STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146188	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF SMITHTON	**107 SOUTH LINCOLN SMITHTON, IL 62285**

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** Based on interview, observation, and record review the facility failed to timely identify, assess, monitor and implement appropriate pressure relieving interventions and treatment to prevent pressure ulcers in 1 of 7 residents (R2) reviewed for pressure ulcers in the sample of 7. This failure resulted in R2 developing a facility-acquired unstageable pressure ulcer to his left heel causing a decline in his rehabilitation. R2 was hospitalized due to the infection of this pressure ulcer. Findings include: 1.R2's Minimum Data Set (MDS), dated [DATE] documents, R2 was severely cognitively impaired. The MDS documented R2 required limited assistance from staff for bed mobility, walking, and eating. The MDS documented R2 was at risk for pressure ulcers and had no pressure ulcers or other skin issues were present on admission. R2's Pressure Ulcer Risk Assessments documented on 3/11/2020, documents R2 was at low risk for pressure ulcer development. R2's Physical Therapy Notes dated 3/13/2020 documents, Initial Assessment documents, (R2) has Full Range of Motion to bilateral upper and lower extremities. Sitting balance normal Static Standing good Dynamic Standing Fair. R2's Physical Therapy Note documented Independent in all functional mobility and ambulatory with no assistive device. R2's Provider Progress Notes, dated 4/7/2020 documents, Shearing noted to the bilateral buttocks with overall some improvement but will continue with calcium alginate .plan to continue to monitor buttocks shearing closely and will await (wound consultant) evaluation. R2's Care Plan, no revision date, was not updated with progressive interventions to address R2's pressure ulcer on his buttocks or to prevent him from developing new pressure ulcers. R2's Provider Progress Notes, dated 4/23/2020 documents, Virtual Visit-Patient continues to deal with wound to the buttocks which nursing staff states that he started to note improvement in the wound. (Wound Consultant) has not evaluated him yet. R2's Treatment Administration Record (TAR) dated 4/2020 documents on 4/23/2020 Discontinue calcium alginate and dressing daily to buttocks. Daily Skin Checks signed out started on 4/5/2020. House barrier cream to buttocks PRN (as needed) R2's Shower Sheets documented 3/12/2020 through 5/07/2020 document no skin issues. R2'S Nurse's Notes dated 5/1/2020 and 5/2/20 document R2's skin condition was normal and documented no pressure ulcers were present. R2's Initial Skin Alteration Record document on 5/3/2020 at 11:52 PM R2 had a deep tissue pressure injury/pressure ulcer on his left heel. The Record document the pressure ulcer unstageable and measured 6 centimeters (cms) by 11 cm x 0.1 wound bed depth. The Note documented there was a 2.5 cm x 5cm x .5 cm black necrotic area in the center of R2's heel. The note documented the tissues was mushy. The National Pressure Injury Advisory Panel documents an unstageable pressure injury as Full -thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue). If slough or eschar is removed, a Stage 2 or Stage 4 pressure injury will be revealed. R2's Physician order [REDACTED]. (Pressure relief boots) both heals, float heels when in bed. R2's Treatment Administration Record (TAR) dated 5/3/2020. Cleanse area to left heel with soap and water. Apply skin prep. Pressure Relief Boots to bilateral lower extremity. Float heels when in bed FYI. V12, R2's Wound Consultant Nurse, documented on 6/2/20 that R2 had an unstageable pressure ulcer injury on his left heel that had 80% necrotic tissue. R2's Physical Therapy Completion note dated, 6/17/2020 documents R2 had a decline in Physical and was being discharged from Therapy. The Note documented (R2) minimal assist required for supine to sit and rolling and moderate assist for sit to stand and stand to pivot transfers from bed to chair. Patient requires instruction for hand placement and technique for all tasks. Patient continues to be unable to ambulate or stand for long periods of time due to wound on left heel. R2 completed on 6/18/2020. On 7/10/2020 at 10:30 AM, V8, Physical Therapy (PT) Assistant stated, (R2) did come in on admission ambulatory without an assistive device. PT worked with balance, OT and Speech worked with his dentures and eating. V8 stated We kept working with him but when he got the wound on his heel he couldn't stand anymore, and we finally had to discharge him. I think we discharged him on 6/18/2020. On 7/10/2020 at 1:45 PM V2 Certified Occupational Therapy Assistant (COTA) stated, (R2) did have an overall decline. He got a wound on his foot, and then he couldn't bear weight with transfers. R2's Care Plan dated 6/18/2020 documents (R2) is at risk for skin impairment due to low blood circulation in lower extremities determined by ABI test. 5/3/2020-Skin impairment to left heel. Followed by Specialized Wound Management (SWM). GOAL; Skin impairment to left heel will show improvement through next review. Interventions: Assess and document progress of area weekly, Assist and encourage resident to turn and reposition as needed, Diet as ordered, ensure adequate food and fluid intake, labs as ordered, monitor area for signs and symptoms of infection; odor; drainage; color; size, notify Medical Doctor of abnormal findings, Pressure Relief boot to left heel, skin assessment weekly, treatment to left heel as ordered. V12 Wound Consultant Note, dated 6/30/20, documented Left Heel measures 5cm width by 9cm x U (unstageable). The Note documented there was a moderate increase in drainage/odor from the pressure ulcer. The Note documented Plan: Spoke with (V7, Power of Attorney/POA) regarding the wound decline this week with increase drainage and odor. Although patient has an appointment with (V13 M.D.) tomorrow I recommend sending to the ER for evaluation today. Discussed patient risk for infection or amputation. R2's Emergency Department (ED) Physical Exam; dated 6/30/2020 documents, There is a large necrotic wound to the left heel with extremely foul-smelling purulent drainage. No significant surrounding [MEDICAL CONDITION]. R2's Hospital Record (V13's) Vascular Consult note dated 7/8/2020 documents, Infected left heel decubitus ulcer with osteo[DIAGNOSES REDACTED]. On Vanco and [MEDICATION NAME] (antibiotics), wound Culture & Sensitivity; (bacteria identified) Morganella, Surgical procedure of left heel debridement on 7/6/2020, dressing change with wound gel daily, (Pressure relief) boot reordered again, Eliquis started, Plan for long term IV antibiotic for osteo, and open heel wound with bone exposure. On 7/14/2020 at 2:30 PM (V2) Director of Nursing stated, Yes, (R2's) was high risk for pressure ulcer development. We do (pressure ulcer) assessments on new admission weekly for 4 weeks, then quarterly. (R2's) left heel was not pressure it was vascular. (R2's) Initial Skin Alteration Record was the document when the left heel wound was first discovered. On 7/15/2020 at 12:18 AM, V13, Vascular Surgeon stated, (R2's) left heel wound is pressure not vascular. Vascular wounds do not develop on those areas of the heel. If I remember correctly (R2) was demented and is unable to know how to turn and reposition himself without staff to tell him what to do. He was not ambulatory in the hospital; he was dependent for care. It was a pressure ulcer. Yes, if the measures were in place the heel could have been prevented. All pressure ulcers can be prevented, but some situations make it hard. If the resident was ambulatory when he came in, then became debilitated and it wasn't caught in time. Yes, if (R2) had a previous pressure ulcer develop then the facility should know he is at risk and have placed him on a pressure prevention program. I don't think in just hours you will see a deep tissue injury with eschar develop. I think there are many factors that contribute to how long it would take to get a Deep tissue injury, depending on how debilitated, and immobile the person is. I would say, maybe a day, more like 2 to 3 days, not in just hours in (R2's) case

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.