Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005722	A. BUILDING: _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)5) 300.1220b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.	S9999		

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S9999	Continued From page 2 Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met evidenced by: Based on observation, interview, and record review the facility failed to perform skin assessments, follow a turning, and repositioning schedule, ensure pressure reduction devices were in place, revise pressure reduction interventions, follow physician's orders for wound treatments, and perform hand hygiene during dressing changes for three of five residents (R20, R40, R9) reviewed for pressure ulcers in a sample of 38. These failures resulted in R40 developing an unstageable pressure ulcer to the left buttock and additional open wounds developed to the cleft between the right and left buttocks less than one week later. These failures also resulted in R20 developing an unstageable pressure ulcer to the left buttock which progressed to a stage IV pressure ulcer.	S9999		

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Findings include:

A Prevention of Pressure Ulcers/Injuries policy dated 7/2017 states to perform a pressure ulcer risk assessment upon admission and to repeat the risk assessment weekly, and upon any changes in condition. This policy also instructs to inspect residents' skin daily and to keep the skin clean and free of exposure to urine, and fecal matter. The policy further states to reposition residents who are chair-bound, or bed bound every hour and more frequently based on the condition of the skin. The policy instructs to review the pressure ulcer prevention interventions and strategies for effectiveness on an ongoing basis. This policy also instructs to select the appropriate support surfaces based on the resident's mobility, continence, skin moisture, perfusion, and overall risk factors. This same policy states to review the pressure ulcer prevention, treatment interventions, and strategies for effectiveness on an ongoing basis.

A Repositioning policy dated 5/2013 states, "Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief." The policy also states, "Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning." This policy further states, "4. For residents with a stage I or above pressure ulcer, every two-hour (q2 hour) repositioning schedule is inadequate. 5. Residents who are in a chair should be on every one-hour (q1 hour) repositioning schedule. 6. If ineffective, the turning and repositioning frequency will be increased." This policy also instructs to document in the medical record the position in which the resident was placed.

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R20 and R40's Wound specialist pressure ulcer information sheet (undated)states, "Pressure ulcers (also called decubitus ulcers or "bedsores") develop when there is injury to the skin and underlying tissue due to pressure for an extended period. This constant pressure reduces the blood supply to that area, preventing the delivery of vital nutrients and oxygen. Pressure ulcers most commonly occur in patients confined to a wheelchair or a bed."

A Dressings, Dry/Clean policy dated 9/2013 states that prior to performing pressure ulcer dressing changes, "5. Wash and dry your hands thoroughly. 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. 9. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface."

1. R20's Minimum Data Set (MDS) assessment date 1/31/19 documents R20 requires extensive assistance for bed mobility, transfers, and toilet use. This same MDS documents R20 has functional limitation in range of motion to one upper and lower extremity and is occasionally incontinent.

R20's Braden Scale for Predicting Pressure Sore Risk dated 1/31/19 documents that R20 is chairfast but otherwise at a low risk for the development of pressure ulcers.

R20's nurse's note dated 3/10/19 documents that R20 has increased, "difficulty manipulating w/c (wheelchair) with paralysis from stroke."

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R20's nurse's note dated 3/15/19 documents R20 developed a 2cm (centimeters) DTI (Deep Tissue Injury) which had a 1cm fluid filled blister over the top of it. This same note documents R20 also had a second DTI to the bottom of his left foot.

R20's nurse's note dated 4/3/19 documents R20 developed an unstageable pressure ulcer to the left upper buttock on that date.

R20's Wound Evaluation and Management Summary dated 4/3/19 documents that R20's physician ordered for R20 to have a gel cushion in R20's chair/wheelchair, and a cream applied to R20's left upper buttock wound then covered with a water proof adhesive gauze every day for wound healing.

