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
	IL6007272	A. BUILDING: ____ B. WING ____	C 02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE WILLOWS	3520 NORTH ROCHELLE PEORIA, IL 61604

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S 000	Initial Comments Complaint #2021514/IL120506	S 000		
S9999	Final Observations Statement of Licensure of Violations: 300.610a) 300.1010)h 300.1210b) 300.1210d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	S9999	**Attachment A** **Statement of Licensure Violations**	

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of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.
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.

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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. 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 record review, and interview, the facility failed to provide thorough skin inspections, develop and implement pressure reducing interventions, provide a skin assessment (Braden Scale) every week for four weeks after admission, and obtain a treatment for a pressure ulcer upon discovery for one of three residents

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(R1) reviewed for pressure ulcers in the sample of three. These failures resulted in R1 developing an infected stage four pressure ulcer that required hospitalization, surgery to debride (remove damaged tissue from a wound) the ulcer, and intravenous antibiotics.

Findings include:

The National Pressure Ulcer Advisory Panel Pressure Injury Prevention Points dated 04/2016 documents, "Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury on admission and weekly for four weeks after admission for long term care residents. Skin Care: Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema. Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices."

The facility's Pressure Sores policy (undated) documents, "The comprehensive assessment and plan of care determines the amount of care needed by each individual resident to ensure that a resident having pressure sores receives the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Resident assessment identifies residents at risk of developing pressure sores and routine preventative care provided. For all residents who have pressure sores identify if measures to assist healing are necessary (relieving pressure, moving resident without shearing, applying medicated dressing, and debriding eschar (dead skin tissue)."

R1's Face Sheet documents that R1 was admitted to the facility on 11-13-19.

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R1's Minimum Data Set (MDS) Assessment dated 2-12-20 documents R1 needed extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. This same MDS Assessment documents is at risk for developing pressure ulcers however is not on a turning/repositioning program or nutrition/hydration intervention to manage skin problems.

R1's Braden Scale for Predicting Pressure Sore Risk dated 11-13-19 and signed by V6 (Licensed Practical Nurse/LPN) documents R1 was at moderate risk of developing a pressure ulcer. This same assessment documents a Braden Scale should be completed on admission for four weeks and then quarterly thereafter.

R1's Medical Record does not include documentation of R1 having a Braden Score done, as instructed, for the four weeks after R1's admission (11-13-19).

R1's Braden Scale for Predicting Pressure Sore Risk dated 2-11-20 and signed by V5 (Treatment Nurse) documents R1 had declined to being a high risk of developing a pressure ulcer.

R1's Care Plan from admission (11-13-19) to discharge (2-18-20) does not include any pressure relieving interventions to prevent pressure and does not indicate that R1 was at high risk for developing a pressure ulcer.

R1's Documentation Survey Report dated 2-1-20 to 2-18-20 (date of R1's discharge) documents the following interventions/tasks: Skin Observation every shift. This same report indicates that R1's skin observations every shift

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was not completed for 13 shifts during this time frame. This report also documents that an open skin area was identified on 2-2-20 at 6:59 AM.

R1's Medical Record does not include an assessment or treatment to the open area identified and documented on 2-2-20.

R1's Skin Observation Tool dated 1-28-20 and 2-11-20 documents R1 had no skin alterations except for excoriation to R1's groin.

R1's Progress Notes dated 2-18-20 at 1:57 PM and signed by V5 documents, "(R1) assessed by writer and noted with rash like areas over left and right buttock. Upon further assessment (R1) also to have severe breakdown between the buttocks. (R1) is incontinent of bowel and bladder, has poor skin turgor, and is unable to voice his needs including pain or discomfort. Contacted Medical Doctor and received orders to send to hospital for further evaluation."

R1's Progress Notes dated 2-18-20 at 2:48 PM and signed by V4 (Registered Nurse/RN) document, "(R1) sent to hospital for evaluation of wound on sacrum/ischium."

R1's Progress Notes dated 2-19-20 at 12:03 AM document, "(R1) admitted to hospital with diagnosis of Decubitus ulcer."

R1's Hospital Discharge Summary dated 2-23-20 and signed by V8 (R1's Hospital Medical Doctor) documents, "(R1) was admitted to the hospital on 2-18-20 with a pressure injury of skin involving the back and buttock. (R1) presented to the emergency department with complaints of a coccyx wound. Surgery was consulted for wound debridement and (R1) was initiated on

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Vancomycin and Zosyn (intravenous antibiotics) therapy. (R1) underwent debridement of the Decubitus ulcer on 2-20-20. Nursing home reports states ulcer has been present for at least two weeks but is getting worse."

