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
	IL6008965	A. BUILDING: ______ B. WING ______	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOME OF SPRINGFIELD	3306 SOUTH 6TH STREET ROAD SPRINGFIELD, IL 62703

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S 000	Initial Comments Complaint #2041314/IL120287	S 000		
S9999	Final Observations Licensure Violations: Section 300.1210a)b)4)5 Section 300.1210d)2)3)5 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 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. 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. 5) All nursing personnel shall assist and encourage residents as often as necessary in an effort to help them retain or maintain their highest	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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practicable level of functioning.

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.

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 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.

This requirement is not met as evidenced by:

Based on interview and record review, the facility failed to promptly assess, treat, and monitor identified pressure ulcers for 1 of 4 residents (R3), reviewed for pressure ulcers, in a sample of 10. This failure resulted in R3 being admitted to the hospital with Sepsis/recurrent fevers due to infective ulcer.

Findings Include:

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R3's Admission Assessment dated 9/6/2019 at 9:16 AM, lists R3 as being "Totally Dependent" on staff for care. The Assessment does not list R3 having any skin issues.

Braden Scale For Predicting Pressure Score Risk, dated 9/3/2019, 9/17/2019, and 9/24/2019, documents R3 as scoring 15, indicating risk for developing pressure ulcers. The Scale also lists R3 having limited sensory perception, being chair fast, with limited mobility.

Braden Scale dated 1/10/2020, documents R3 as scoring 9, indicating very high risk for developing pressure ulcers.

R3's Care Plan, undated, documents R3 was admitted to the facility with a pressure ulcer on left 4th toe. The Care Plan fails to list any other identified skin issues for R3.

Skin/Wound Note dated 12/18/2019 at 10:01 PM, documents, "Note Text: Resident (R3) 5 area of concern on his buttocks and coccyx Aide this shift stated that the areas were not there when she worked on Sunday. There is a blister on his right buttock that measures 1cm (centimeters) x (by) 1 cm. Area around it is redden and non blanchable. On inside of his right buttocks there is an open blister that measures 2 cm long x 2 cm wide. Skin inside blister is a bright red. Skin around blister is redden and non blanchable. On his coccyx is an open blister that measures 2cm long x 1.5cm wide. Skin inside blister is bright red and skin surrounding is redden and non blanchable. Just below this is another open area that measures 0.5cm long x 0.5cm wide. Area around it is redden and non blanchable. On the inside of his left buttocks is a white blister that

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measures 0.5cm long x 0.3cm wide. Area around it is redden and non blanchable. Resident's wife did state that he was complaining of a sore bottom over the last weekend. Will continue to monitor."

Skin/Wound Note dated 12/18/2019 at 10:04 PM, documents "new several shallow open areas noted to area between cheeks of buttocks near coccyx - (V3, wound nurse) notified - she (V3) assessed and applied Mepilex dressings - will fax her assessment notes to Dr. (V22)."

Nurse's Note dated 12/20/2019 at 9:33 AM, documents R3 "has breakdown on his bottom. It is excoriated and has open areas where blisters have burst."

Nurse's Note dated 12/22/2019 at 10:13 PM, documents that R3's physician (V22) was "refaxed notification of areas - note on copmmunication (sic) book and on desk calendar to notify him at office tomorrow for orders."

Nurse's Note dated 12/24/2019 at 3:41 PM, documents "Resident's (R3) coccyx and buttocks are a bright red with 3 open areas. Bright red area is 13cm long x 17 cm wide and cover all of both buttocks. He has an open area on his coccyx that measures 3cm long x 2cm wide. Area is bright red with yellowish center and white around the edges. An open area on his left buttocks is 2.5cm long x 3cm wide bright red with a white edge. On his right buttocks is an open area 2.5cm long x 1.5cm wide, bright red in center and white along the edges. Resident complained of pain rating a 10 on the 0-10 scale. He was visibly crying and calling out in pain. He was given a PRN (as needed) Norco. Will continue to monitor."

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Nurse's Note dated 12/26/2019 at 9:36 PM, documents "resident (R3) changed twice on buttocks - saturated w (with) foul smelling serous drainage from coccyx wound - yellow in center - (V3/wound nurse), notified - she check wound - says (V24/Medical Director) supposed to be here tomorrow and if POA (Power of Attorney) wants him to, maybe he can look at it - noted for dayshift tomorrow to follow up by calling his office."

