1 is a paraplegia with 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.<br><br>On 3/19/24 at 12:30 PM, R1 stated incontinent care is not done when needed. R1 is incontinent of bowel, and it is not good on his wounds to not get changed when needed.<br><br>2. R2's Medical Records documents R2 was admitted to the facility on [DATE] with a diagnosis of Cellulitis, Inflammatory Disorders of Scrotum, Unspecified Open Wound, Left Lower Leg, Subsequent Encounter, Unspecified Open Wound, Right Lower Leg, Subsequent Encounter, Non-Rheumatic Mitral Valve Insufficiency, and Vitamin D Deficiency.<br><br>R2's Minimum Data Set/MDS assessment dated [DATE], documents R2 has a BIMs (Brief Interview for Mental Status) of 15 (cognition intact). R2 requires clean up assistance for toileting. R2 is occasionally incontinent of bowel and bladder.<br><br>On 3/18/24 at 10:40 AM, R2 stated it takes staff a long time to answer call lights when R2 needs changed.<br><br>3. R3's Medical Records documents R3 was admitted to the facility on [DATE] with a diagnosis of Unspecified Sequel of Cerebral Infarction, Other Enthesopathy of Left Foot and Ankle, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Other Intravertebral Disc Degeneration, Lumbar Region, Essential (Primary) Hypertension, Abdominal Aortic Aneurysm, without Rupture, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Cervicalgia, Cellulitis of Left Lower Limb, Cellulitis of Right Lower Limb.<br><br>R3's Minimum Data Set/MDS assessment dated [DATE], documents R3 has a BIMs (Brief Interview for Mental Status) of 15 (cognition intact). R3 is dependent for toileting, bed mobility, and most activities of daily living. R3 is always incontinent of urine and frequently incontinent of bowel.<br><br>On 3/18/24 at 10:00 am R3 stated, They don't change us and don't get us out of bed. At bedtime they only have one CNA and we lay in feces for hours.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. R4's Medical Records documents R4 was admitted to the facility on [DATE] with a diagnosis of Peripheral Vascular Disease, Diabetes Mellitus due to Underlying Condition with Hyperosmolality without Nonketotic Hypercalcemic-Hyperosmolar Coma, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Atherosclerosis of Native Arteries of Extremities with Intermittent Claudication, Chronic Respiratory Failure, Venous Insufficiency, Chronic Diastolic (Congestive) Heart Failure, and Chronic Atrial Fibrillation.<br><br>R4's Minimum Data Set/MDS assessment dated [DATE], documents R4 has a BIMs (Brief Interview for Mental Status) of 15 (cognition intact). R4 is dependent for toileting, bed mobility, and most activities of daily living. R4 is always incontinent of urine and frequently incontinent of bowel.<br><br>On 3/20/24 at 1:00 PM R4 stated the facility has staffing issues on all shifts. Incontinent care is not done when it is needed. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875<br><br>Based on interview, and record review, the facility failed to provide required staff to assist and monitor residents during breakfast, failure to answer call lights timely, and failure to provide incontinent care for dependent residents. This failure has the potential to affect all 55 residents residing in the facility.<br><br>Findings include:<br><br>The Nurse Staffing policy (not dated) documents, It is the policy of (the facility) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by (the state agency). Each skilled care resident shall receive at least 3.8 hours of nursing and personal care each day and 2.5 hours of nursing and personal care each day for a resident needing intermediate care.<br><br>The facility's Facility assessment dated [DATE], documents the average daily census is 55 residents. It does not include staffing requirements necessary to meet the needs of the resident based on the resident population and census.<br><br>On 3/18/24 at 10:00 am R3 stated that on 3/4/24 he did not get out of bed until the afternoon, however, was unable to recall exact time. The facility does not have enough staff to take care of the residents. R3 turns on his call light for help and nobody answers it. R3 also stated, They don't change us and don't get us out of bed. At bedtime they only have one CNA and we lay in feces for hours.<br><br>On 3/18/24 at 10:40 AM, R2 stated the facility is short staffed most of the time. It takes a long time to be able to get out of bed in the morning and get dressed for breakfast. R2 does not remember the date but one day last week R2 did not get breakfast until 10:00 AM due to staff not getting him up. It takes staff a long time to answer call lights when R2 needs changed.