R1's Operative Notes dated 2-20-20 document, "Procedure: Debridement of Sacral Decubitus Ulcer. Brief Findings: Two Sacral Decubitus wounds, bone exposed in anterior wound. Debridement taken to muscle. Wound Class: Four. The inferior wound measure 7.0 cm (centimeters) x 3.0 cm x 0.5 cm deep and the superior wound measures 6.0 cm x 5.0 cm x 2 cm deep. Upon inspection of the sacrum there is obvious dead devitalized tissue overlying the sacrum in two regions."

On 2-26-20 at 9:15 AM V4 (RN) stated, "The treatment nurse (V5) came and got me to look at (R1's) skin area on 2-18-20. (V5), (V1/Administrator), and I all decided that the wound was bad and (R1) needed to be sent to the emergency room for treatment. The wound was in the center of (R1's) butt crease, red in color in the center, and had two purple areas on each side. I did not document anywhere what the wound looked like and did not measure the wound. I do not do skin checks on the residents. The treatment nurse does the skin checks."

On 2-26-20 at 9:30 AM V5 (Treatment Nurse) stated, "On 2-18-20 V9 (Certified Nursing Assistant/CNA) and I laid (R1) down after lunch. We cleaned (R1) up after (R1) had a bowel movement. That is when I noticed (R1) had two necrotic areas. The area was bad, and I knew it was beyond what treatment I could provide within the facility. (R1's) wound needed treated at the hospital. (V9) said to me that the wound had

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been there for a while but was unsure how long. The staff should have reported the wound to a nurse when it was first found. We could have prevented the wound from becoming that bad. I am the only staff that does (R1's) skin checks weekly. Whenever I checked (R1's) skin I just looked at his skin. I never separated his butt cheeks to look for wounds when I did his skin checks. (R1) was in a low bed so it was hard to re-position him. (R1) was totally dependent on staff for re-positioning. After I did the Braden Scale for Predicting Pressure Sore Risk Assessment on 2-11-20 and determined (R1) was at a high risk for developing a pressure ulcer, I should have developed and implemented pressure relieving interventions to prevent (R1) from developing pressure ulcers. (R1) did not have any pressure relieving interventions implemented. I am new to this position and thought that the care plan coordinator would implement pressure relieving interventions. (R1) did not have a Braden scale assessment done every week for four weeks after (R1) was admitted to the facility. I am just learning and did not realize the Braden scale was supposed to be done on admission and every week for four weeks after admission. (R1's) skin checks were supposed to be done every shift by the CNA's and were not completed as documented. The first documentation of (R1) having an open area was on 2-2-20. I was not made aware of (R1) having an open area on 2-2-20. (R1) did not have an order to treat the open area."

On 2-26-20 at 11:30 AM V7 (Care Plan Coordinator) stated, "I got (R1's) Braden Scale Scores indicating (R1) was at a moderate and high risk for developing pressure ulcers. I guess I am not sure what to do with those scores once I get them. (R1) did not have a pressure relieving

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care plan with interventions to prevent pressure ulcers. (R1) probably should have had individualized pressure relieving interventions put into place."

On 2-26-20 at 1:15 PM V10 (R1's Physician) stated, "The facility should have identified (R1's) pressure ulcer when it was a stage one and notified me to get (R1) a treatment, some laboratories done, and pressure relieving interventions. It should not have been found at a stage three or four."

On 2-26-20 at 1:20 PM V9 (CNA) stated, "(R1) had an open area to his bottom for a while. I am not sure exactly how long. The CNA's would just put cream on the area."

On 2-26-20 at 1:45 PM V2 (Director of Nursing) stated, "When the treatment nurse does a weekly skin check, all areas of the skin should be observed to the best of the nurse's ability. I am not sure what we (the facility) does when a resident's Braden Scale indicates the resident is at high risk of developing a pressure ulcer. Pressure relieving interventions should be implemented and a pressure relieving care plan should be developed at the least. The physician should have been notified when (R1's) open area was first found to at least get a treatment order or get referral to the wound specialist."

On 2-26-20 at 2:15 PM V8 (R1's Hospital Physician) stated, "(R1) was brought to the emergency room with a necrotic coccyx pressure wound that was infected into (R1's) bone. (R1's) pressure ulcer was so bad that it would have had to developed and worsened for weeks prior. That pressure ulcer did not develop overnight. The facility should have recognized that pressure

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S9999	Continued From page 9 ulcer at a stage one and treated it as soon as it developed to prevent the pressure ulcer from getting as bad as it was when (R1) arrived at the hospital. (R1's) pressure ulcer had to be treated with intravenous antibiotics and surgery to debride the ulcer." (A)	S9999		