Nurse's Note dated 12/27/2019 at 3:22 PM, documents V22, R3's physician, was called and gave orders to send to Emergency Room (ER) for evaluation and treatment of wounds on coccyx.

Emergency Department (ED) Triage Notes dated 12/27/19 at 3:29 PM, documents "Pt (R3) arrives for evaluation of ulcer on bottom. Per ems (Emergency Medical Services) pt has Stage 2 ulcer that started producing drainage with foul odor. States he may have progressed to stage 3. Pt is tearful upon arrival."

ED notes dated 12/27/19 at 4:18 PM, documents R3 was being recommended for admission to the hospital. Laboratory studies were performed with results as follows: White Blood Count 15.1, with reference range of 4.0 to 10.8; Chloride 108, reference range 98 to 107; Glucose 113, reference range 74 to 106; Blood Urea Nitrogen (BUN) 22, reference range 7 to 18; Creatinine 1.61, reference range 0.70 to 1.30; and Calcium at 8.2, with a reference range of 8.5 to 10.1.

Nurse's Note dated 12/29/2019 at 8:27 PM, documents "(R3) diagnosis is infected pressure ulcer. He is receiving IV (intravenous) therapy. Plastics is following and will determine plan once

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infection is under control."

Nurse's Note dated 1/4/2020 at 9:41 PM, documents "Spoke with his (R3) nurse. She states (R3) continues to receive IV therapy and wound care. He (R3) had an MRI (Magnetic Resonance Imaging) that showed questionable osteomyelitis so they are awaiting on ID (Infectious Disease)."

Nurse's Note on 1/7/2020 at 1:24 PM, documents the facility called the hospital for a progress report and was told R3 was on "different kinds of IV antibiotics and his cultures show multiple organisms."

Hospital Discharge Summary dated 1/9/2020 at 2:51 PM, documents R3 was discharged from the hospital with the following diagnoses in part: "Discharge Diagnoses: Sepsis/recurrent fevers due to infective decubitus ulcer, Coccygeal/sacral decubitus pressure ulcer, Failure to Thrive, and Rheumatoid Arthritis."

Nurses Notes dated 1/9/2020 at 4:00 PM, documents R3 returned to the facility "readmitted to the hospice program to room 310 per ambulance with family(wife)."

On 02/20/2020 at 7:50 AM, V2, Director of Nursing (DON) stated R3 had a developed a pressure ulcer that was "acquired here" at the facility. V2, DON, also stated initially R3's pressure ulcer was a Stage 1 then progressed "probably to a Stage 3, and there was drainage."

On 2/20/2020 at 2:35 PM, V5, Certified Nursing Assistant (CNA), stated "his (R3) bottom started because he wasn't always being layed down on previous shifts. He (R3) went downhill from

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there."

On 2/20/2020 at 3:00 PM, V6, Licensed Practical Nurse (LPN), stated R3 had pressure ulcers to his coccyx, and "It just seemed his wounds were deteriorating."

On 2/24/2020 at 12:42 PM, V2, DON, stated "I would expect them (staff) to call doctor immediately and if not able to reach to call the medical director and not to fax, and to notify family immediately too."

On 2/25/2020 at 2:35 PM, V2, DON, stated she didn't become aware of R3's multiple areas and blistering until 12/18/2019. She stated that R3 went to the hospital via ambulance on 12/27/19 and was admitted for "wound treatments." She stated he returned to the facility on 1/9/2020 on Hospice services, and subsequently died on 1/12/2020.

Based on interview and record review, the facility failed to notify the physician timely with a change of condition for 1 of 7 residents (R3), reviewed for change of condition, in a sample of 10. This failure resulted in R3 being admitted to the hospital with Sepsis/recurrent fevers due to infective ulcer.

Findings Include.

