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S 000	Initial Comments Complaint# 1815058/IL104682 Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure 1 of 2 violations 300.610a) 300.1210b) 300.1210c) 300.1210d)1) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess a resident's bowel status and follow the facility's bowel management protocol, and failed to assess a resident's meal and fluid intakes and output.

This failure resulted in the resident being admitted to an intensive care unit with the diagnoses of bowel obstruction, dehydration, urinary tract infection and sepsis.

This applies to 1 of 3 residents (R1) reviewed for fluid intakes and bowel and bladder function.

The findings include:

R1's August 1, 2018 history and physical from a local hospital shows she has diagnoses including multiple sclerosis, a previous stroke, type 2

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diabetes mellitus, polyneuropathy, hypertension chronic kidney disease, previous abdominal surgery with a colostomy.

On August 3, 2018 at 8:20 AM, R1 was lying in bed in the intensive care unit (ICU) of a local hospital. An intravenous (IV) line was attached to R1's right arm infusing IV antibiotics to R1.

On August 3, 2018 at 8:20 AM, V13 (R1's ICU Registered Nurse-RN) said when R1 was admitted to the hospital she was very sick. V13 said R1's urine in her catheter bag was very dark and she was lethargic. V13 said R1's colostomy was not draining stool because she had a bowel obstruction. V13 also said R1 was dehydrated and had sepsis. V13 said R1 was receiving two different antibiotics due to her sepsis.

On August 7, 2018 at 2:13 PM, V3 (Certified Nursing Assistant-CNA) said R1 would not drink much. V3 said R1 had a colostomy. V3 said the CNAs document the resident's outputs in the bowel and bladder book up at the nurse's desk. V3 said she worked July 30, 2018; the night before R1 was sent to the hospital. V3 said she had called the Nurse (V8-Licensed Practical Nurse-LPN) into R1's room because R1 had been throwing up and there was swelling under R1's colostomy. V3 said from 4-10 PM on July 30, 2018 R1's urine output was brownish in color. V3 said when she worked the next afternoon R1's urine was brownish in color and the swelling under R1's colostomy had increased.

On August 7, 2018 at 1:20 PM, V6 (LPN) said she worked the day shift (7 AM-3 PM) on July 30, 2018. V6 said R1 was spitting up a sputum like liquid on her shift. At 12:52 PM, V11 (LPN) said R1 had one emesis during the shift she worked

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on July 31, 2018 (7 AM-3 PM shift). V11 said she does not know what R1's urine or bowel outputs were that shift.

On August 7, 2018 at 1:38 PM, V9 (CNA) said she worked July 31, 2018 on the 7:00 AM - 3:00 PM shift. V9 said R1 did not seem quite right on her shift; she was not making sense. V9 said she reported this to the Nurse on duty.

On August 7, 2018 at 9:04 PM, V7 (LPN) said she worked the overnight shift from July 30-July 31, 2018. V7 said she does not remember if the CNAs said anything to her about the color or odor of R1's urine. V7 said the CNAs do not give her an amount of how much fluids R1 drinks. V7 said R1 usually does not drink a lot. V7 said R1's abdomen was distended and firm around the colostomy. V7 said she does not remember if she looked at R1's catheter that night or not.

On August 7, 2018 at 12:37 PM, V8 (LPN) said V3 (CNA) called her to R1's room on July 30, 2018 on the 3-11:00 PM shift. V8 said R1's abdomen was distended and firm and R1 threw up a brown coffee-colored liquid. V8 said when she came in the next day for the 3-11 PM shift R1 was very confused and the abdomen was more distended and she did not like how R1 looked. V8 said R1 usually does not drink well.

On August 7, 2018 at 12:52 PM, V11 (LPN) said R1 had one emesis during the shift she worked on July 31, 2018 (7 AM-3 PM shift). V11 said she does not know what R1's urine or bowel outputs were that shift.

On August 7, 2018 at 2:25 PM, V2 (Director of Nursing) said R1's Bowel and Bladder Assessment Tracking forms for July 2018 show

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R1 did not have a bowel movement for 6 days (July 24, 2018 -July 29, 2018). V2 said R1's meal, snack and fluid consumption forms were not filled out correctly either (only 3 meals in the 31 days of July were filled in). V2 said if staff had initiated the facility's bowel protocol they may have been able to prevent R1's bowel obstruction.

