STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fondulac Rehabilitation & Hcc	901 Illini Drive East Peoria, IL 61611

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30678 Based on interview and record review, the facility failed to ensure resident safety prior to repositioning for one of three residents (R1) reviewed for incidents and accidents in the sample of three. This failure resulted in R1 sustaining a deep leg laceration requiring a hospital visit, receiving 13 stitches, and antibiotic treatment. Findings include: The facility's Skin condition Monitoring policy and procedure, dated 1/18, documents It is the policy of this facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. 1. Upon notification of a skin lesion, wound, or other skin abnormality, the Nurse will assess and document the findings in the nurses' notes and complete the QA (Quality Assurance) form for Newly Acquired Skin condition . 3. Any skin abnormality will have a specific treatment order until area is resolved . 4. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: c. Prevention techniques that are in use for the resident. The Residents' Rights for People in Long-Term Care Facilities, dated 1/18, documents Your rights to safety includes the following: The facility must provide services to keep your physical and mental health at their highest practical levels and Your facility must be safe, clean, comfortable and homelike. The undated Certified Nurses Aide/CNA Job Summary documents CNAs provide personal care and assistance to residents to assure their safety and comfort and demonstrates support of the philosophy of (the facility) by adhering to policies, procedures, and established Standards of Nursing Practices. The Clinical Medical Record for R1 documents R1 with the following diagnoses: Chronic Obstructive Pulmonary Disease, Emphysema, Dysphagia, Scoliosis, Osteoporosis, Abnormal Posture, and Muscle Wasting. The Nurse Progress Note for R1, dated 2/4/25 at 6:44 am, documents nurse was notified of R1 with leg injury and noted R1 with deep tissue skin tear. CNA reported R1 was injured during transfer from bed to the chair and was sent to the local hospital. (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 0689 Level of Harm - Actual harm Residents Affected - Few	The Skin Tear report for R1, dated 2/4/25, documents Nurse was notified by V6 CNA that R1's leg was injured with deep tissue skin tear to her right lower leg, No injuries observed at the time of incident, and was sent to the local hospital for evaluation. The local hospital record for R1, dated 2/4/25, documents the reason for R1's visit as Laceration of right lower extremity, initial encounter. Primary Dx (diagnosis): Leg pain, anterior right with laceration repair. The Medication Administration Record documents R1 received the pain medication Norco 7.5-325 mg (milligrams) one time at 8:44 am and lidocaine-Epinephrine 1% 10 ml (milliliters) was injected one time on 2/4/25 at 10:03 am. An x-ray of R1's right tibia and fibula was obtained on 2/4/25 at 9:02 am and findings as: Laceration related soft tissue changes are seen overlying the mid anterior tibia. R1 was treated for a laceration of right lower extremity. The current Order Summary Report for R1, documents a 2/5/25 physician order for Cephalexin (antibiotic) 500 mg (milligrams) one capsule four times daily for leg wound. The Infection Progress Note for R1, dated 2/4/25, documents R1 to receive Keflex 500 mg (milligrams) one capsule four times daily for 7 days for leg wound. The Nursing Progress Note for R1, dated 2/4/25 at 1:47 pm, documents R1 returned from the local hospital with 10.5 cm (centimeter) deep tissue laceration with 13 stitches to R1's right leg mid-calf. The Nursing Progress Note for R1, dated 2/4/25 at 8:09 pm, documents New order for Abt (antibiotic) d/t (due to) laceration on LLE (left lower extremity). The current Care Plan for R1, documents 2/4/25 Laceration to right lower extremity with intervention to monitor for s/s of infection and on 2/10/25 exchange bed frame. The Incident Progress Note for R1, dated 2/10/25, documents After investigation it was determined that the skin tear/laceration occurred while CNA was titling (reclining wheelchair) back due to restlessness. (R1) put her leg over side of chair and received a 10.5 cm (centimeter) laceration to right lower extremity from bottom edge of bed requiring 13 stitches. Intervention: replace bed frame, terminate CNA (V6), and monitor s/s (signs and symptoms) of infection. The facility Investigation for R1's incident, dated 2/4/25, documents V5 CNA assisted V6 Former CNA to mechanically transfer R1 from her bed to a reclining back wheelchair and left R1 in her room. V5 reported there were no injuries at the time of the transfer. Shortly after V6 saw R1, in her room, attempting to get out of the wheelchair. V6 reported R1's leg got stuck under edge of bed as V6 was tipping R1's reclining wheelchair backward. V4 RN (Registered Nurse) was notified and assessed R1 with a large bleeding wound on lower anterior and lateral aspect of right lower leg. V3 ADON (Assistant Director of Nursing) reported assessed R1's leg and noted a large skin tear to anterior/lateral aspect of distal right leg. V6 Former CNA reported to V3 ADON that R1 was attempting to get out of the reclining wheelchair, so V6 Former CNA attempted to recline R1 back and R1's leg hit the lower edge of the bed causing the skin tear. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility Final Notification Form for R1, dated 2/10/25, documents R1 received a laceration to right lower leg, was sent to the local hospital. After investigation it was determined that skin tear/laceration occurred while CNA (V6) was tilting (reclining) chair back due to restlessness. (R1) put her leg over side of chair and received a 10.5 cm (centimeter) laceration to right lower extremity from bottom edge of bed requiring 13 stitches. Intervention: Replaced bed frame, terminated CNA and monitor for s/s (signs and symptoms) of infection. The Incident Log dated 3/20/25 documents R1 with skin tear on 2/4/25. On 3/20/25 at 11:00 am. V1 AIT (Administrator in Training) stated R1 required help for everything, was not cognitively intact, and did not move around on her own. V6 Former CNA was moving R1's wheelchair and caught R1's leg on a bolt on the bend of the bed causing a skin tear to R1's leg. R1 was sent out to the hospital and came back with stitches. On 3/21/25 at 12:12 pm, V3 ADON (Assistant Director of Nursing) stated she was called down to R1's room to assess R1's right leg due to the nurses doing shift change report and noted a deep open wound bleeding wound to R1's right leg and a small amount of blood on R1's bed frame. V6 reported (V6) reclined R1's wheelchair and R1's right leg hit the lower edge of the bed frame causing the skin tear. V3 ADON confirmed V6 should have looked to see where R1's legs were prior to moving R1's wheelchair and that V6 was terminated for sleeping on third shift and causing the skin care. On 3/21/25 at 12:20 pm, V5 CNA stated she helped V6 mechanically lift R1 from her bed into her wheelchair, there were no injuries during that time, and then V5 left R1's room. V5 stated she didn't see R1's wound until R1 returned from the hospital. It was a pretty large skin tear that was stitched back up. On 3/21/25 at 3:30 pm, V1 AIT stated V6 should have looked to see where R1's legs were prior to moving R1 and V6 was terminated after working that shift for poor work performance and sleeping on the job. V1 stated the facility does not have a QA form for Newly Acquired Skin condition for R1 due to no longer using the form.