Skin/Wound Note dated 12/18/2019 at 10:01 PM, documents, "Note Text: Resident (R3) 6 area of concern on his buttocks and coccyx Aide this shift stated that the areas were not there when she worked on Sunday. There is a blister on his right buttock that measures 1cm (centimeters x (by) 1 cm. Area around it is redden and non blanchable. On inside of his right buttocks there

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is an open blister that measures 2 cm long x 2 cm wide. Skin inside blister is a bright red. Skin around blister is redden and non blanchable. On his coccyx is an open blister that measures 2cm long x 1.5cm wide. Skin inside blister is bright red and skin surrounding is redden and non blanchable. Just below this is another open area that measures 0.5cm long x 0.5cm wide. Area around it is redden and non blanchable. On the inside of his left buttocks is a white blister that measures 0.5cm long x 0.3cm wide. Area around it is redden and non blanchable. Resident's wife did state that he was complaining of a sore bottom over the last weekend. Will continue to monitor."

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Area is bright red with yellowish center and white around the edges. An open area on his left buttocks is 2.5cm long x 3cm wide bright red with a white edge. On his right buttocks is an open area 2.5cm long x 1.5cm wide, bright red in center and white along the edges. Resident complained of pain rating a 10 on the 0-10 scale. He was visibly crying and calling out in pain. He was given a PRN (as needed) Norco. Will continue to monitor."

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Nurse's Note dated 12/29/2019 at 8:27 PM, documents facility called the hospital and informed "(R3) diagnosis is infected pressure ulcer. He is receiving IV (intravenous) therapy. Plastics is following and will determine plan once infection is under control."

Hospital Discharge Summary dated 1/9/2020 at 2:51 PM, documents R3 was discharged from the hospital in part with the following diagnoses: "Discharge Diagnoses: Sepsis/recurrent fevers due to infective decubitus ulcer, Coccygeal/sacral decubitus pressure ulcer, Failure to Thrive, and Rheumatoid Arthritis."

Nurses Notes dated 1/9/2020 at 4:00 PM, documents R3 returned to the facility "to the hospice program to room 310 per ambulance with

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family(wife)."

On 02/20/2020 at 7:50 AM, V2, Director of Nursing (DON), stated R3 had an initial "change of condition" on 12/18/19 when new open area and blisters were noted and while the facility attempted to reach R3's physician via facsimile (fax), the facility did not receive a response. V2 stated the facility failed to notify the Medical Director of the R3's change of condition when unable to reach R3's physician.

On 2/24/2020 at 12:42 PM, V2, DON, stated "I would expect them (staff) to call doctor immediately and if not able to reach to call the medical director and not to fax, and to notify family immediately too."

On 2/25/2020 at 2:19 PM, V2 stated R3's wound information were faxed, not called to V22, R3's physician, and V22, physician, should have been called because the facility can't not verify V22 got the information at the time of the fax.

On 2/25/2020 at 2:35 PM, V2, DON, stated she didn't become aware of R3's multiple areas and blistering until 12/18/2019. She stated that R3 went to the hospital via ambulance on 12/27/19 and was admitted for "wound treatments." She stated he returned to the facility on 1/9/2020 on Hospice services, and subsequently died on 1/12/2020. V2 stated R3's wounds were acquired at the facility.

On 2/26/2020 at 3:35 PM, V24, Medical Director for the facility, stated he would expect after a reasonable amount of time if the facility was unable to contact the primary physician, he would expect the facility to contact him as the Medical Director.

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Facility Policy entitled Notification of Changes, undated, documents, "Purpose: Ensure resident and/or resident representative notification of specific changes during the resident's stay in the facility. Procedure: 1. The facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his/her authority, the resident representative(s) when there is - A significant change in the resident's physical, mental or psychosocial status (that is, deterioration in health, mental, or psychosocial status; A need to alter treatment significantly (to commence a new form of treatment); or A decision to transfer or discharge the resident from the facility."

Facility Pressure Ulcer Protocol for Stage 1 and 2, dated 12/1/2019, documents "If there is no improvement or decline in condition of the wound, call the Dr. for further orders."

Based on observation, interview, and record review, the facility failed to timely reposition 3 of 4 residents (R4, R5, R6), reviewed for pressure ulcers, in a sample of 10.

Findings include:

1. On 2/20/2020 at 3:20 PM, R4 was transferred with a mechanical lift from her recliner to the toilet by V10, Certified Nursing Assistant (CNA). R4's bilateral buttocks had deep red creases from her coccyx, that extended across her upper bilateral buttocks.