On August 7, 2018 at 1:58 PM, V12 (RN, ICU Nurse) said she took care of R1 the morning after she was admitted to the hospital. V12 said R1 was very lethargic received two medications to aid with her blood pressure due to her systolic blood pressure being in the sixties on admission. V12 said there was no output to R1's colostomy on admission. V12 said she believes R1 received 5-6 liters of fluids since admission to the hospital.

R1's Nurse Progress Notes of April 28, 2018 show R1 has a history of dehydration. Progress notes of May 17, 2018 show she has a history of UTI's.

R1's May 4, 2018 Dehydration Risk Screening shows R1 is at risk for dehydration.

R1's care plan for the indwelling urinary catheter with a revision date of February 5, 2018 shows Monitor I&O (intake and output) and record every shift.

R1's Nurse Progress Notes of July 30, 2018 show "Resident had an emesis episode of brown water no solids this evening. When assessing resident this Nurse noticed that around her colostomy her abdomen is distended and firm.

R1's Nurse Progress Notes of July 31, 2018 show "Resident had large emesis this morning at

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approximately 9:30 AM of dark brown/black liquid ...Ostomy intact to left abdomen with dark brown/black liquid stool inside bag. Left abdomen rounded and firm ...Resident continues to complain of some nauseousness and with light groaning."

R1's care plan for the potential for constipation related to decreased mobility with a revision date of February 5, 2018 shows "Follow facility bowel protocol for bowel management. Record bowel movement pattern each day. Describe amount, color and consistency.

The facility's policy and procedure titled Intake, Measuring and Recording, with a revision date of November 2013 shows "The following information should be recorded in the resident's medical record, per facility guidelines: 1. The date and time the resident's fluid intake was measured and recorded. 2. The name and title of the individual who measured and recorded the resident's fluid intake. 3. The amount (in milliliters-ml) of liquid consumed. 4. The type of liquid consumed."

The facility's policy and procedure titled Output, Measuring and Recording, with a revision date of November 2013 shows "The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24 hour period. "7. Carefully observe the level of urine in the graduate. Maintain eye level so that you can see the number reached by the level of the urine. 8. Record the amount noted on the output side of the intake and output record. Record in ml."

The facility's policy and procedure titled Catheter Care, Urinary with a revision date of November 2013 shows "Input/Output 1. Observe the resident's urine level for noticeable increases or

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decreases. If the level stays the same, or increases rapidly report it to the physician or supervisor. 2. Maintain an accurate record of the resident's daily output as indicated.

On August 7, 2018 at 2:25 PM, V2 (Director of Nursing) handed this surveyor the facility's PRN (as needed) Medication Information form with a revision date of December 2009. V2 said this form lists the bowel protocol to follow when a resident has not had a bowel movement (BM) in 72 hours. The protocol shows nursing staff should give the resident 30 ml milk of magnesia (MOM) on the day shift, followed up with a bisacodyl (laxative) 10 mg (milligram) suppository on the 3-11 shift if no BM after the MOM was given. If there has not been a BM after the suppository, the 11 PM-7 AM shift will follow up with a fleet enema.

V14's (Hospital Cardiologist) Consult notes from a local hospital dated August 1, 2018 show "Patient is very lethargic with a metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function). Patient had hypotension with systolic blood pressure in the 70's. Urinalysis reported from (another hospital that R1 originally was sent to) showed significant abnormality suggestive of urinary tract infection. White blood cell count was 20.8 (normal range is 4.8-11.0). Lactic acid was 4.0 (normal range is 0.4-2.0).Computertography (CT) of the abdomen showed multiple dilated loops of small bowel and air-fluid level suggestive of small bowel obstruction. Severe sepsis protocol was initiated and patient was given 2.7 liters of normal saline bolus and then transferred to another hospital. Patient received broad-spectrum antibiotics. Blood pressure remains poor in spite of Levophed

