

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/10/2025
NAME OF PROVIDER OR SUPPLIER  Sullivan Healthcare & Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  11 Hawthorne Lane Sullivan, IL 61951	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</b></p> <p>Based on observation, interview and record review the facility failed to assess, monitor, and notify physician to obtain treatment orders timely and failed to implement care plan interventions for one (R2) resident's documented open buttock wounds out of three residents reviewed for incontinence care in a sample list of seven residents. This failure resulted in R2's reddened bilateral buttock areas to deteriorate to open wounds.</p> <p>Findings include:</p> <p>R2's undated Face Sheet documents medical diagnoses of Quadriplegia, Diabetes Mellitus Type II, Spinal Stenosis, Arthrodesis, Cervicalgia, Obesity, Radiculopathy Cervical Region, Sensorineural Hearing Loss, Neuropathy, Retention of Urine, Depression, Syndrome of Inappropriate secretion of Antidiuretic Hormone and Anxiety.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 as moderately cognitively impaired. This same MDS documents R2 depends on staff for all cares including toileting, bed mobility, transfers, showering and personal hygiene.</p> <p>R2's Care plan intervention dated 10/4/24 instructs staff to place an incontinence brief on R2 when up and to check incontinence brief every two hours and change as needed.</p> <p>On 1/9/25 at 11:30 AM R2 was laying on his back in his recliner chair in his room. No staff present in room.</p> <p>On 1/9/25 at 1:50 PM V5, V9, V10 Certified Nurse Aides (CNA) transferred R2 from his recliner chair to his bed using a total body mechanical lift and then provided incontinence care. V5 CNA cross contaminated R2's open wounds on bilateral buttocks with the soiled towel used to provide bowel incontinence care for R2 by wiping directly over R2's open wounds. R2's bilateral buttocks had nickel sized open, dark red areas with dark purple peri wounds.</p> <p>On 1/9/25 at 2:05 PM V5 Certified Nurse Aide (CNA) stated cross contaminating R2's wounds could cause an infection. V5 stated V5 started work at 8:00 AM, was assigned to R2 and had not been in R2's room at all on her shift. V5 CNA stated V5 thought V9 CNA had been in R2's room to offer to help him to turn/position and provide incontinence care.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/9/25 at 2:15 PM V9 CNA stated V9 got R2 up for the day at 7:30 AM and had not been in R2's room since V9 got R2 up. V9 CNA stated V9 was assigned to R2's hall but not directly to R2. V9 CNA stated V5 CNA was assigned to R2 and should have helped R2.</p> <p>On 1/9/25 at 3:10 PM V2 Director of Nurses (DON) stated sometimes R2 does refuse turning/positioning and incontinence care but R2 would not have the opportunity to refuse if the staff don't ask him. V2 DON stated the staff should be asking R2 if he would like to be turned/positioned and provided incontinence care at least every two hours. V2 DON stated R2 has an indwelling urinary catheter but should still be assisted every two hours and as needed with incontinence care. V2 DON stated R2 has had open areas on his buttocks in the past, so it is very important to keep R2 repositioned, clean and dry. V2 DON stated cross contaminating R2's wound during incontinence care could cause an infection of R2's wounds. V2 DON stated V2 is unable to find a policy for turning/positioning and cross contaminating wounds. V2 DON stated the staff are expected to turn/position incontinent residents every two hours and maintain a clean field when providing incontinence care to protect any wounds in that area.</p> <p>On 1/10/25 at 11:50 AM V8 Registered Nurse (RN) stated V8 visualized R2's bilateral buttocks on 12/24/24 after V15 Certified Nurse Aide (CNA) brought her the shower sheet. V8 stated V8 visualized R2's buttocks while R2 was laying on his back on a shower bed. V8 RN stated R2's bilateral buttocks had reddened areas but from what V8 could see, she did not see any open areas. V8 RN stated she should have notified V11 Physician for a treatment order, documented R2's newly acquired areas and documented a full assessment of R2's bilateral buttocks skin evaluation but did not.</p> <p>On 1/10/25 at 1:50 PM V7 Certified Nurse Aide (CNA) stated V7 replaced R2's mattress with a newer one due to R2 complained that R2 could feel a metal bar on his buttocks when he was in bed. V7 CNA stated R2's mattress needed replaced badly due to the middle of it being caved in.