STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146020	A. BUILDING _____ B. WING _____	**09/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSEVILLE REHAB & HEALTH CARE	**145 S CHAMBERLAIN ST, BOX 770 ROSEVILLE, IL 61473**

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 interview and record review, the facility failed to reposition a resident as needed to prevent pressure ulcers for one (R1) of three residents reviewed for pressure ulcers in a sample of three. Findings include: Facility Preventive Skin Care policy, revised 1/18, documents, It is the facility's policy to provide preventive skin care through repositioning and careful washing, sensing, drying and observation of the skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers .Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two hours. R1's skin assessment for predicting pressure ulcer risk, dated 4/10/20, documents R1 as being at high risk for pressure ulcers with no current unresolved pressure ulcers. R1's facility medical record does not document resident was turned and repositioned every two hours. R1's facility medical record, dated 5/19/20, documents, Medical doctor notified of current wound status. Stasis ulcer to inner right lower extremity. R1's hospital documentation, dated 6/17/20 at 4:33 AM, documents, Complete head to toe assessment upon arrival and completed. Pressure injury to left internal heel (blistered, bleeding). Pressure injury to right external ankle, necrotic center, slough and bleeding around edges. Right buttock two open areas noted to be dark red, small amount of bleeding. Left buttock one open area noted to be dark red. Generalized sacral and buttock redness, blanchable. Very bony sacral prominence. On 9/5/20 at 2:20 PM, V2, Director of Nursing (DON), stated they were not aware of any wounds on R1 prior to him going to the hospital on [DATE]. V2, DON, stated they only knew about and documented the right lower extremity wound.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to perform hand hygiene during a pressure ulcer dressing change for one (R2) of three residents reviewed for pressure ulcers in a sample of three. Findings include: Facility Aseptic Wound and Skin Treatment Procedure, revised 1/18, documents Purpose: To prevent contamination of the wound, protect wound from mechanical injury, to stimulate, restore and promote circulation and healing, prevent further deterioration of skin tissue, prevent necrosis of deeper body structures, and to promote resident comfort. Procedure: 13) Put on clean gloves. 14) Clean the wound as ordered. 15) Place soiled sponges used for cleaning wound in plastic bag. 16) Remove gloves and place in plastic bag. 17) Wash your hands. 18) Put on clean gloves. 19) Apply dressing. R2's treatment administration record (TAR), dated 8/25/20, documents, Cleanse left heel with wound cleanser, pat dry, skin prep peri wound. Apply duoderm. Change every 72 hours and as needed. On 9/4/20 at 10:43 AM, V3, Licensed Practical Nurse (LPN), performed R2's left heel pressure ulcer wound care. V3, LPN, set the supplies on the bedside table, asked another nurse to help lift R2's leg, put on clean gloves, sprayed the wound with wound cleaner, cleaned the wound with gauze, threw the gauze away, took off the gloves, put a new pair of gloves on, grabbed a skin prep pad, applied the skin prep, threw the skin prep pad away, took off the gloves, put new gloves on, opened the dressing, applied the dressing, dated it with a marker, put the sock back on, took off the gloves and then washed her hands prior to leaving the room. On 9/5/20 at 1:07 PM, V2, Director of Nursing (DON), verified that V3, LPN, should have cleaned the wound, taken off the gloves, performed hand hygiene, then put on clean gloves prior to applying the bandage during R2's dressing change.

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.