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(a medication to help stabilize blood pressure) drip. At this point we decided to give two units of blood transfusion as hemoglobin was low with acute abdomen and then also started on vasopressin (another medication to help stabilize blood pressure). Patient received IV steroid. NG tube in place. V14's notes show "Assessment: Hypotension secondary to septic shock. Severe sepsis most likely cause is ischemic bowel disease contributed by urinary tract infection. Small bowel obstruction with high probability of incarcerated hernia. Metabolic encephalopathy. Chronic kidney disease. Plan: Broad -spectrum antibiotics. IV fluid continued at 125 cubic centimeters an hour. Most likely patient is going to need surgical intervention. Because of multi-organ failure patient is going to need multidisciplinary approach and ICU management is anticipated for a few days after surgery. (A)

Licensure 2 of 2 violations
300.610a)
300.1210b)
300.1210d)2)
300.1210d)5)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually

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by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced

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by:
Based on observation, interview, and record review, the facility failed to identify areas of pressure on a resident prior to them deteriorating to deep tissue injuries (DTI) and the facility failed to follow their policy and procedure for dressing changes.

This failure contributed to R1 developing 3 deep tissue injuries and one stage I pressure injury to her right foot.

This applies to 2 of 3 residents (R1, R2) reviewed for pressure injuries in the sample of 3.

The findings include:

1. R1's Minimum Data Set (MDS) assessment of July 26, 2018 shows she is cognitively intact. R1's Braden Scale (determines a resident's risk of developing a pressure injury) Assessment of March 20, 2018 and June 19, 2018 shows she is at high risk for developing a pressure injury.

R1's June 16, 2018 - July 15, 2018 Treatment Administration Record (TAR) shows an order for "Bilateral heels: Apply heel protectors on at all times. Remove every shift for skin checks." The TAR shows the order was initiated on March 8, 2015.

R1's Skin Integrity care plan with a revision date of May 22, 2018 shows diagnoses of left side hemiplegia, multiple sclerosis and contractures to her left lower extremity. R1's Minimum Data Set (MDS) assessment of July 26, 2018 shows she requires extensive assist of 2 staff members for bed mobility, is dependent on staff for transfers, toileting, personal hygiene and bathing. The MDS shows R1 has impaired range of motion.

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On August 3, 2018 at 8:20 AM, R1 was sitting in her bed in the intensive care unit of a local hospital. R1 had a bandage around her right foot and pressure reducing boots on bilaterally. R1 said she also had a pressure injury on her buttocks. R1 said V10 (R1's husband) was the one who did the dressing changes for her pressure injuries at the facility. R1 said V10 was the one who noticed the wounds on her foot.

R1's Progress Notes of May 22, 2018 show "Assessed resident for wound care as day RN (Registered Nurse) reported a small open area to her buttocks. Stage III coccyx 1.0 centimeter (cm) x 1.0 cm. Wound base is red with pink peri area that has surrounding scar tissue from previously healed wound. Scant amount of slough (non-viable tissue) noted to wound bed center."

R1's Nurse Progress Notes of May 25, 2018 show it was R1's husband, not the Nursing staff that identified the new pressure injuries to R1's right foot. The notes show "Resident's husband notified this Nurse at this time of a new reddened area to (R1's) heel. Nurse assessed area. Large, round, red/dark purple/black area approximately 5 centimeters (cm) across noted to resident's right heel."

R1's Progress notes of May 26, 2018 (the following day) show "Resident presents with a deep tissue injury to right great toe 2 cm x 1 cm skin intact. Discolored dark blue/red. Deep tissue injury to right lateral foot below the 5th digit 2.3 cm x 1.5 cm skin intact. Discolored dark red. Deep tissue injury to right lateral heel 4.5 cm x 4.4 cm black in color. Non-blanchable. Stage I to left lateral foot below the 5th digit 1.0 cm x 0.8 cm. Red in color and non-blanchable. Resident

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also has new area to left buttock 2.0 cm x 1.0 cm. Wound base is pink with pink peri area and no drainage and no odor."

R1's Progress Notes of July 18, 2018 (R1's most recent assessment by facility staff) shows "Rounded with (V14-Wound Care Physician/Surgeon) today ...Assessment as follows: Right heel: 3.0 cm x 2.3 cm wound bed is pink with granulation tissue noted to bed and pink peri area. Small amount of serosanguinous drainage. No odor. Right foot lateral: 6.0 cm x 3.5 cm dark, dry eschar (dead, non-viable tissue) noted to wound bed with irregular borders and outer edges have granulation tissue forming. Pink peri area. No drainage. No odor. Sacral wound 4.0 cm x 4.0 cm x 1.5 cm. Wound bed is red with surrounding pink scar tissue to the peri area. Scant amount of tan drainage and no odor.

