

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Lewis Memorial Christian Vlg		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 West Washington Springfield, IL 62702	

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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112</p> <p>Based on interview, observation, and record review, the facility failed to identify, monitor, provide education to resident and family, and implement interventions to prevent pressures ulcers for 2 of 3 residents (R2, R3), reviewed for pressure ulcers, in the sample of 6. This failure resulted in R2 and R3 sustaining facility acquired pressure ulcers while residing in the facility.</p> <p>Findings include:</p> <p>1. R2's Admission Record, print date of 4/3/24, documented that R2 was admitted on [DATE] with a diagnosis of a left femur fracture.</p> <p>R2's Minimum Data Set, (MDS), dated [DATE], documented that R2 was cognitively intact and required substantial to maximum assistance for all mobility.</p> <p>R2's Physician Orders, documented, Specialized turning schedule every two hours for turning and repositioning to maintain skin integrity. Start date of 2/20/24.</p> <p>R2's Physician Orders, documented, Anasept Antimicrobial External Gel 0.057 % (Sodium Hypochlorite) Apply to L (left) heel topically everyday shift for Wound healing Cleanse with WW (wound wash), then apply anasept, then calcium alginate, cover with dry dressing. start date of 2/27/2024 07:00.</p> <p>R2's Physician Orders, documented, Cleanse R (right) heel with WW, then apply skin prep every day shift. Start date of 2/27/2024 07:00.</p> <p>R2's Nurses Note, dated 2/17/2024 21:26, documents, Nursing Note Text: Writer observed wound to L heel and DTI (deep tissue injury) to R (right) lateral heel. MD (Medical Doctor) aware, and wife aware. Writer cleansed and applied dry dressing and elevated heels. Resident expresses no pain at this time.</p> <p>R2's Progress Note from Orthopedic MD, dated 2/20/2024 at 09:27, documented, Resident cannot be in bed for more than 8 hrs (hours) at time to decrease worsening of L heel ulcer. Wife with resident at appt (appointment) and is updated.</p> <p>R2's Braden Scale, dated 2/15/24, documented that R2 was a high risk for developing pressure ulcers.</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Skin & Wound Evaluation, dated 2/17/24, documented that R2 had a new facility acquired Left heel Stage 3 Pressure ulcer that measures 3.7 cm (centimeters) x (by) 3.7 cm x 2.2 cm. This pressure ulcer had light serous drainage.</p> <p>R2's Initial Wound Evaluation & Management Summary, dated 2/19/24, documented, (R2) had 2 Pressure Ulcers; Site 1 a Unstageable Pressure Deep Tissue Injury of the right lateral heel measuring 1 x 1.5 cm Recommendations: Off - Load wound; Reposition per facility protocol; float heels in bed; prevalon boot. Site 2 a Stage 3 Pressure Ulcer of the left posterior heel Full Thickness which measures 3.5 x 2 x 0.2 cm. Recommendations: Off - Load wound; Reposition per facility protocol; float heels in bed; prevalon boot.</p> <p>R2's Care Plan did not address current pressure ulcers.</p> <p>On 4/2/24 from 10:20 AM until 2:10 PM, R2 remained in his wheelchair based on 15 minute interval checks without benefit of meaningful turning, repositioning, or offloading of pressure. R2 also wore normal shoes and not prevalon boots.</p> <p>On 4/2/24 at 2:10 PM, R2 was questioned if he preferred to stay in the wheelchair all day, R2 stated that he does not prefer to sit in the wheelchair all day because it hurts his bottom. He stated that he does have a sore on his bottom and one on his heel.</p> <p>On 4/2/24 at 2:15 PM, V5, Certified Nurses Aide (CNA), stated that R2 likes to sit up in his wheelchair all day.</p> <p>On 4/4/24 at 8:39 AM, V2, Director of Nurses, (DON), and V8, Registered Nurse (RN) entered R2's room. R2 was in his wheelchair with normal shoes on. V2 held the leg up and V8 did the treatments. R2's bilateral shoes were removed. The left heel dressing removed. The left outer heel has an approximate 1 cm x 1cm pressure ulcer the wound bed is red the edges were white, V8 cleansed area with wound cleanser, put anasep gel, calcium alginate and a dry dressing on the pressure ulcer. The right heel has a small intact necrotic area which had skin prep applied.