R20's care plan dated 5/23/18 states that R20 is at risk for pressure ulcer development related to immobility. The care plan further instructs for R20 to use a pressure reduction cushion in his wheelchair and instructs staff to follow facility policies for prevention, and treatment of skin breakdown. R20's care plan does not identify that R20 has any pressure ulcers, identify any pressure ulcer treatments, or that any additional pressure ulcer preventive measures were developed after 5/23/18.

On 4/7/19 at 10:00a.m. V17 (Certified Nurse Aide/ CNA) stated that R20 has taken a decline in his strength over the past month. V17 stated that R20 can no longer self-propel in the wheelchair and needs more assistance with mobility because of increasing weakness. V17 also stated that R20 cannot use his right arm at all, has an amputation to his right leg, and a cushioned boot to his left leg. V17 stated that R20 is supposed to be transferred to bed and provided incontinence care

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after meals.

On 4/8/19 at 10:08a.m. R20 was in his room seated in a wheelchair, which did not have a pressure reduction cushion in place, next to his bed. R20 had a cushioned boot to the left lower leg and had an above the knee amputation to the right leg. R20 stated that he had been seated in the wheelchair since 7:00a.m. and had been waiting a long time after breakfast for staff to transfer him back to bed. R20 stated he wanted to lay down because his buttocks were sore because of having a pressure ulcer. R20 stated that he is supposed to lay down after meals, but he always must wait a long time for staff to assist him. R20 stated that sometimes when he pushes his call light, so staff can help him with toileting, R20 will have to wait up to one- and one-half hours for someone to answer which causes R20 to soil himself. R20 stated that he had a pressure reduction cushion for his wheelchair at the time of his admission in 5/2018 but that staff removed it a long time ago and R20 doesn't know where it went. R20 stated that he had become much weaker lately and could no longer adjust himself or propel himself in the wheelchair. R20 stated his right arm was paralyzed because of a stroke and he now has a new onset of weakness in his left arm which is the arm he used to propel the wheelchair. At 10:15a.m. V13 (CNA) and V6 (CNA) entered R20's room to transfer R20 to bed. V13 and V6 wrapped a safety belt around R20's waist and, using extensive assistance, lifted R20 from the wheelchair into the bed. V6 verified that R20 does not use a pressure reduction cushion in his wheelchair. V13 and V6 left R20's room without offering to toilet R20 or check and change R20's incontinence brief.

On 4/8/19 at 10:59a.m. V14 (Licensed Practical

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Nurse) stated that R20 does not have any pressure ulcers besides the wounds to R20's left foot. V14 reviewed R20's physician's orders sheet and Treatment Administration Sheets for 4/2019 and stated that R20 had no orders for a treatment to a pressure ulcer to R20's buttocks. V14 entered R20's room to examine R20's buttocks wounds. V14 loosened the tape from R20's incontinence brief which was full of fecal material and assisted R20 to turn to the side. R20's left buttocks had an open wound which did not have a dressing in place and which measured approximately 1.5cm (centimeters) long x 1.2cm wide x 0.3cm deep with a tannish pink wound bed. R20 also had two new open wounds to the cleft between the right and left buttocks. V14 reapplied R20's soiled incontinence brief over R20's open wounds. V14 asked V15 (Registered Nurse) to check R20's wound documentation to see if R20 was supposed to have a dressing to R20's buttocks wounds. V15 stated that R20's wound physician had documented R20'a left buttock wound on 4/3/19 and had ordered a cream and adhesive dressing to be applied daily. V15 stated that those orders were not transcribed into R20's electronic physician's orders which is a transcription error. V15 stated R20's wound specialists notes did not identify any other wound to R20's buttocks. V14 also verified that R20 does not use a pressure relief cushion to R20's wheelchair.

R20's Treatment Administration Record (TAR) dated 3/2019 to 4/8/19 does not document that nursing staff perform skin assessments to monitor for skin breakdown for R20. These same TARs do not show documentation that R20's physician ordered left buttock pressure ulcer treatment was administered from the time the wound developed 4/3/19 to 4/8/19.