R1's July 3, 2018 Progress Notes written by V15 (Registered Nurse/Wound Care Nurse) show "Spoke with resident's husband regarding wound care concerns. Spouse denies that he has been scrubbing wife's wounds as reported by nursing. Showed resident and spouse proper wound care technique for (R1's) right foot wounds and sacral wound. Spouse was given opportunity to return demo wound care ...Informed resident and spouse that I will still be seeing them on a regular basis, as I need to be able to personally track progress. "

On August 7, 2018 at 2:25 PM, V2 (Director of Nursing) said V10 should not be doing the wound care for R1's pressure injuries. V2 said the Nurses need to do the dressing changes so they can assess for signs of infection and monitor for worsening of the wounds. At 4:42 PM, V2 said staff should be looking at the resident's skin when

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providing care and when giving showers. V2 said staff should have identified R1's pressure area, not V10 (R1's husband).

On August 7, 2018 at 3:42 PM, V14 (Surgeon/Wound Care Physician) said he expects the Nursing staff to perform the treatments to R1's pressure injuries. V14 said V10 is not qualified to do the dressing changes and the Nursing staff need to monitor the wounds for signs of infection and worsening of the wounds.

On August 7, 2018 at 10:27 AM, V4 (Licensed Practical Nurse-LPN) said the Nurses need to perform the dressing changes to R1 so they can monitor the wound and update the Doctor if the wound gets worse. At 10:50 AM, V5 (LPN) said V10 (R1's husband) did R1's dressing changes.

On August 7, 2018 at 12:52 PM, V11 (LPN) said V10 did do some of the dressing changes.

2. R2's Admission Record shows she was admitted to the facility on February 25, 2018 with a stage IV pressure injury to her sacral region, a stage III pressure injury to her buttocks and has diagnoses including breast cancer, hypothyroidism, chronic obstructive pulmonary disorder, and cellulitus of left lower limb.

On August 7, 2018 between 8:20 -8:50 AM, V5 (LPN) was performing dressing changes for R2's pressure injuries on her left foot, her bilateral posterior thighs and her coccyx area. V5 sprayed wound cleanser to the wound on R2's foot, wiped the wound bed, cleaned the intact skin around the wound bed (periwound), and using the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008379	A. BUILDING: _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREST NURSING PAVILION	515 NORTH MAIN SANDWICH, IL 60548

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

gauze wiped inside the wound bed again. While cleaning the pressure injury to R2's right posterior thigh, V5 took gauze and started wiping three inches away from the pressure injury and continued wiping in one continuous motion into the wound bed. V5 cleaned the pressure injury to R2's left posterior thigh using the same technique. V5 said she did not realize that she cleaned the areas around the wounds then cleaned the wound beds with the same contaminated gauze.

On August 7, 2018 at 4:42 PM, V2 (DON) said it is not acceptable to wash the periwound area then the wound bed. Staff should clean from the middle of the wound bed and then go out. V2 said the nurses should use a different gauze to clean the wound bed and the periwound skin.

The facility's policy and procedure titled Pressure Ulcer Treatment with a revision date of November 2013 shows "The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. General Guidelines: 1. The pressure ulcer treatment program should focus on the following strategies: a. Assessing the resident and the pressure ulcer(s) ...c. Pressure ulcer care. D. Managing bacterial colonization and infection." The policy shows "Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the wound care was given. 2. The name and title of the individual performing the care. 3. Any change in the resident's condition. 4. Any change in the wound data (i.e. color, size, pain, drainage, etc.) from last dressing change. 5. Resident tolerance of the procedure. 6. Any problems or complaints made by the resident related to the procedure.

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S9999	Continued From page 14 The facility's policy and procedure titled Dressings, Dry/Clean with a revision date of November 2013 shows "15. Review the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. 16. Cleanse the wound. Use a syringe to irrigate the wound, if using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated are (usually, from the center outward)." The facility's policy and procedure titled Pressure Ulcers/Skin Breakdown-Clinical Protocol with a revision date of November 2013 shows "2. In addition, the nurse shall monitor and document/report the following: a. Vital signs; b. Full screening of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue ..." (B)	S9999		