STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145636	A. BUILDING _____ B. WING _____	**10/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHARLESTON REHAB & HEALTH CC	**716 EIGHTEENTH STREET CHARLESTON, IL 61920**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 to develop and implement pressure reducing interventions, failed to repeatedly complete skin risk assessments, and failed to repeatedly complete treatments as ordered by the Physician for one of three residents (R1) reviewed for pressure ulcers in the sample list of three. Findings include: The facility's Preventative Skin Care policy, dated 1/2018, documents, All residents will be assessed using the (skin assessment) Scale at the time of admission and weekly x (times) 4 then will be reassessed at least quarterly and/or as needed. Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two hours. Special mattresses and/or chair cushions will be used on any resident identified as being at high risk for potential skin breakdown. The facility's Skin Condition Monitoring policy, dated 1/2018, documents, Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: a. Characteristic 1. Size 2. Shape 3. Depth 4. Odor 5. Color 6. Presence of granulation tissue or necrotic tissue. b. Treatment and response to treatment. Observe and measure pressure ulcers at regular intervals. c. Prevention techniques that are in use for the resident. R1's Face Sheet documents R1 was admitted to the facility from an acute care hospital on [DATE]. R1's Nursing Admission Assessment documents R1 had some scars and some bruising, but does not document the presence of any pressure ulcers or open wounds. This assessment does not assess a skin risk or document interventions to prevent skin breakdown. R1's Nurse's Notes, dated 4/23/20 at 1:00 PM, do not document any skin conditions. R1's medical chart does not document a skin risk assessment being completed until 6/16/20, which documented R1 was at high risk for skin breakdown. R1's Admission Minimum Data Set (MDS), dated [DATE], documents R1 was totally dependent on two staff for bed mobility, transfers and bathing. This MDS documents R1 was incontinent of bowel and bladder. This MDS also documents R1 was at risk for developing pressure ulcers/injuries and R1 was admitted with no unhealed pressure ulcers/injuries. This MDS documents Pressure Ulcers were triggered as a care area that should have been added to R1's Care Plan. R1's Care Plan, with a start date of 5/19/20, does not document R1 is at risk of skin breakdown, nor does it document any interventions put in place to prevent skin breakdown. The first skin issue documented on R1's Care Plan is dated 7/17/20, and documents a culture and sensitivity of a coccyx wound was completed. There were still no interventions documented on the Care Plan regarding pressure ulcers or skin risk. R1's Nutritional Assessment, dated 5/22/20, completed by V6, Dietician, documents two pressure ulcers, one on the right buttocks and one on the right heel. R1's medical chart does not contain information of when R1's pressure ulcers began. Wound Physician notes, dated 6/4/20, document an initial evaluation of an unstageable wound on R1's right heel that measured 6 cm (centimeters) x (by) 4 cm and the depth was not measurable due to the wound being covered 100% (percent) with black necrotic tissue. V12 Wound Physician recommended R1 have heel protectors to both feet when in bed. R1's Medical Record had no treatment records documenting pressure ulcer treatments for April and May of 2020. R1's Treatment Administration Record (TAR), dated 6/17/20 - 6/30/20, document treatment orders for a stage 3 pressure ulcer to the left buttocks, and a treatment order for the coccyx, but does not document a treatment order for the right heel. R1's TAR, dated 7/1/20 - 7/31/20, documents a treatment order for the left and right buttocks and coccyx to apply calcium alginate and foam without a border everyday. This treatment was not signed as completed on 7/10/20 and on 7/12/20. This TAR documents an order for [REDACTED]. This TAR documents an order for [REDACTED]. The facility's Weekly Skin log, dated 9/15/20, documents R1 had a stage 4 pressure ulcer on the right heel and a stage 3 pressure ulcer on the coccyx that were both acquired in the facility. R1's Physician order [REDACTED]. On 10/6/20 at 10:12 AM, V4, Care Plan Coordinator, stated the MDS triggers areas to put on the care plans due to certain triggers for skin. If it triggered for (R1) it should've been on (R1's) care plan and interventions should have been developed. V4 stated V4 is not sure why it's not on (R1's) care plan. V4 stated according to the (skin risk assessment) everyone is at risk for skin issues. V4 stated V4 doesn't know why someone did not care plan (R1's) skin risk. On 10/6/20 at 1:05 PM, V5, Wound Nurse, stated the nurses are supposed to fill out a new wound/new area form when a new skin issue is found. V5 stated R1's wounds should be documented in the Nurse's Notes, or there should be a new wound or new area form filled out for R1. V5 stated V5 does not know why there is no documentation in R1's Nurse's Notes regarding R1's wounds. On 10/6/20 at 1:18 PM, V2, Director of Nursing, stated there should be a newly acquired skin (assessment) sheet for R1's wounds in R1's medical record. V2 stated V2 does not know why there is no information regarding R1's wound being found in R1's chart. On 10/6/20 at 1:26 PM, V1, Administrator, stated V1 thought R1 came to the facility with the wounds. V1 stated V1 doesn't know any information about when the wound started.

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