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On 4/10/19 at 9:15a.m. and 10:20a.m., V2 (Director of Nurses) verified that R20's care plan dated 5/23/18 instructs for R20 to have a pressure reduction cushion in R20's wheelchair. V2 stated that the facility disposed of R20's original cushion at the time R20 was admitted because the cushion was soiled. V2 verified that R20's physician ordered a new pressure reduction cushion on 4/3/19 after R20 developed an unstageable pressure ulcer to the left buttock. V2 stated that the cushion had been ordered but had not arrived as of 4/10/19. V2 stated that nursing staff do not currently perform skin assessments on residents to detect and prevent pressure ulcers. V2 stated that R20 is chair bound but states she believes he can reposition independently and therefore, is not on a turning and repositioning program. V2 stated residents should be turned and repositioned every two hours and should be checked for incontinence and their incontinence briefs changed at that time. V2 could not provide any pressure ulcer prevention measures that were implemented after R20 developed an unstageable pressure ulcer to the left buttock on 4/3/19 in order to prevent the pressure ulcers from developing in the cleft between R20's right and left buttock.

On 4/10/19 at 12:45p.m. V20 (R20's Physician) stated that R20's unstageable left buttock pressure ulcer and pressure wounds between the right and left buttock could have been avoided if R20 had been using a pressure reduction cushion in his wheelchair and if he had been turned and repositioned at least every two hours.

2. R40's MDS assessment dated 9/13/19 Section G, Functional Status, documents R40 requires extensive assistance of one person for bed

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mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. This same section also documents that R40 has no functional limitation in range of motion to the upper or lower extremities. Section M, Skin Conditions, documents R40 did not have any pressure ulcers.

R40's annual MDS dated 12/6/19 Section G, Functional Status, documents R40 is totally dependent on staff for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. This same section also documents that R40 has a functional limitation in range of motion to both upper extremities. Section M, Skin Conditions, documents R40 has one unstageable pressure ulcer.

R40's care plan dated 3/28/19 documents that R40 is at risk for further skin breakdown related to immobility, current pressure ulcers, bowel incontinence, and because R40 requires assistance from staff for cares. R40's care plan interventions of lay down after breakfast and lunch to offload, pressure reducing cushion for chair and/or wheelchair, treatments/dressings as ordered by the physician, and pressure reducing mattress were all initiated between 1/2017 and 10/2017. R40's intervention to use a pressure reducing cushion to the chair was added a second time on 1/30/19.

On 4/7/19 at 10:55 V16 (Licensed Practical Nurse) stated that R40 had a stage IV pressure ulcer to R40's left buttock but that it was healed and no longer required a treatment and dressing.

On 4/9/19 at 10:51a.m. R40 was seated in a specialized wheelchair with no pressure relief

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cushion in place. V17 (Certified Nurse Aide/CNA) and V6 (CNA) entered R40's room to transfer R40 to bed. V17 stated that R40 had been seated in the wheelchair since 8:00a.m. that morning when V17 assisted her with morning cares. V17 stated that R40 is supposed to be turned and repositioned every two hours. V17 and V6 used a mechanical lift to transfer R40 from the wheelchair to the bed. R40 did not move her arms or legs at any time during the transfer. Once R40 was in the bed, V17 and V6 proceeded to removed R40's soiled incontinence brief to provide care. There was an open wound to R40's left buttock which was covered with fecal material and which measured approximately 1.5cm (centimeters) long x 0.5cm wide x 0.3cm deep. V17 stated she thought there was supposed to be a dressing to R40's wound but that V16 (Licensed Practical Nurse) had told V17 that R40's wound was healed and didn't need a dressing. V17 verified that R40's wheelchair did not have a pressure relief cushion in place stating that R40 does not use one.