Braden Scale for Predicting Pressure Score Risk, dated 12/10/19, documents R4 scoring an 11, indicating she is at high risk for pressure ulcers.

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Physician's Progress Note dated February 2020, documents R4 having Alzheimer's disease and generalized muscle weakness.

Progress Note dated 12/24/2019, at 9:12 PM, documents, "Stage 1 pressure ulcer to buttocks has healed."

Progress Note dated 2/5/2020 at 8:44 PM, documents R4 having "Stage 2 pressure ulcer to coccyx has healed. Discontinue dressing."

R4's Care Plan, dated February 2020, documents R4 "has potential impairment to skin integrity of all areas r/t (related to) muscle wasting and immobility." The Care Plan further documents as an intervention to "Observe/identify/document potential causative factors for alterations in skin integrity."

2. On 2/20/2019 at 2:30 PM, R5 was lying in bed. V7, Licensed Practical Nurse (LPN) and V8, CNA, unfastened R5's incontinent brief and rolled her onto her right side. When V8 exposed R5's buttock, there were deep red creases from her left hip that extended down to her left thigh. When R5 was rolled onto her back, V8 removed the front of R5's incontinent brief, and deep red creases were noted throughout R5's perineum that extended up to her navel. V7, LPN, stated, "She (R5) didn't lie down until 12:30 (PM) or 1:00 (PM) and was up in her chair." V8, CNA, stated that R5 had been up before breakfast which was "about 8:00 (AM)."

Progress Note 2/5/2020 at 9:18 PM, documents R5 having had a Stage 2 pressure ulcer to her coccyx.

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Braden Scale for Predicting Pressure Score Risk, dated 9/17/2019, documents R5 scoring a 12, indicating she is at high risk for pressure ulcers.

3. On 2/20/2020 at 3:10 PM, after being transferred to bed from her chair by V9 and V8, CNAs, R6 was noted to have a covered dressing to her coccyx and open areas to her left and right inner buttocks. R6 was also noted to have deep creases to her bilateral hips that extended across her bilateral mid thighs. V6, LPN, stated, "I'm going to get a treatment for that," referring to R6's open wounds to her right and left inner buttocks.

On 2/20/2020 at 3:15 PM, V6, LPN, measured the wounds as follows: left inner buttock 1.5 centimeters (cm) long by 1.5 cm wide, with the right inner buttock that measured 2.5 cm wide by 3.5 cm. long.

R6's Care Plan, dated 11/20/2019, documents R6 having an Activities of Daily Living (ADL) self-care performance deficit related to fatigue. The Care Plan further documents R6 "has potential for skin breakdown r/t mobility status, chronic edema and moisture."

Braden Scale for Predicting Pressure Score Risk, dated 5/19/2019, documents R6 scoring a 15, indicating she is at risk for pressure ulcers.

Physician Order Sheet for R6 dated 2/20/2020, documents R6 having received an order for a "Stage 2 ulcer r (right) inner buttock," and and order for a "stage 1 areas on coccyx (l {left} inner buttock) per standing order."

On 2/25/2020 at 1:28 PM, V2, DON, stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008965	A. BUILDING: ______ B. WING ______	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOME OF SPRINGFIELD	3306 SOUTH 6TH STREET ROAD SPRINGFIELD, IL 62703

(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		

she was under the impression that R6's wounds observed by surveyor on 2/20/2020 were open, and not a Stage 1. V2 further stated V6, LPN, should not have staged one of the wounds as a Stage 1, because V6, Wound Nurse, does all the staging of wounds. V2 stated the latest quarterly skin risk assessment (Braden) that she could locate was done on 5/19/2019.

On 2/25/2020 at 1:24 PM, V2, DON, stated when a resident has a history of pressure ulcers it is necessary that they get turned and positioned and/or repositioned at least every 2 hours and more frequent to prevent break down from recurring and/or developing pressure "tremendously fast" again.

On 2/25/2020 at 2:35 PM, V2, DON, stated the facility didn't have a specific policy for timely repositioning, but it is expected for residents to be repositioned every 2 hours or more frequent.

Facility Pressure Ulcer Protocol for Stage 1 and 2, dated 12/1/2019, documents "If there is no improvement or decline in condition of the wound, call the Dr. for further orders."

(A)