STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131 Based on interview and record review, the facility failed to fully assess and complete a skin inspection assessment upon admission, obtain initial treatment orders upon admission, perform daily skin checks, and provide weekly documentation assessments for one (R1) of three residents reviewed for pressure ulcer/skin conditions in a sample of three. Findings include: R1's medical record documents he was admitted to the facility on [DATE] and discharged from the facility on 4/11/25. R1's medical record documents the following diagnoses: Gangrene of right leg with right above the knee amputation, Rhabdomyolysis (breakdown of muscle tissue), Diabetes, and Muscle Wasting. R1's Braden Score, dated 3/25/25, documents R1 is at high risk for pressure ulcers. R1's Admission note, dated 3/25/25, documents Sacrum open area noted upon admission. R1's current care plan for the facility documents (R1) admitted to the facility with an open area to his sacrum. admitted with a Stage three pressure injury to the coccyx. R1's Minimum Data Set/MDS, dated [DATE], documents R1 is not cognitively intact, requires substantial/maximum assistance of two people for activities of daily living, uses a wheelchair, is frequently incontinent of bowels, at risk for pressure ulcers, and has a surgical wound. R1's Skin Inspection/Nursing Weekly Assessment ordered every Tuesday in the afternoon, with an order date of 3/25/2025, documents on 4/1/25 and 4/8/25 the skin inspection/nursing weekly assessment was signed off by the nurses on R1's TAR/Treatment Administration Record, but R1's medical record has no documentation on R1's pressure ulcer to his coccyx. (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's skin and wound note, dated 4/8/25 at 3:05PM by V10 NP/Nurse Practitioner, documents the following: Reason for visit: New admission to the facility, skin/wound assessment. His medical history includes the following: Type 2 Diabetes Mellitus/DM, Chronic Anemia, Smoking, Peripheral Artery Disease/PAD, and Atrial Fibrillation/Afib where these co-morbidities could delay wound healing. Patient also seen today for a stage three pressure ulcer to his coccyx that was present on admission. SKIN: History of a chronic wound to coccyx; Primary Etiology: Pressure Ulcer/Injury; Stage/Severity: Stage 3; Wound Status: Present on Admission; Size: 3 cm/centimeters x 2 cm x 0.2 cm. Calculated area is 6 sq/square cm. Wound Base: 0% epithelial, 100% granulation, 0% slough; Exposed Tissues: Epithelium, Dermis, Subcutaneous; Wound Edges: Attached; Peri-wound: Intact; Treatment Recommendations: 1. Cleanse with wound cleanser, 2. apply Hydrocolloid to base of the wound, 3. change PRN/as needed, and three times per week. R1's medical record has an order, dated 4/9/25, for the following: Wound. Coccyx. Cleanse with wound cleanser. Pat dry. Apply Hydrocolloid three times a week and PRN/as needed every night shift on Tuesday, Thursday, and Saturday. On 4/30/25 at 1:16PM, V2 DON/Director of Nursing verified R1's medical record documents R1 has an open area to his coccyx upon admission (3/25/25), and on 4/9/25 (14 days after admission) the facility obtained orders for R1's stage three pressure ulcer to his coccyx. V2 also verified there was no further documentation or orders in R1's medical record regarding any treatment to R1's pressure ulcer to his coccyx prior to 4/9/25; no completed skin inspection assessment upon admission (3/25/25); no daily skin checks; and no weekly documentation on R1's pressure ulcer was in his medical record. On 4/30/25 at 2:30PM, V1 Administrator stated, We missed it (R1's pressure ulcer) upon admission, (R1) did not have wound orders when he admitted , and we did not get wound orders until 4/9/25 when (V10 NP) saw (R1). Facility Pressure Ulcer policy, revised 8/31/23, documents When a pressure ulcer is identified, whether in-house or upon a resident's admission, the area will be assessed, a skin inspection assessment shall be completed, and initial treatment orders started per physician orders. Daily skin checks shall be initiated on residents with a pressure wound to provide increased monitoring from nursing staff. Resident may be referred to wound physician for evaluation and treatment. Physician order for treatment will include: Specific site, Type of treatment, and how often treatment is to be completed. Documentation of the pressure ulcer must occur upon identification and at least once a week and as needed until healed. Assessment is to include: Characteristics: (size, depth, color, drainage); presence of granulation tissue, necrotic tissue; treatment; prevention (turning and repositioning, skin care, protective devices); and update physician and resident/Power of Attorney.