STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145024	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINECREST MANOR	**414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054**

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 -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify an area of pressure prior to it deteriorating to a deep tissue injury for 1 of 7 residents (R81) reviewed for pressure injuries in the sample of 23. The findings include: R81's face sheet printed on 3/5/20 shows she has [DIAGNOSES REDACTED]. The facility assessment dated [DATE] shows R81 has short term and long term memory problems, and has severely impaired cognitive skills for daily decision making. The assessment shows R81 required extensive assist of two staff members for bed mobility, transfers, toileting, dressing and personal hygiene. The assessment shows R81 was at risk of developing pressure injuries, however there were no pressure injuries at that time. The facility assessment dated [DATE] shows R81 had an unstageable pressure injury. R81's care plan titled Potential for/Reality of Impaired Skin Integrity shows she is at high risk of developing a pressure injury related to immobility, limited mobility, incontinence, and dependence on staff. The care plan shows an area on left heal on 12/10/19. The care plan shows that same day (12/10/19) Float heels off bed. daily skin checks by nurse. Weekly documentation. On 3/3/20 at 9:40 AM, V6 LPN (Licensed Practical Nurse) identified R81 as a resident on the memory care unit with a pressure injury. V6 said the pressure injury was on R81's left heel. On 3/5/20 at 10:59 AM, V3 LPN performed a dressing change for the pressure injury to R81's left heel. R81 had an open area measuring 0.8 centimeters (cm) x 1.2 cm x 0.2 cm to her left heel. On 3/5/20 at 10:13 AM, V2 DON (Director of Nursing) said a suspected deep tissue injury was identified on R81's left heel on 12/10/19. The next day on 12/11/19 it was classified as pressure. V2 said she was not sure what caused the pressure injury to R81's left heel. V2 said the facility staff started floating R81's heels that same day the pressure injury was identified. V2 said the facility assessment prior to R81 developing a pressure injury to her left heel shows she required extensive assist of 2 staff members for mobility and transfers. V2 said during that time R81 also required extensive assist from staff for her dressing and bathing needs. The facility's skin evaluation form dated 12/10/19 shows R81 had a 3 centimeter (cm) x 4 cm oval, tender, purple/pink/flesh tone intact skin to left heel. The skin evaluation form dated 12/11/19 (the next day) shows a pressure ulcer to left heel, skin is intact. Area is purple/black in color with no drainage noted. The surrounding skin is fleshtoned and blanches (turns white when pressed on). The area measured 2 cm x 1.5 cm with 100% eschar (dead, non-viable tissue). On 3/5/20 at 9:18 AM, V5 Nurse Practitioner said prior to the development of eschar tissue you would see redness first, then non-blanching skin (skin that does not turn white when pressed on), then you may see some whitening around the area and maybe some swelling. Finally the tissue would start turning darker colors. R81's bedside care plan located in her room does not identify heel-lift pillows or heel protectors in bed as one of the interventions in place for off-loading heels. The facility's 2/19/16 policy and procedure titled Pressure Ulcer Prevention shows residents in long term care facilities have increased potential for developing pressure ulcers. (The facility) believes this potential can be significantly decreased with proper preventative measures. The policy shows for all residents within the facility that are considered at moderate or high risk will have daily skin checks done by the CNAs (Certified Nursing Assistants) during routine daily care on residents in skilled units and at least weekly for low risk in intermediate care area. Basic preventative care is provided by the CNAs. The policy shows basic preventative measures include using devices, such as pillows or pads to reduce pressure when indicated. Sheepskin/heel/elbow protectors may provide comfort and reduce friction and shearing forces

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