STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

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S 000	Initial Comments Complaint Investigation #1976086/IL114980	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210 d)3) 300.1210 d)5) 300.1810 b) 300.3240 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 300.1810 Resident Record Requirements

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

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S9999	Continued From page 2	S9999		

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 evidenced by:

Based on interview and record review, the facility failed to implement timely interventions to prevent a high risk resident from developing a pressure injury, and failed to identify the resident's pressure injury before it became an unstageable wound. The wound subsequently became infected with a drug-resistant organism and the resident was sent to the emergency room.

This applies to 1 of 5 residents (R1) reviewed for pressure ulcers in the sample of 8.

The findings include:

R1's Face Sheet showed he was admitted to the facility on July 26, 2019, with diagnoses of paraplegia, malnutrition, bladder and prostate cancers, and encounter for antineoplastic radiation therapy.

R1's August 2, 2019, Minimum Data Set (MDS) showed R1 required extensive assistance of two people for bed mobility, had impairments to both legs, and was always incontinent of bowel. The same MDS showed R1 had no pressure ulcers, and R1 was at risk of developing pressure ulcers. The MDS showed R1 was not using a pressure reducing device for R1's wheelchair or bed, and R1 was not on any turning and repositioning program.

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S9999	Continued From page 3	S9999		

On August 21, 2019, at 10:15 AM, V12 (Wound Physician) stated "coming in the door [R1] was at high risk for skin breakdown." V12 stated radiation can affect a person's vasculature, and R1 was paraplegic and could not move or feel below the waist, was incontinent of stool, and was bony. V12 stated he "expects things to be put in place" to minimize risk.

R1's July 26, 2019, Nursing Admission Assessment in R1's EMR was incomplete, and the completed handwritten paper copy showed R1 was at high risk for skin breakdown. R1's EMR showed the paper copy was uploaded into R1's EMR on August 19, 2019 (the day after R1 was sent to the hospital for his wound).

R1's progress notes showed R1's coccyx wound was noted on August 8, 2019, 13 days after his admission. V14's (Wound Nurse) August 8, 2019, assessment of R1's wound showed it was first identified as a deep tissue pressure injury with 100% necrotic tissue and serosanguineous drainage. The photo included on the assessment showed black tissue on the bony prominence of R1's coccyx.

On August 21, 2019, at 8:55 AM, V3 RN (Registered Nurse) stated pressure injuries "should be identified way before they're unstageable." V3 added residents should be assisted to turn if they are paraplegic.

R1's EMR also showed CNA (Certified Nursing Assistant) Skin Observation documentation asking if R1 "has a skin alteration." Every answer leading up to the identification of R1's pressure injury, including the day it was identified, and until R1's transfer to the hospital showed "no." On August 21, 2019, at 12:45 PM, V5 RN (Director of

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S9999	Continued From page 4	S9999		

Nursing) stated CNAs have to really look at the resident and read when charting, adding "they can't just go on 'auto-pilot'."

On August 21, 2019, at 10:35 AM, V11 (CNA) stated she usually works the long-term group and she "just knows" who to turn. V11 stated there is nothing in resident's rooms that lets staff know someone needs to be turned and repositioned. On August 21, 2019, at 12:45 PM, V5 stated the use of turning and repositioning as an intervention has to be "loaded" into the system so CNAs are aware a resident needs to be turned, and it does not automatically trigger in the EMR system.

R1's Electronic Medical Record (EMR) showed turning and repositioning was initiated on August 13, 2019 (five days after the identification of the unstageable deep tissue injury).

R1's August 17, 2019, culture of his wound showed a positive result for drug-resistant bacterial growth. R1's August 18, 2019, discharge note showed V12 (Wound Physician) gave orders to send R1 to the hospital for evaluation and treatment of R1's infected coccyx wound.

The facility's May 1, 2015, Wound Care Program policy showed "It is the policy of this facility to ensure that residents whose clinical conditions and medical diagnosis potentiate the risk for skin breakdown and development of pressure ulcers are properly identified, assessed and managed according to current regulatory guidelines and standard of care ..."

(B)