STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE CREST HEALTH CARE	**3300 WEST 175TH STREET HAZEL CREST, IL 60429**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy on change in condition by failing to notify the physician within 24 hours of a change in condition,and failed to notify the attending physician of the development of blisters for 10 days of the initial observation of the blister for 1 of 1 residents (R1) reviewed for change in condition. Findings Include: On 7/21/2020 at 2:05pm, R1 was observed with three intact pink skin discoloration. R1 had a small circular pink area on the left index large knuckle. Two thin elongated flat oval pink skin discolorations under the second smaller knuckles on left index and middle finger. R1 was unable to report what happened related to [DIAGNOSES REDACTED]. alteration/blister. On 7/22/2020 at 12:05pm, V2 (Director of Nursing/DON) said, staff must complete a skin assessment for any blisters, notify the doctor and family. On 7/22/2020 at 1:00pm, V7 (Wound Care/Treatment Nurse) said I was unaware of R1's blister. I would have update the doctor, got an order if needed, placed the skin alteration on a weekly skin assessment sheet and notified the family immediately. I didn't notify the family or doctor. On 7/22/2020 at 3:20pm, V9 (Nurse) said, R1 had a blister. The treatment nurse was called. . If the treatment nurse is not working, I am supposed to call the doctor and the family. WhenI called the treatment nurse, she became responsible for calling the doctor and the family. The treatment nurse did not work my shift. I called her cell phone. We are never off duty. I did not call the doctor/family. On 7/22/2020 at 4.06pm, V12 (Nurse Practitioner) stated the nurse asked me to see R1 because the family had some concerns on 7/7/2020. V12 didn't recall being notified prior to that date about R1's blisters. On 7/22/2020 at 4:34pm, V2 (DON) said the facility didn't have an incident, investigation, doctors' notification or any documentation associated with R1' blisters. Progress note dated 6/27/2020 documents: R1 noted with some swelling to left hand and fluid filled blister on left index finger. Treatment Nurse made aware of blister. physician progress notes [REDACTED]. Broken blisters on left hand. Blister of finger: To left index and middle finger. Policy: Change in condition physician notification overview guidelines: #2. Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise and thorough manner generally with in twenty-four hours or sooner. Policy: Pressure Injury and Skin Condition Assessment: #7. At the earliest sign of pressure injury or other skin, the resident, legal represented and attending physician will be notified.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their care plan policy by not revising the plan of care for a newly identified skin blister for 1 of 1 (R1) residents reviewed for care plan revisions. Findings Include: On 7/21/2020 at 2:05pm, R1 was observed with three intact pink skin discolorations. R1 had a small circular pink area on the left index large knuckle. Two thin elongated flat oval pink skin discolorations under the second smaller knuckles on left index and middle finger. On 7/22/2020 at 12:05pm and 4:34pm, V2 (Director of Nursing/DON) said care plans are updated after every incident. There is no documentation associated with R1' blisters. On 7/22/2020 at 1:00pm, V7 (Wound Care/ Treatment Nurse) states she was unaware of R1's blister. V7 stated, I didn't have a treatment in place nor do I have any documentation associated with R1's skin alteration/blister. All skin alterations/blisters should be charted in the progress notes, on the treatment administrator records and the care plan should be updated with a problem, intervention and goal. On 7/22/2020 at 3:26pm, V9 (Nurse) said,the discoloration pink healed scar tissue could have been associated with a blister. On 7/23/2020 at 10:53am, V15 (Care Plan Coordinator) stated R1 is not my resident. R1 should have had a skin condition added to the care plan. physician progress notes [REDACTED]. Blister of finger on the Left Index and Middle Finger. R1's care plan did not document any skin alterations/blister related to R1's blisters. Policy: Care Plan: All residents will have comprehensive assessments and individualized plan of care developed to assist them in achieving and maintain their optimal status: 8b. When a change occurs in a resident condition, the care plan is then reviewed and updated. Policy: Pressure Injury and Skin Condition Assessment: #21. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care.
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** Based on interview and record review, the facility failed follow its policy on pressure injury and skin condition assessment by not notifying the physician and obtaining physician orders [REDACTED]. Findings Include: On 7/21/2020 at 2:05pm, R1 was observed with three intact pink skin discoloration. R1 had a small circular pink area on the left index large knuckle. Two thin elongated flat oval pink skin discolorations under the second smaller knuckles on left index and middle finger. On 7/22/2020 at 1:00pm, V7 (Wound Care/ Treatment Nurse) said, I don't have any treatments for R1's blister. R1's blister should have been placed on a place a weekly skin assessment sheet and on the treatment administrator records. I wasn't aware of R1's blister. On 7/22/2020 at 3:26pm, V9 (Nurse) stated R1's blister should have been charted in the computer under risk management skin assessment, described the affected area on the body figure on the skin assessment from. V9 reports that was not done. . On 7/22/2020 at 4:34pm, V2 (Director of Nursing) said, staff should have completed a skin assessment for R1's blister. V2 states there is no documentation of R 1's blister. Progress note dated 6/27/2020 documents: R1 noted with fluid filled blister on left index finger. physician progress notes [REDACTED]. Blister of finger on the Left Index and Middle Finger. Bath and Skin Report for June 2020 was blank. Non-Pressure Ulcer/Wound Report dated June -July 2020: No documentation for R1's blister. Treatment administration record for June: No documentation for R1's open blister. Policy: Pressure Injury and Skin Condition Assessment: Purpose: To establish guidelines for assessing, monitoring and documentation the presence of skin breakdown and assuring interventions are implemented. #15. A notation will be made in the nurse note, treatment administration record or on weekly bath sheets when no skin problems are observed.

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.