STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/23/2024
NAME OF PROVIDER OR SUPPLIER Dixon Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Division Street Dixon, IL 61021	

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 - 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** 35119 Based on observation, interview, and record review the facility failed to prevent pressure injuries for residents at risk for pressure, failed to initiate treatment orders when pressure injury was found, failed to monitor a pressure injury for signs and symptoms of infection for 2 of 4 residents (R1, R3) for pressure in the sample of 4. This failure resulted in R1 developing a Stage 3 pressure injury to her right heel that became infected and R3 developing two Stage 2 pressure injuries to his sacrum. The findings include: 1. R1's Nursing Admission data collection dated 10/3/24 shows R1 was admitted on [DATE] due to hysterectomy with bladder sling, no impaired skin integrity, abdominal area has 3 small incision sites. On 11/23/24 at 8:47 AM, R1 was sitting up in a wheelchair at the dining room table eating breakfast. R1 had heel protective boots on both feet and a mechanical lift sling underneath her. R1 said she was doing ok and had the boots on because her foot hurt her. On 11/23/24 at 9:20 AM, V3 Registered Nurse was in R1's room, just finishing wrapping R1's heel with a gauze dressing. V3 said R1 has an unstageable pressure wound to her right heel. V3 said the wound started off as a deep tissue injury and then the area turned black and fell off. V3 said it got infected and R1 was put on antibiotics. V3 said now it is a large area on her heel with white and yellow slough and R1 is seeing the wound doctor now. V3 said when R1 was admitted she was able to stand and pivot and now R1 is transferred with a mechanical lift because she is unable to bear weight on the right foot. V3 said R1 is alert and oriented to self, place, but has some developmental delays so it takes a little bit for her to make her needs known. On 11/23/24 at 10:06 AM, V2 Director of Nursing said she is the acting wound nurse right now. V2 said R1 was sent to see a wound doctor at the local hospital when her wound started getting worse and was looking visibly bigger. V2 said not all residents with pressure injuries see the wound doctor only those whose wounds that the medical doctor think needs more care. V2 could not recall if R1's wound became infected. On 11/23/24 at 11:30 AM, R1 was in bed with heel boots in place. R1 said her foot hurt a little right now, but not like it did at first. R1 said she doesn't like to have a sore foot. (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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(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 - Actual harm Residents Affected - Few	On 11/23/24 at 12:34 PM, V2 said a Certified Nursing Assistant mentioned to her that R1 had something on her heel and the nurse on duty did a change in condition report (SBAR). V2 said when she first assessed R1's wound on 10/19/24 (during the weekly pressure ulcer assessments), it was a dark brown/purple area to the right heel and was not open at the time. V2 said she notified the doctor and got orders for treatment. V2 said she was not aware of any changes to R3's wound until 11/11/24. V2 said when she assessed R1's wound on 11/11/24 she noticed the wound was worse, and had opened up at one end with yellow slough and clear yellow drainage. V2 said she did not notice an odor. V2 said she saw R1's wound before V6 Nurse Practitioner (NP) saw R1 on 11/11/24. V2 said V6 saw R1 and ordered antibiotics for the wound and to see the wound doctor. V2 said R1 was seen by the wound doctor at the local hospital on 11/18/24. On 11/23/24 at 1:40 PM, this surveyor with V2 observed R1's wound. R1 had a large irregular open wound with depth. R1's wound was almost R1's entire heal approximately 2 x 4 centimeter and had depth. R1's wound contained yellow slough and this surveyor could smell a foul odor through a surgical mask. V2 completed wound care and applied the treatment to R1's wound. R1 said several times that her foot hurts a little bit. R1's SBAR dated 10/19/24 at 2:35 PM shows open area to right outer aspect of heel. This form does not contain measurements or a description of the wound. The facility's Weekly Pressure Ulcer Report for R1 dated 10/21/24 shows first observation, facility acquired stage 1, right heel, 1.5 x 1.5 x 0.0 centimeters, with treatment orders betadine and foam dressing daily 10/22/23. This document does not contain a description of the wound. R1's Physician Orders shows treatment orders for R1's right inner heel were ordered on 10/22/24 (3 days after wound was found). The facility's Weekly Pressure Ulcer Report for R1 dated 10/28/24 and 11/4/24 shows no change in status, with no description of wound. R1's Skin Check Weekly report dated 10/17/24 shows no new changes this week. with no description of the wound. R1's Physician Communication Form dated 11/10/24 shows Nurse to Provider Communication: Please