</p> <p>On 1/10/25 at 1:55 PM V7 CNA showed R2's previous pressure reducing mattress had a large two feet by two feet area in the middle that was extremely caved in. A side view of R2's previous mattress showed that R2's mattress was not in a straight line, but the middle section was so bowed, it showed through the opposite side of the mattress.</p> <p>On 1/10/25 at 3:00 PM V3 Wound LPN stated R2 has a history of having open sores on his buttocks that open and close. V3 stated R2's shower sheets dated 12/24 and 12/27 both document open sores on R2's bilateral buttocks. V3 Wound Nurse/LPN stated R2's bilateral buttock wounds were either closed reddened areas on 12/24/24 and deteriorated to being open by 12/31/24 or R2's buttock wounds were open on 12/24/24. V3 stated R2 did not get treatment orders, V11, V12 Physicians were not notified so nothing got done with R2's wounds, R2's wounds were not measured, assessed or monitored and R2's care plan was not updated with any new interventions on 12/24/24. V3 stated V11 Wound Physician rounds every Thursday but due to the holidays, V11 did not round for those two weeks. V3 stated the facility should assess, which includes measuring and describing a resident's wounds, weekly. V3 stated R2 was never put on the list for residents for V3 to review weekly. V3 Wound Nurse/LPN stated V8 Registered Nurse (RN) reported on 1/10/25 that V8 did visualize R2's buttock wounds on 12/24/24 and said they were reddened areas. V3 stated there is no documentation of this and due to the lack of monitoring, there is no way to know if R2's wounds were closed. V3 Wound Nurse/LPN stated the only information has about R2's buttock wounds is from the shower sheets which document R2's wounds as being open. V3 Wound Nurse/LPN stated V3 did review the shower sheets dated 12/24/24 and 12/27/24 but did not follow up with the nursing staff or visualize R2's bilateral buttock wounds until 12/31/24.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41970</p> <p>Based on observation, interview and record review the facility failed to prevent cross contamination during incontinence care and failed to provide timely incontinence care for one (R2) out of three residents reviewed for timeliness of incontinence cares in a sample list of seven residents.</p> <p>Findings include:</p> <p>R2's undated Face Sheet documents medical diagnoses of Quadriplegia, Diabetes Mellitus Type II, Spinal Stenosis, Arthrodesis, Cervicalgia, Obesity, Radiculopathy Cervical Region, Sensorineural Hearing Loss, Neuropathy, Retention of Urine, Depression, Syndrome of Inappropriate secretion of Antidiuretic Hormone and Anxiety.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 as moderately cognitively impaired. This same MDS documents R2 depends on staff for all cares including toileting, bed mobility, transfers, showering and personal hygiene.</p> <p>R2's Care plan intervention dated 10/4/24 instructs staff to place an incontinence brief on R2 when up and to check incontinence brief every two hours and change as needed.</p> <p>On 1/9/25 at 11:30 AM R2 was laying on his back in his recliner chair in his room. No staff present in room.</p> <p>On 1/9/25 at 1:50 PM V5, V9, V10 Certified Nurse Aides (CNA) transferred R2 from his recliner chair to his bed using a total body mechanical lift and then provided incontinence care. V5 CNA cross contaminated R2's open wounds on bilateral buttocks with the soiled towel used to provide bowel incontinence care for R2 by wiping directly over R2's open wounds. R2's bilateral buttocks had nickel sized open, dark red areas with dark purple peri wounds.</p> <p>On 1/9/25 at 2:05 PM V5 Certified Nurse Aide (CNA) stated cross contaminating R2's wounds could cause an infection. V5 stated V5 started work at 8:00 AM, was assigned to R2 and had not been in R2's room at all on her shift. V5 CNA stated V5 thought V9 CNA had been in R2's room to offer to help R2 to turn/position and provide incontinence care.</p> <p>On 1/9/25 at 2:15 PM V9 CNA stated V9 got R2 up for the day at 7:30 AM and had not been in R2's room since V9 got R2 up. V9 CNA stated V9 was assigned to R2's hall but not directly to R2. V9 CNA stated V5 CNA was assigned to R2 and should have helped R2.</p> <p>(continued on next page)</p>		

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