STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145547	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEKALB COUNTY REHAB & NURSING	**2600 NORTH ANNIE GLIDDEN ROAD DEKALB, IL 60115**

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 a pressure injury prior to becoming unstageable for a resident at risk for pressure, and failed to implement pressure relieving interventions for one of three residents (R2) reviewed for pressure in the sample of five. The findings include: R2's face sheet shows [DIAGNOSES REDACTED]. R2's facility assessment, dated 8/5/20, shows severe cognitive impairment and requiring extensive staff assistance with bed mobility, transfers, locomotion, dressing, eating, toilet use, and personal hygiene. R2's pressure sore risk assessment, dated 8/1/20, shows a moderate risk for pressure sores. The facility's pressure ulcer log shows R2 has an unstageable, right inner heel wound. On 10/8/20 at 10:35 AM, R2 was seated in an upright chair in the 200 wing, near the nurse's station. R2 was being assisted by a CNA (Certified Nurse Aide) to open packages of new shirts. R2 wore socks on both feet and one slipper on her left foot. R2's right heel was resting directly on the floor. At 10:45 AM, R1 was seated in her wheelchair near a window and her right heel was resting directly on the floor. At 10:55 AM, R2 was seated in her wheelchair in the hallway. Again, her right heel was resting directly on the floor. On 10/8/20 at 10:35 AM, V3 (Registered Nurse) stated R2 has a pressure wound on her right heel. V3 said it was discovered on 9/18/20 and at an unstageable DTPI (deep tissue pressure injury) level. V3 said R2 has an order for [REDACTED]. V3 said nurses and aides are responsible to inspect resident skin and immediately report any changes. V3 said it is important to find skin issues right away to prevent pressure ulcers from becoming worse. On 10/8/20 at 10:00 AM, V6 (CNA) stated residents should be checked for skin changes every day and notify the nurse immediately if any redness, tears, bruising, or change is discovered. V6 said residents are also checked during each weekly shower. R2's nurse progress note, dated 9/18/20, states: Resident noted to have unstageable DTPI (deep tissue pressure injury) to right inner heel. Area measures 3.2 x 3.7 cm (centimeter). Area has bruising and callus area on bruised area only. Area is unblanchable and intact. Resident appears to have discomfort on palpation . R2's weekly wound notes show the unstageable DTPI was found on the right inner heel on 9/18/20. The wound measured 3.2 x 3.7 centimeters. The weekly wound notes show the most recent assessment was on 10/2/20 and the wound now measures 3.5 x 4 centimeters. On 10/8/20 at 12:25 PM, V4 (CNA) stated R2 should have a foam boot on her right heel at all times. V4 said R2 should be wearing the boot until the pressure ulcer is completely healed. At 12:30 PM, V5 (Registered Nurse) stated R2 does not like to wear the pressure relieving boots, so we elevate her heels in a chair to take the pressure off of them or put pillows under her legs. On 10/8/20 at 1:00 PM, V2 (Director of Nurses) stated it is important to find skin changes early to avoid residents having pain or the potential of infection. V2 said CNAs should be inspecting resident's skin during all morning and evening care. V2 said skin should also be inspected at each weekly shower and any changes reported to the nurse. V2 said the PM shift nurses also are responsible for daily skin checks. V2 said R2 likes to be out of bed a lot and enjoys sitting by the nurse's station. V2 said R2's heels should be elevated while she is there. R2's skin/pressure care plan, start dated 11/12/18, states under the approach section: Conduct a systematic skin inspection daily with am/pm cares and weekly with showers. Pay particular attention to the bony prominences. The care plan shows a second approach section stating: Report any signs of skin breakdown on (R2) sore, tender, red, or broken areas. A third approach states: Use pillows to relieve pressure on (R2's) heels. The facility's undated Guidelines for Preventing Skin Breakdown policy states: 1. Carefully inspect the resident's skin during care and report any signs of irritation or break down. 7. Avoid positioning on impaired skin. 19. Report to nurse; any abnormalities noted such as cuts, bruises, irritation, redness, open areas, rashes, bleeding.

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.