<br><br>On 3/19/24 at 12:30 PM, R1 stated that there is not enough staff and incontinent care is not done when needed. R1 is incontinent of bowel, and it is not good on his wounds to not get changed when needed.<br><br>On 3/20/24 at 1:00 PM R4 stated the facility has staffing issues on all shifts. Incontinent care is not done when it is needed.<br><br>On 3/18/24 at 10:47 AM, V3 (Ombudsman) stated that on 3/4/24, R3 called at 8:00 AM and said he was wet and had not been changed since night shift. Around 9:30 AM, R3 called V3 again and said R3 still had not been changed. V3 called the facility and told the facility receptionist that V3 was not going to hang up until someone went to change R3. V3 stated that residents were complaining they were three hours late getting breakfast because staff were not getting them to the dining room. There was only one CNA for the whole building on day shift and management was working the floor.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145239 | A. Building<br>B. Wing | 03/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cornerstone Rehab & Hc | 5533 North Galena Road<br>Peoria Heights, IL 61614 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 3/18/24 at 11:03 AM, V4 (Ombudsman) stated V4 got to the facility at 9:20 AM on 3/4/24 and a resident in the dining room yelled and asked if V4 was a nurse because they wanted to eat. The were several residents sitting in the dining room waiting on their breakfast. V4 asked kitchen staff (unknown) why the residents were not eating breakfast and was told they could not serve the food until there was a CNA in the dining room to monitor the residents. V4 went to find V1 so the residents could get fed. V1 was working the floor as a CNA. V4 told V1 the residents were not being fed. V4 then went to check on R3 and he was still in bed and had not had breakfast. V4 saw R1's light on and R1 and R2 (R1's roommate) were both still in bed and they both said they had not had breakfast yet. V4 also stated that on 3/4/24 she got a call from V3 (Ombudsman) asking V4 to go to the facility to check on the residents. V3 had got a call from R3 stating he was incontinent and needed changed. R3 had the call light on when V4 got to R3's room at 9:30 AM and R3 said that the light had been on for a long time, and he had not been changed since the night shift left. V4 then went to R1's room that had the call light on. R1 wanted to have a nurse look at his dressing. While V4 was talking to R1 she noticed that R2 (R1's roommate) was wet. R2's (disposable brief) was engorged with urine. R2 said he would like to be changed but no one had come to answer the call light and change him. R2 said R2 hated to complain because he did not want to make anyone mad at him. V4 walked the halls looking for a nurse to look at R1's dressing and a CNA to change R2 and R3. V4 found a CNA (unknown) making a bed and asked her to help R2 and R3. The CNA had an attitude and acted like making the bed was more important than changing the residents. It was 10:30 AM before R3 got changed. V4 found V1(AIT) working the floor as a CNA. V4 stated, I walked the halls and there was only one CNA that I could find. I know that it was at least 30 minutes after I got to the facility before R2 was changed. I have no idea how long R2 had been waiting. V4 told V1(AIT) of her concerns about the care of the residents.<br><br>On 3/18/24 at 12:49 PM, V2 (Dietary Manager) stated if a resident gets their food late it is because the facility is short staffed. Sometimes the CNAs are running behind bringing residents to the dining room. Normally the CNA's serve the meals.<br><br>On 3/19/24 at 1:00 PM, V11 (CNA) stated regarding staffing in the facility, There are not many of us. V11 stated, We come to work in the morning and residents are soaked or soiled and we have to change them.<br><br>On 3/19/24 at 1:30 PM, V10 (CNA) stated there is not enough staff on any shift. It is normal to come in and be the only CNA in the building. The staff do what they want and come to work and leave as they please. V10 stated, Residents are not being toileted and changed.