| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| S 000 | Initial Comments<br><br>Complaint #1866353/IL106118 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)5)<br>300.3220f)<br>300.3240<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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resident to meet the total nursing and personal care needs of the resident.

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:

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 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

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 Regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to complete and

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document weekly skin assessments per facility policy and failed to implement pressure relieving methods to prevent pressure ulcers for one resident (R3) of three residents reviewed for pressure ulcers in a sample of 3 residents. These failures resulted in R3 acquiring 2 pressure ulcers after admission. These pressure ulcers deteriorated to stage IV (four) until R3 was hospitalized for Sepsis related to wound infection requiring surgical debridement.

Findings include:

1.) R3's Physician's Order Sheet (POS) for September 2018 document R1 was admitted 5/5/18 with diagnoses including: Deep Venous Thrombus of left leg, Dementia, Heart Disease with a Pacemaker.

V1 Administrator documented in R3's progress note dated 5/5/18 at 5:00PM "resident admitted to us from (local hospital) via transport van. (R3) is aware of limitations and that (R3) is here for short term rehab (rehabilitation) to home program."

R3's admission "Observation Detail" by V4, Licensed Practical Nurse (LPN) dated 5/5/18 at 4:50PM documents "No Pressure Sores" R3's Braden skin assessment completed by V5, Licensed Practical Nurse (LPN) documents R3 as "not at risk." R3's quarterly Braden Skin Assessment dated 8/7/18 by V11, Registered Nurse (RN) documents R3 as "Moderate Risk"

R3's progress note by V12, Registered Nurse (RN) dated 5/28/18 at 1:59AM documents "stage 2 pressure ulcer to left heel measures 4.5 cm (centimeters) x 3 cm. Area is dark, no skin opening, border is reddened."

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| S9999 | Continued From page 3<br><br>R3's progress note by V4, Licensed Practical Nurse (LPN) dated 6/6/18 at 6:01PM documents "pressure ulcer to left foot is open and draining serosanguinous fluid. Eschar present."<br><br>R3's progress note by V12, Registered Nurse (RN) dated 6/20/18 at 4:05AM documents "Dressing to left heel done, eschar and smell noted."<br><br>R3's progress note by V13, Licensed Practical Nurse (LPN) dated 7/2/18 at 5:48PM documents "Pressure Ulcer to left heel is unstageable 100% eschar. POA (power of attorney) requesting wound specialist."<br><br>R3's progress note by V12, Registered Nurse (RN) dated 7/17/18 at 6:56PM documents "resident came back from wound clinic with new orders."<br><br>R3's progress note by V12, Registered Nurse (RN) dated 9/2/18 at 2:53 AM documents "dressing to left heel done as ordered. Noted old dressing loosely intact. Upon removal noted several maggots on old dressing. Noted foul smell."<br><br>R3's progress note by V15, Licensed Practical Nurse (LPN) dated 9/17/18 at 12:53AM documents "Dressings changed this shift, heavy drainage noted to left heel, malodorous. Resident voiced discomfort and pain during treatment."<br><br>2.) R3's progress note by V12, Registered Nurse (RN) dated 6/15/18 at 6:36AM documents "noted pressure ulcer stage 1 on right hip. Measured to the widest 1.9 cm x 1 cm. area is black, surrounding border red, non-blanching, skin intact." | S9999 | | |

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R3's progress note by V12, Registered Nurse (RN) dated 7/7/18 at 12:36 AM documents "Dressing to right hip done, no active drainage noted, no smell noted, wound bed 100% slough."

R3's progress note by V5, Licensed Practical Nurse (LPN) dated 7/16/18 at 1:14 AM documents "Area to the back of res (resident) right hip continued, area cleaned and foam dressing applied, some drainage and odor noted."

R3's progress note by V14, Licensed Practical Nurse (LPN) dated 8/26/18 at 4:59AM documents "Residents dressing changed to right hip, minimal amount of drainage noted. Malodorous. 2.5cm x 2cm."

R3's progress note by V5, Licensed Practical Nurse (LPN) dated 9/10/18 at 1:38AM documents "Treatment continued to pressure ulcer to (R3's) back, some drainage noted, malodorous."

R3's progress note by V12, Registered Nurse (RN) dated 9/16/18 at 12:33AM documents "Dressing to right hip done, area with 100 percent slough, smell noted, skin border reddened."

R3's progress note by V15, Licensed Practical Nurse (LPN) dated 9/17/18 at 12:53AM documents V6, Medical Doctor (MD) "advised to give (R3) Tylenol and send (R3) to the hospital for labs and testing."