On 4/9/19 at 11:10a.m. V28 (Licensed Practical Nurse) stated that R40 does not have any pressure ulcers. V28 looked through R40's physician's orders and noted that R40 had an order for a calcium medicated dressing covered with an adhesive dressing to be changed daily for R40's unhealed stage IV pressure ulcer to the left buttock. V28 stated that the order was not transcribed correctly because it did not include a time of day the dressing should be changed and therefore, R40's left buttock stage IV pressure ulcer had not been receiving that treatment since it was ordered by R40's physician 3/27/19.

R40's Treatment Administration Records (TAR) dated 3/2019 to 4/9/2019 document that R40's

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stage IV left buttock pressure ulcer has not received R40's physician ordered wound treatment by nursing staff since 3/27/19.

On 4/10/19 at 11:25a.m. V5 (MDS) Coordinator verified that R40 had a significant change in condition sometime following her MDS assessment on 9/13/18 and before her annual MDS assessment on 12/6/19. V5 stated that R40's significant change was not recognized and therefore, a significant change in status assessment was not conducted. V5 stated that if R40's significant change in status had been recognized, R40's care plan would have addressed R40's increased risk for skin break down with additional interventions to prevent the development of pressure ulcers, such as increased turning and repositioning. V5 verified that R40's care plan did not include any new interventions since 10/2017.

R40's wound physician's note dated 12/5/19 documents R40 was initially assessed for the development of a new unstageable pressure ulcer to the left buttock on that date. R40's wound physician's note dated 3/6/19 documents that R40's wound had deteriorated to a stage IV pressure ulcer.

On 4/10/19 at 9:15a.m. and 10:20a.m., V2 (Director of Nurses) verified that R40's current pressure ulcer risk reduction care plan does not include any new interventions since 2017 to address R40's increased pressure ulcer risk following the development of a stage IV pressure ulcer. V2 stated that R40's pressure ulcer developed on 11/30/18 as an unstageable pressure ulcer then progressed to a stage IV pressure ulcer in 1/2019. V2 verified that R40's care plan instructs for R40 to have a pressure

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reduction cushion to R40's wheelchair. V2 also verified that R40 was not provided with a pressure relief cushion. V2 stated that nursing staff do not currently perform skin assessments on residents to detect and prevent pressure ulcers. V2 stated that R40 is chair bound and requires turning and repositioning every two hours. V2 could not provide any pressure ulcer prevention measures that were implemented after R40 developed an unstageable pressure ulcer to the left buttock on 11/30/18 in order to prevent that pressure ulcer from progressing into a stage IV pressure ulcer on 3/6/19. V2 stated that R20 does have a pressure reduction air mattress which was not offered by the facility but instead was purchased by R40's family at the end of 1/2019.

On 4/10/19 at 1:31p.m. V25 (R40's physician) stated that R40 has taken a significant decline. V25 stated that R40's stage IV left buttock pressure ulcer could have been avoidable if staff had used the pressure relieve cushion in R40's wheelchair as ordered. V25 stated that he expects that R40's pressure ulcer treatment is provided by nursing staff as ordered.

3. R9's current Physician Order Sheet documents to cleanse R9's bilateral heels with wound cleanser, apply a medicated gauze, cover with a pad, then wrap with gauze daily and as needed.

04/09/19 09:23am, V7, RN (Registered Nurse) washed his hands, applied gloves, then removed R9's soiled dressing from his right heel. V7 then cleansed the wound and changed his gloves. V7 then applied the medicated dressing to R9's wound and wrapped it with a gauze dressing. V7 then removed R9's soiled dressing from his left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005722	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

(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 heel, cleansed the wound then changed his gloves, applied the medicated dressing and wrapped it with gauze. V7 did not perform any hand hygiene during R9's pressure ulcer cares. V7 stated that he did not have anywhere to perform hand hygiene during R9's care, so he did not do it. V7 also verified that there is a sink in the room a few feet away from where R9's wound care was being done. V7 stated that he does not know the policy, because that is to many details. On 4/10/19 at 9:00am, V2, Director of Nursing, verified that hand hygiene is to be performed when moving from a soiled area to a clean area. (B)	S9999		