</p> <p>On 4/4/24 at 8:45 AM, V2, DON, and V8, RN, were both asked why R2 does not wear the prevalon boots during the day instead of his shoes, V8 stated that he does not like the boots because it hurts his leg with the fracture. Both were questioned why he doesn't lay down throughout the day to offload, V2 stated his wife does not want him to. V2 stated that he brought in a recliner for him and R2 refused to sit in it. R2 stated that he does not like to sit in the recliner. V2 and V8 both stated that they have educated R2 and the wife and they still don't want off loading or prevalon boots during the day.</p> <p>On 4/4/24 at 12:10 PM, V2, DON, stated that he has documentation that R2 and his wife were educated on the importance of offloading and pressure relief. V2 stated that it was documented that R2 and R2's wife does not want him in bed during the day or wearing the boots and he would supply that information.</p> <p>On 4/4/24 at 1:07 PM, R2's Physician Orders, Nurses Notes, Social Service Notes, Care Plans were reviewed. Documentation that R2 and R2's wife have been educated on the importance of pressure relief was not found.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>At time of exit on 4/8/24, documentation of R2 or R2's wife being educated on the importance of offloading or pressure relief was not provided by the facility.</p> <p>2. R3's Admission Profile, print date of 4/3/24, documented that R3 was admitted on [DATE] with diagnoses of aftercare for pacemaker placement, Diabetes Mellitus and Atrial Fibrillation.</p> <p>R3's MDS, dated [DATE], documented that R3 was cognitively intact, required substantial to maximum assistance with rolling, was dependent upon staff for all mobility, and was frequently incontinent of bowel and bladder.</p> <p>R3's Braden Scale for Predicting Pressure Sore Risk, dated 3/12/24, documented that R3 was at risk for developing pressure ulcers.</p> <p>R3's Braden Scale for Predicting Pressure Sore Risk, dated 3/31/24, documented that R3 was at risk for developing pressure ulcers.</p> <p>R3's Nurses Note, dated 3/17/2024 at 2:35 PM, documented, DTI (deep tissue injury) to bilateral heels. Skin prep and foam dressing applied. Heel protector boots in place. No edema noted. Continues with skilled therapy. Resident/Family Education and Teachback: wound interventions</p> <p>R3's Skin and Wound Evaluation, dated 3/17/24, documented that staff have identified a new Pressure Ulcer Deep Tissue Injury on the right medial heel. This Evaluation did not measure the pressure ulcer.</p> <p>R3's Skin and Wound Evaluation, dated 3/17/24, documented that staff have identified a new Pressure Ulcer Deep Tissue Injury on the left heel. The pressure ulcer measured 4.5 cm x 3.1 cm x 2.0 cm.</p> <p>R3's Skin and Wound Evaluation, dated 3/18/24, documented that staff have identified a new Pressure Ulcer Deep Tissue Injury on the right heel. The pressure ulcer measured 6.7 cm x 3.1 cm x 2.7 cm.</p> <p>R3's Wound Note, dated 3/22/2024 07:32, documented, Skin/Wound Note Data: Writer spoke with resident and family in regard to wounds. Informed them that resident would benefit from having in house Wound MD eval and tx (evaluation and treatment) wounds for optimal healing Action: Resident and family gave verbal and written consent for Wound MD to eval and tx.</p> <p>R3's Initial Wound Evaluation and Management Summary, dated 3/25/24, documented that R3 had an unstageable pressure ulcer to the right heel measuring 3cm x 3cm, an unstageable pressure ulcer to the left heel measuring 0.5cm x 1cm, and a stage 3 pressure ulcer to the left buttocks measuring 2.5cm x 0.5cm x 0.2cm with Light Sero- Sanguinous exudate.</p> <p>R3's Wound Evaluation and Management Summary, dated 4/1/24, documented that there were no changes in R3's pressure ulcers to the left and right heel or the left buttocks.</p> <p>On 4/2/24 R3 remained in bed from 8:25 AM until 1:30 PM with 15 minute interval checks without benefit of meaningful turning, repositioning, or offloading of pressure areas.</p> <p>On 4/2/24 at 9:06 AM, R3 stated that she does have heel and buttock pressure ulcers. R3 stated that she isn't turned and reposition often.