R3's discharge summary from local hospital dated 9/26/18 at 1:29PM by V17, Medical Doctor (MD) states primary diagnosis as "Sepsis secondary to decubitus ulcers."

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3.) On 7/24/18 at 10:45AM during R3's visit to the wound clinic V7 Physician's Assistant (PAC) documented the wound on R3's left heel as "Unstageable measuring 5.4 centimeters cm in length by 4.8. cm in width by 0.2 cm in depth with a medium amount of red/brown drainage." At the same visit V 7 documented the wound on R's right gluteus as "Stage III (three) with a medium amount of sanguinous drainage." V7 ordered "obtain overlay for patient's bed and (specialized) cushion to off-load area at all times."

On 9/14/18 during R3's visit to the wound clinic V7 Physician's Assistant (PAC) documented the wound on R3's left heel as "Unstageable measuring 5.0 centimeters cm in length by 4 cm in width by 0.4 cm in depth with a medium amount of red/brown drainage." At the same visit V7 documented the wound on R3's right gluteus as "Stage III measuring 2.2cm in length by 2.2cm in width by 1.5 cm in depth with a large amount of sanguinous drainage." V7 ordered "obtain low air loss mattress for patient's bed and (specialized) cushion to off-load area at all times."

On 10/1/18 at 3:00PM V10, R3's family member and power of attorney stated. R3 "didn't get any special mattress or overlay for the bed until the day (R3) was hospitalized for the infection" (9/19/18). "I brought them (facility staff) the written order from the wound clinic back in July but (R3) never got any special mattress."

On 10/1/18 at 3:30PM V8, Certified Nursing Assistant (CNA) stated R3 "had the regular mattress just like on all of the beds here (at the facility) until (R3) got back from the hospital (9/26/18). We try to turn and reposition (R3) at least every 2 hours, but (R3) is a 2 person lift and by the time we get help it is always more that 2

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| S9999 | Continued From page 6<br>hours,"<br><br>On 10/2/18 at 10:34AM V1 Administrator stated Until (R3) went to the hospital (9/19/18) (R3) was using a (pressure relief) mattress. The manufacturer's specifications state the "clinical indications" for this model as "Prevention to Stage II (two) (wounds)"<br>The wound clinic documented a "Stage III" to R3's right gluteus as well as an "unstageable" pressure ulcer on R3's left heel as of 7/24/18.<br><br>On 10/1/18 between 12:30PM and 3:30PM R3 was in bed on R3's back without benefit of turning or repositioning. On 10/3/18 8:00AM and 10:38AM R3 was in bed on R3's back without benefit of turning or repositioning.<br><br>On 10/3/18 at 10:40AM V9, Certified Nursing Aide, (CNA) stated "yes I know (R3) hasn't been turned since at least 8:00AM. We just haven't gotten to it yet."<br><br>On 10/2/18 at 9:32AM V3, Assistant Director of Nursing was completing wound vacuum dressings to R3's left heel and right gluteal wounds. At 9:32AM the low air loss mattress on R3's bed was placed on "therapy" mode which disables the pressure reducing features of the mattresses so that the resident can be turned easier during a treatment. At 11:00AM V3 discovered that the appropriate dressing supplies were not available to complete the right gluteal wound treatment. V1, Director of Nursing went to the local hospital to get supplies to complete the dressing. V1 returned with the supplies at 12:40PM. During the time between 9:32AM and 1:00PM the pressure reducing properties were disabled since the bed was not taken off "therapy" mode during that time. | S9999 | | |

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On 10/1/18 at 2:00PM V1, Administrator supplied "Wound Management" documentation for both R3's wounds. There was no documentation on either wound from 7/22/18 until 8/30/18. V1 and V2, Director of Nursing (DON) confirmed that there was no documentation of wound assessments during this time.

The facility's policy "Pressure Injury Treatment and Protocol" revised 7/16 states "Weekly Individual treatment report will be done and put on clinical chart."

On 10/3/18 at 8:49AM V6, Medical Doctor (MD) stated (R3) "has severe peripheral arterial disease, so I can't say with certainty the pressure area to the left heel could have been avoided. However, the area to the right gluteal was certainly caused by pressure and most likely could have been avoided.

On 10/3/18 at 11:15AM V7, PAC from the wound clinic stated "The first issue we had with (R3's) care was when I ordered the low air loss mattress. (R3) needed that for offloading. R3 had no prior history of pressure ulcers. These wounds could have been avoided if (R3) had been turned and repositioned and the mattress would certainly have slowed down the deterioration of the wounds. As it was (R3) came to the nursing home with intact skin, developed 2 pressure areas which became infected and ended up in the hospital with sepsis. The wounds required surgical debridement by a plastic surgeon."

(A)