<br><br>On 3/20/24 at 9:59 AM, V14 (Resident Care Coordinator) stated she started at the facility on 3/4/24. V14 stated V14 got to the facility at 9:00 AM, and it was chaos. The management team were working the floor and V14 was told to start working the floor. V14 said it was so chaotic that several residents were still in bed, call lights were on and residents needed to be gotten up for breakfast. V14 took over staffing on 3/11/24. V14 said V14 was not shown how to figure what the staffing needs were and not given any tools to use. V14 was told to staff six CNAs on days, five CNAs on evenings and four CNAs on nights. V14 said when V14 took over the staffing the daily schedule would not have all the positions covered. There were blank spaces on the sheet where a name should be. The shortage of staff was not from call offs it was because staff were not scheduled.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 3/20/24 at 1:00 PM V18 (R4's Family Member) was at the facility visiting R4. V18 stated R4 often waits hours with her call light on before she gets assistance. V18 often comes to the facility and can hear his mom screaming for help from the desk. V18 stated the facility has staffing issues often on all shifts. V18 has come to the facility, and they only have two CNAs working in the building.<br><br>On 3/21/24 at 10:44 AM, V1 stated it's hard for her to say who or how many staff were working on 3/4/24 because there were so many changes with staffing the first week of March. V1 was shown the daily staffing sheet for 3/4/24 and she could not say who was working. V1 stated, I am not sure who was at the facility on 3/4/24 but I can't believe there was only one CNA. It is hard because we are using so much agency. The first week of March was complicated because V19 (Previous Director of Nursing) had left the facility and she was doing the schedule. Our goal is to be at six CNAs on days, five CNAs on evenings and four CNAs on nights.<br><br>On 3/21/24 at 1:58 PM, V16 (Regional Director of Operations) stated that she was unaware the Facility Assessment needed to specify the number of staff required to care for the residents. V16 thought since the Facility Assessment documents the facility staffing is based on the Staffing Calculator that was all that was needed.<br><br>The Daily Staffing Calculations were compared to the Daily Punches from 3/1/24 to 3/20/24. During that time the census ranged from 59 residents to 54 residents. The total number of hours needed for non-nursing staff ranged from 111.60 hours daily to 102.23 hours. The actual hours worked ranged from 35.10 hours to 94.01 hours.<br><br>On 3/4/24 (the day of the complaint) there were 59 residents, a need of 111.60 hours of non-nursing care, and documented punch hours worked as 31.27 hours. There were an additional 16 hours of CNA coverage documented from an agency. The documented CNA hours are as follows; (days) V23 (CNA) 6:19 AM- 7:15 AM, V21 (CNA) 7:47 AM - 8:42 PM, V22 (CNA) 11:00 AM - 1:00 PM, (evenings) V22 (CNA) 2:00 PM-10:00 PM, (nights) V30 (CNA) 10:00 PM -6:25 AM, V31 (Agency CNA) 10:00 PM - 6:00 AM, and V32 (Agency CNA) 9:52 PM - 6:00 AM.<br><br>The Long-Term Care Facility Application for Medicare and Medicaid dated 3/21/24 documents 55 residents reside in the facility. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875<br><br>Based on interview and record review the facility failed to complete their facility assessment to include the staffing requirements needed to care for the resident population and census. This failure has the potential to affect all 55 residents residing in the facility.<br><br>Findings include:<br><br>The facility's Facility assessment dated [DATE], documents the average daily census is 55 residents. It does not include staffing requirements necessary to meet the needs of the resident based on the resident population and census.<br><br>On 3/20/24 at 9:59 AM, V14 (Resident Care Coordinator/Licensed Practical Nurse) stated that she took over staffing on 3/11/24. V14 said V14 was not shown how to figure what the staffing needs were and not given any tools to use. V14 was told to staff six Certified Nursing Assistants/CNAs on days, five CNAs on evenings and four CNAs on nights.<br><br>On 3/21/24 at 9:50 AM, V1 (Administrator in Training) stated she does not know if there is a Facility Assessment that documents how the facility should staff.<br><br>On 3/21/24 at 1:58 PM, V16 (Regional Director of Operations) stated she was unaware the Facility Assessment needed to specify the number of staff required to care for the residents. V16 thought since the Facility Assessment documents the facility staffing is based on the Staffing Calculator that was all that was needed.<br><br>The Long-Term Care Facility Application for Medicare and Medicaid dated 3/21/24 documents 55 residents reside in the facility. |