look at right heel- it is getting worse, foul odor, moderate amount of drainage; and NP/Doctor Response/Orders/Follow Up: 11/11/24- Get R1 into hospital wound care please (re :heel wound-right), Bactrim Ds twice daily for 7 days (heel wound), until seen by wound doctor , cleanse right heel wound with wound cleanser-gently scrub to remove drainage-apply an antibiotic/collagen product and cover with foam dressing. Change dressing every 3 days or if dressing comes off. Foam dressing needs to be securely taped around wound, Keep bilateral heels off bed or any pressure. The facility's Weekly Pressure Ulcer Report for R1 dated 11/11/24 shows Status-Worsened, right heel unstageable, 1.8 x 4.2 x 0.2 centimeters, moderate exudate, no odor. The facility's Weekly Pressure Ulcer Report for R1 dated 11/18/24 shows Status-Worsened, right heel unstageable, 2.0 x 4.0 x 0.3 centimeters, moderate exudate, mild odor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's NP Progress Note dated 11/11/24 shows right heel pressure ulcer with foul odor and moderate amount of drainage. Will get her into local Hospital Wound Care as she does need debridement. She does have bilateral heel pads on however she still needs these heels offloaded. Discussed plan of care with nursing staff, they verbalized understanding. R1's Hospital Wound Care Visit Report dated 11/18/24 shows new patient presents to the clinic today after developing a pressure wound after having surgery and being in a nursing care facility. Patient is currently at local nursing care facility, developed a wound a little over a week ago on the posterior aspect of the right heel. Right heel wound is a chronic stage 3 pressure injury. Initial wound encounter measurements are 3.19 x 3.76 x 0.1 cm depth. Necrotic adipose tissue is exposed. There is a large amount of serosanguineous drainage noted which has a mild odor. The patient reports a pain level of 5/10. The wound margin in irregular, wound bed has no-granulation, yes-slough. Advised patient to off-load foot ulcer. Expected duration of skilled wound care therapy 1-3 months. On 11/23/24 at 1:00 PM, V6 NP was called and a message left. There was no return call. 2. On 11/23/24 at 9:35 AM, V4 Certified Nursing Assistant had just finished providing incontinence care for R3. V4 said R3 has a pressure injury on his left hip and a patch on his shoulder but she didn't think he had any other wounds. V4 said R3's bottom was red but there was no open areas that she had seen during care. V4 rolled R3 to his side, and lowered his brief. R3's sacral area was visibly red and there were two small openings on his sacrum area. V4 said R3 should be turned and repositioned every 2 hours and she had not reported R3's redness to his bottom or applied any cream. V4 said she was not sure how long R3's bottom had been red. V5 LPN came into the room and assisted to hold R3. V3 LPN came in and assessed and measured the openings. V4 said both wounds are Stage 2 pressure injuries since the wounds are open. V4 said the lower opening on R3's sacrum measured 1 x 0.4 cm and the upper wound measured 0.5 x 0.2 cm. V4 cleaned both wounds and applied a dressing. V5 said she would notify the doctor and get treatment orders. On 11/23/24 at 12:34 PM, V2 said R3 openings on his sacrum are new, he had nothing there previously. V2 said R3 is at risk for pressure and has pressure reducing interventions of low air loss mattress and wheelchair cushion, float heels, and turn and reposition every 2 hours to reduce pressure. V2 said if R3 had redness to his bottom, cream should be applied. V2 said she was aware that R3 had been having some loose stools which could cause breakdown. V2 said the doctor was notified of R3's wounds and treatment orders were obtained. R3's Progress Note dated 11/23/24 at 10:10 AM, shows resident was noted to have open areas to sacrum. MD notified of new areas. R3's Care Plan shows R3 has actual skin impairment to skin integrity related to decreased mobility, incontinence/moisture, friction and shearing, nutrition and disease process. R3 was admitted with wound to left hip. Interventions: apply moisture barrier with each incontinence episode, and resident needs assistance to turn/reposition frequently and as required. R3's Wound Physician Visit Summary Report dated 11/20/24 shows R3 has a stage 3 full thickness pressure injury to left lateral thigh. Discussed importance of offloading, pressure relief and frequent turning and repositioning changes. Staff present for all education and verbalized understanding. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Pressure Ulcer/Pressure Injury Prevention Policy dated 3/2022 shows An individual plan of prevention will be developed to meet the needs of the resident. It will include the consideration of mechanical support surfaces, nutrition, hydration, positioning, mobility, continence, skin condition, and overall clinical condition of the resident as well as the risk factors as they apply to each individual. The goal is for the resident to be free of preventable pressure ulcer/pressure injury.