

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/17/2025
NAME OF PROVIDER OR SUPPLIER  Stonebridge Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  902 South McLeansboro Benton, IL 62812	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to obtain and implement physician orders for wound care for 1 (R1) of 3 residents reviewed for wound care in the sample of 9.</p> <p>The findings include:</p> <p>R1's admission Record documented R1 was admitted to this nursing home on 9/20/2022 with diagnosis of stroke with right sided paralysis. R1's Minimum Data Set (MDS) dated [DATE] documents R1 had a Brief Interview for Mental Status (BIMS) score of 01, indicating R1 has severe cognitive impairment. This MDS also documented R1 has one Stage IV Pressure Ulcer that was present on admission.</p> <p>R1's admission assessment titled Admit/Readmit Screener, dated 4/26/25 documented R1 was admitted via wheelchair from hospital and had a pressure area to his coccyx. There were no measurements or description of the wound documented on the Admit/Readmit screener or the nurse progress notes.</p> <p>R1's Order Summary Report with active orders as of 5/30/25 documented there were no orders for wound care from 4/26/25 until 5/2/25.</p> <p>R1's Treatment Administration Record (TAR) dated 4/1/30-4/30/25 indicated there were no treatments ordered for R1's coccyx wound to be done beginning on 4/26/25. The same TAR dated 5/1/25-5/30/25 documented a treatment to begin on 5/2/25 of cleanse area to sacrum (coccyx) then apply manukah honey absorbent dressing and cover with silicone border dressing every night shift for wound care.</p> <p>On 6/3/25 at 11:23am, V11 (Licensed Practical Nurse/LPN) said he was working on 4/26/25 when R1 returned to the facility from the hospital. V11 said that R1 had a wound on his sacrum/coccyx upon re-admission. V11 said all he was told from the out of state hospital that R1 was discharged from was that R1 had a non-blanchable area to coccyx. V11 said the wound had a wadded up dressing on it and the middle was deeper. V11 said he wasn't sure about the stage of the wound. V11 said they started off with Silvadene and calcium alginate dressing. V11 said that he believes either the doctor or the nurse practitioner okayed the calcium alginate, he does not remember. V11 said he did pass it on in report and thinks he wrote it on the 24-hour shift report. V11 said that V9 (Registered Nurse/RN) was helping him since he was new to the facility.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 6/3/25 at 2:55pm, V7 (LPN/Infection Preventionist/IP) said that R1 came back to the facility on 4/26/25 with the sacrum/coccyx wound. V7 said that the nurse that admitted R1 should have documented a wound note with measurements and R1 would have been seen the following Thursday. V7 said she was not notified about the wound on the sacrum/coccyx until 4/28/25. V7 said she got the order for treatments on the coccyx wound on 5/2/25.</p> <p>On 6/4/25 at 9:35am, V10 (RN) said she worked day shift on 4/27/25. V10 says it's usually after around 10am when she starts her treatments. V10 said that R1 did not have a treatment on the TAR to be done. V10 said she knew he came back with a wound and when she saw there was not a treatment, she knew it had to be cleaned. V10 said she went with what the wound doctor always orders which is cleanse, apply Silvadene, calcium alginate and cover with dry dressing.</p> <p>On 6/4/25 at 10:03am, V8 (RN) said that R1 had an area on his behind and when she looked at the TAR there was no treatment listed on there. V8 said she would never leave a wound without a dressing, and they had been putting Silvadene, calcium alginate and dry dressing on it. V8 said she does not remember if it was on the 24-hour report sheet or not.</p> <p>On 6/4/25 at 11:08am, V5 (Physician) said he thought he remembered staff calling for wound orders. V5 said he figured he would go ahead and do something until the wound physician could see R1. V5 said he thought he ordered calcium alginate with dry dressing, which is what wound care generally does. V5 said he does not remember which nurse called him.</p> <p>On 6/4/25 at 11:15am, V9 (RN) said she was told about R1's wound and did look at it. V9 said she put a treatment on it, cleansed, applied Silvadene, calcium alginate and a dry dressing. V9 said it was very hectic and she may have not put a note in on it. V9 said she also put in the order, she just wanted to put something on it. V9 said she didn't remember which doctor ordered it.</p> <p>On 6/5/25 at 11:46am, V14 (RN) stated that she worked the night of 4/26/25 after R1 had returned from the hospital earlier that day. V14 said there was no open area on R1's coccyx before he went to the hospital. V14 said she tries to do her treatments in the evenings after her medication pass, but V11 (LPN) took care of it on days so she didn't have to do it. V14 said an order will show on the TAR if she has to do one, but this happened with R1 a long time ago. V14 then said that an order did pop up for R1 to cleanse, apply Silvadene cream and apply calcium alginate and cover the wound with dry dressing. V11 said if the order was not put in, it would not show up for her to do. V14 said that usually it goes on the 24-hour shift report, but she does not remember if she put it on there or not. V14 said she also worked on 5/1/25 and she did a treatment on R1's wound but does not remember if it showed on the TAR for her to do. V14 said that R1 was able to make his needs known. V14 said she got to where she could understand R1, or he would shake his head yes or no.</p> <p>Facility Policy labeled Telephone Orders (undated) documents Verbal telephone orders may only be received by licensed personnel (e.g. (for example) RN, LPN, pharmacist, physician). Orders must be reduced to writing by the person receiving the order and recorded in the resident's medical record.</p> <p>Facility Policy labeled Medication Orders (undated) documents Treatment Orders- When recording treatment orders, specify the treatment, frequency and duration of the treatment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Facility Policy labeled Pressure Ulcers/Skin Breakdown- Clinical Protocol (undated) documents Assessment and Recognition In Addition, the nurse shall describe and document/report the following: Full Assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue.</p>		