STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008866	A. BUILDING: _____ B. WING _____	C 07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Complaint Investigation 2025373/124643	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1220 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)	S9999		

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S9999	Continued From page 2 These Requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to perform physician ordered wound care, implement interventions to prevent the worsening of a pressure ulcer, and follow the facility's wound policy for one of three residents (R3) in a sample of five. This failure resulted in R3's pressure ulcer worsening, increasing in size and eventually requiring R3 to be admitted to a local hospital for a surgical debridement and care of pressure ulcer. Findings include: The facility's Wound Care Policy, revised October 2010, documents to use a disposable cloth to clean off the overbed table, then place supplies on the table. Then wash and dry your hands thoroughly, put on gloves, loosen tape and remove dressing. Wash and dry hands again, apply PPE (personal protective equipment) as required. Use a no touch technique, sterile tongue blades or applicators to remove ointments from their containers, pour liquid solutions directly onto gauze on their papers. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Place one gauze to cover all broken skin. Remove the dry gauze, then apply treatment as indicated. This policy also documents that the following information should be recorded in the resident's medical record: type of wound care, date and time wound care was given, position the resident was in, person performing treatment, all assessment date (wound bed color, size drainage, ect.), the signiture and title of person recording the data.	S9999		

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S9999	Continued From page 3	S9999		

The facility's Pressure Ulcers/Wounds policy, 11/10/19, documents that a Wound nurse or designee will monitor all wounds and will obtain new treatment orders for wounds which have shown no improvement for two weeks in a row unless expected decline. A care plan will reflect skin issues and interventions will be put into place.

R3's Braden score dated 5/29/20 and 6/19/20 document a score of 15, indicating that R3 is a high risk for pressure ulcers. R3's current care plan does not address R3's pressure ulcer at all. There are no interventions or goals put into place to prevent R3's pressure ulcer from worsening.

R3's admission skin assessment, dated 5/29/20, documents a three inch round stage four pressure ulcer on his sacral area. R3's wound measurements dated 6/1/20 document the sacral wound measures 3cm (Centimeters) by 3.5cm by 1.7cm depth. On 6/8/20 the measurements were 5cm by 5cm by .5cm depth. On 6/15/20 R3's wound measured 5cm by 3.2cm by 3.5 cm. R3's medical record does not have documented measurements for the weeks of 6/22/20 and 6/29/20. R3's wound measurements on 7/7/20 were 10cm by 4.5cm by 3.4cm. On 7/13/20 the measurements were 10.2cm by 7cm by 3cm. No measurements were documented for the week of 7/21/20.

R3's Admission Physician Order Sheet, dated 5/29/20, documents to cleanse R3's coccyx wound with normal saline, apply debrideing solution to the wound bed, then cover with a medicated foam and a 4x4 dressing, secure with tape, two times daily - 8:00am and 4:00pm. This same form documents to do a body audit three times a day. R3's Treatment Administration

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S9999	Continued From page 4 Record dated 5/29/20-5/31/20 does not have any documentation that R3's wound care to his coccyx or skin audit was completed as ordered. R3's POS (Physician Order Sheet) dated 6/1/20 documents to apply a medicated cream to the peri-wound then soak 4x4 gauze with a medicated (Dankins) solution then pack the wound with the 4x4's, cover with an ABD, tape securely, daily. This form also documents to do a body audit three times daily. On 6/8/20 the wound care order was changed to two times daily instead of daily. On 6/15/20, R3's POS documented to continue the same treatment to the wound, but added to check R3 frequently, so stool (feces) does not get on the skin or dressing. R3's 6/1/2020-6/29/2020's TAR (Treatment Administration Record) has no documentation that R3's wound care or skin audit was done at all on 6/1/20, 6/9/20, and 6/30/20. R3's treatment order to his coccyx/sacral wound was changed on 6/8/20 to two times daily; R3's TAR does not have the new treatment orders on it. R3's treatment was only done one time daily instead of the two times as ordered. This form also has only the order to do the skin audit one time daily. R3's Progress Notes dated 6/30/20, document to send R3 to to the emergency room for a rapid COVID 19 test, then to get a total debridement of his sacral wound. R3's Emergency Room Notes, dated 6/30/20 documents that R3's wound measured 10cm by 8 cm by 3.5cm with necrotic tissue on the top of sacrum/coccyx bone with fascia involved, and the wound is unstageable. R3 was readmitted to the facility on 7/3/20. R3's readmission orders were to continue the same wound care two times daily. R3's TAR, dated July 2020, has no documentation that R3's wound was completed on 7/5/20, 7/6/20, 7/9/20 7/16/20, 7/19/20 and 7/25/20 on the 2:00pm - 10:00pm shifts and on 7/11/20, on the 10:00pm - 6:00am	S9999		

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S9999	Continued From page 5 shift. R3's body audit was not done on 7/4/20 and 7/6/20. On 7/27/20 at 11:00am, V4 (Licensed Practical Nurse/LPN) removed R3's brief to assess his dressing to his coccyx/sacral area. The dressing was intact but had feces on it; the dressing was not dated or initialed. V4 and V5 (LPN) returned with the supplies to do R3's wound care. V4 and V5 applied PPE before entering the room. V5 set the treatment supplies on the foot of R3's bed (not on a overbed table), then removed the soiled dressing, including the medicated packing, placed in a plastic bag at the foot of the bed. V5 cleansed R3's wound with medicated solution, disposed of the medicated gauze, then with the same gloves on, applied the medicated cream to the outside of the wound with her finger tip. V5 then put an ABD dressing over the top of the wound, initialed and dated the dressing. V5 did not do any hand hygiene any time during R3's wound care and was not wearing sterile gloves as documented in the facility's wound policy. V5 did not follow the physician wound care order to pack R3's wound with the medicated solution on the 4x4's. On 7/27/20 at 2:00pm V3 (LPN/Wound Nurse) verified that hand hygiene is to be done when moving from a dirty area to a clean. V3 verified that at no time is the finger tip used to apply medications. V3 stated the medicated solution is to be packed into R3's wound and left there until the next treatment. V3 stated that if the TAR is not signed out, then the treatment is considered not to be done as ordered. V3 verified that wound measurements are to be done on a weekly basis. On 7/27/20 at 2:30pm, V1 (Administrator) verified that wound care and treatments are to be	S9999		

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S9999	Continued From page 6 completed as ordered. V1 stated that if they are not signed out then they are not done. V1 could not provide any wound care measurements for R3 for the weeks of 6/22/20, 6/29/20 and 7/21/20. On 7/29/20 at 8:45am, V14 (R3's Primary Care Physician) verified that wound and physician orders are to be carried out as ordered. V14 also stated that wound care interventions should be put into place and followed to prevent worsening of pressure ulcers. On 7/29/20 at 9:00am, V13 (Clinical Wound Care Nurse Consultant) verified that R3's treatment order is to soak 4x4 gauze in medicated solution, pack the wound with it, then cover with a dressing. Cleanse with normal saline prior to using the medicated solution. V13 stated that she is no longer working at the facility because the treatments were not being done as ordered. V13 stated that she was not notified of R3's pressure ulcer worsening between 6/15/20 and 7/7/20. (A)	S9999		