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 10:47 AM, V6, RN, entered R3's room to check R3's heels. R3 was lying on her back the same position she was in at 9:06 AM. R3's bilateral heel boots were removed. R3's right heel had a black necrotic area the approximate size of a quarter. The left heel had a darkened area approximately 1 cm long. The heel boots were replaced. R3 was not repositioned or offered / encouraged to repositioning.</p> <p>On 4/2/24 at 12:07 PM, R3 and V3, R3's daughter, both stated that no one has been in the room to provide repositioning for R3.</p> <p>On 4/2/24 at 12:45 PM, V6, RN, and V4, CNA entered R3's room. V6 removed the soiled pressure ulcer dressing to the sacrum buttock area. The right buttocks had MASD (moisture associated dermatitis) which was bleeding slightly, the sacrum had a dime size area pressure ulcer that was bleeding, the left buttocks had a pressure ulcer area approximately the size of a quarter, the wound bed was bleeding, the peri wound was whitish pale pink. The area was cleansed with ww, and a hydrocolloid dressing was placed.</p> <p>On 4/4/24 at 2:55 PM, R3 was lying in bed with her heel boots on. R3 stated that the staff have been coming in and turning her every 2 hours from side to side since yesterday.</p> <p>On 4/4/24 at 2:55 PM, V9, R3's Granddaughter, stated that she was the one that found the heel pressure ulcers. She stated that she found them on 3/14/24 and that she did tell the nurse about it.</p> <p>On 4/4/24 at 3:15 PM, V2, DON, stated that he would look for documentation related to why the wound doctor saw R3 on 3/25/24 for a pressure ulcer located on the buttocks when there was not any other documentation of the pressure ulcer. V2 also stated that the nursing staff should measure any new pressure ulcer when they notice it and document on it.</p> <p>On 4/8/24 upon exit, there was no documentation of when R3's buttock pressure ulcer developed or if R3's right heel pressure ulcer was measured when first noted.</p> <p>The facility provided pressure ulcer policy, Skin / Pressure Ulcer Risk Evaluation, policy, dated 1/16/14, it did not document how to treat actual pressure ulcers.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112</p> <p>Based on interview, observation, and record review, the facility failed to provide complete incontinent care for 2 of 3 residents (R1, R3) reviewed for bowel and bladder incontinence, in the sample of 6.</p> <p>Findings include:</p> <p>1. R1's Admission Profile, print date of 4/2/24, documented that R1 was admitted on [DATE] with diagnoses of a right broken ankle and weakness.</p> <p>R1's Minimum Data Set, (MDS), dated [DATE], documented that R1 was cognitively intact, required substantial / maximum assistance for all mobility and toileting, was always incontinent of urine and occasionally incontinent of bowel.</p> <p>On 4/2/24 at 9:58 AM, V3, Certified Nurses Aide, (CNA), transferred R1 from her wheelchair to bed. R1's incontinent brief was removed. It was soiled with urine. R1 took one pre-moistened periwash cloth and wiped once down the labia. R1 was then rolled over to her left side, with one cloth, V3 wiped the buttocks in circles, did not cleanse entire buttocks, and then took one cloth and wiped the rectal area up and down.</p> <p>2. R3's Admission Profile, print date of 4/3/24, documented that R3 was admitted on [DATE] with diagnoses of aftercare for pacemaker placement, Diabetes Mellitus and Atrial Fibrillation.</p> <p>R3's MDS, dated [DATE], documented that R3 was cognitively intact, dependent on staff for toileting needs and was frequently incontinent of bowel and bladder.</p> <p>On 4/2/24 at 12:11, V3, CNA, and V4, CNA, entered R3's room to provide care. V4 removed the incontinent pad and brief. The pad was full of liquid stool. V4 wiped the labia once with a premoisten periwash cloth, R3 was then rolled over to her side, R3's buttocks and rectal area were cleansed. R3 was rolled onto her back, V4 wiped the labia once. The cloth had stool on it. V4 then placed the incontinent pad and brief into place, covered R3 up and told her the nurse would be in shortly to change the pressure ulcer dressing.</p> <p>On 4/2/24 at 12:45 PM, V6, Registered Nurse (RN), and V4, CNA, entered R3's room. R3 had a small amount of liquid stool. V4 cleaned the buttocks and rectal area. V4 did not cleanse R3's periarea.</p> <p>On 4/4/24 at 3:15 PM, V2, Director of Nurses (DON), stated that he expects staff to cleanse all soiled skin during incontinent care.</p>		