STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	01/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomington Rehabilitation & Hcc	1925 South Main Street Bloomington, IL 61701

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34048 Based on observation, interview and record review the facility failed to implement pressure ulcer risk assessments and failed to use an aseptic technique during wound care for one of one residents (R4) reviewed for pressure ulcers in a sample of five. Findings include: The facility's Wound Program Guideline, undated, documents that upon admission a full body skin check should be completed, along with a Braden (pressure ulcer risk assessment), and Nutritional assessment. (Pressure Ulcer Risk) assessments would be completed with the first four weeks of tracking. A wound assessment along with a skin assessment should be completed. The facility's Competency Assessment Wound Care policy, revised 2010, documents The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. 1) Use a disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place items to used during procedure the clean field. 2) Wash and dry your hands thoroughly. 3) Position resident and place a disposable cloth next to resident (under the wound) to serve as a barrier to protect the be linen and other body sites. 4) Put on exam gloves, loosen tape and remove dressing. 5) Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6) Put on gloves. Gowns will be necessary if soiling of your skin or clothing with blood is likely. 7) Use a no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers .10) Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11) Place one gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 12) Remove dry gauze. Apply treatments as indicated. R4's TAR (Treatment Administration Record), dated 12/1/24 through 12/31/24, documents daily skin checks. R4's TAR documents that R4's daily skin checks were done on 12/2/24, 12/7/24, 12/8/24, 12/26/24, 12/30/24 and 12/31/24. The rest of the month there is no documentation that R4's skin assessments were conducted. R4's wound care TAR could not be located for the month of December 2024. R4's TAR, dated 1/1/25 through 1/25/25, documents to do skin checks weekly based on (Pressure Ulcer Skin Assessment) every day shift on Thursdays. R4's skin checks were not signed out as being done on 1/2/25, 1/9/25 and 1/23/25. R4's wound care is not signed out as being completed on 1/6/25, 1/9/25, 1/10/25, 1/17/25 and 1/22/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomington Rehabilitation & Hcc	1925 South Main Street Bloomington, IL 61701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Wound Assessment and Plan, dated 1/14/25, documents to cleanse the base of R4's left great toe and mid inner foot, apply a knitted mesh with medicated honey and cover the wound. Cleanse R4's left heel pressure ulcer, left inner lower leg and right heel with normal saline or sterile water, apply a medicated dressing to the wound bed, then cover with an abdominal pad and gauze wrap. Change dressings daily and as needed. On 1/24/25 at 1:10pm, R4 was in bed lying on his left side. R4's bed was in the lowest position. R4's sheets had several bright red bloody spots noted. V6, Licensed Practical Nurse, applied gloves and removed R4's dressing, dated 1/23/25, from his left foot. V6 was bending over the bed, attempting to look at R4's wounds, with her hair falling on the bed. V6 cleansed R4's heel with wound cleanser, then set it back down on the bed. V6 cleansed the entire area around the wound and the wound with the same gauze. V6 removed her gloves and applied clean ones. V6 then cleaned R4's left inner ankle with betadine, then set his foot back on the bed. V6 squeezed out the medicated honey onto her gloved finger then applied it to R4's heel. V6 did not cover R4's heel with medicated dressing. V6 also applied the medicated honey to R4's left ankle wound wound with the same gloved hand that touched the heel wound. V6 then changed her gloves and cleansed the wound to R4's left great toe. V6 rubbed the medicated honey on the wound with her gloved fingers. V6 rubbed the medication over the packing that still remained inside of the wound. V6 then removed the packing and again rubbed the medicated honey onto the wound with her gloved fingers. V6 applied the medicated dressing and covered the wound. V6 changed her gloves and removed the dressing from R4's right foot. V6 cleansed R4's heel wound with wound cleanser, then set his heel back onto the bed. V6 then applied the medicated honey to her gloved fingers and rubbed it onto the wound. V6 then applied the medicated dressing and covered the wound. On 1/24/25 at 2:00pm, V6 verified that she did not perform hand hygiene during R4's wound care. V6 also stated that she should not have set R4's clean wounds on the bed, or put the medicated creams on with her fingers. V6 stated that she did not have R4's orders with her in the room, so she is unsure if she did all the wound care according to his orders. On 1/25/25 at 10:00am, V3, Assistant Director of Nursing/Infection Preventionist, stated that V6 should have either washed her hands or used hand sanitizer during R4's wound care. V3 stated that hand hygiene should be done when going from a soiled area to a clean area. V3 also verified that V6 should have had her hair pulled back and not falling onto R4's soiled sheets. V3 stated that R4's December 2024 TARS can not be located. V3 also stated that she went through R4's medical record and could not find his skin assessments or his pressure ulcer risk assessments. V3 stated that is a treatment is not signed out, then it is assumed that the treatment was not done as ordered. V3 verified that Pressure Ulcer Skin Assessments are to be completed on admission and quarterly. V3 stated that if a resident is a high risk for pressure ulcers, then a daily skin assessment is to be completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34048 Based on observation, interview and record review the facility failed to follow Enhanced Barrier Precautions while performing wound care for one of two residents (R4) reviewed for Enhance Barrier Precautions in a sample of five. Findings include: The facility's Enhance Barrier Precautions policy, revised 4/22/24, documents that EBP (Enhanced Barrier Precautions) expand the use of PPE (Personal Protective Equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities to transfer of MDRO's (multi-drug resistant organism) to staff hands and clothing. This form also documents that the use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for resident with MDRO infection or colonization. On 1/24/25 at 9:30am, there was an isolation cart containing PPE outside of R4's room. There was an enhanced barrier sign on the door, indicating to wear gowns, gloves and masks during high contact care. On 1/24/25 at 1:10pm, V6, Licensed Practical Nurse, entered R4's room to perform wound care. V6 donned gloves and removed R4 soiled dressing from his bilateral lower extremities. The dressings contained a serosanguineous drainage. V6 then continued to complete R4's wound care. V6 did not don a gown or mask while performing high contact care. On 1/24/25 at 2:00pm, V6 verified that she did not don the appropriate PPE during wound care on R4. V6 stated that all she put on was her gloves and not a gown. On 1/25/25 at 9:00am, V3, Infection Preventionist, verified that V6 should have donned full PPE when doing wound care on R4.