

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2020
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NAME OF PROVIDER OR SUPPLIER STEPHENSON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2946 SOUTH WALNUT ROAD FREEPORT, IL 61032
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(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
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violation: 2 of 2 Violations</p> <p>Complaint 2018478/IL128102</p> <p>300.696a) 300.696c)2)7) 300.1020a) 300.1020b) 300.1210b) 300.3240a)</p> <p>Section 300.696 Infection Control</p> <p>a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.</p> <p>c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):</p> <p>2) Guideline for Hand Hygiene in</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>Health-Care Settings</p> <p>7) Guidelines for Infection Control in Health Care Personnel</p> <p>Section 300.1020 Communicable Disease Policies</p> <p>a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).</p> <p>b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to implement transmission based precautions for a resident experiencing COVID-19 symptoms, failed to implement appropriate hand hygiene and appropriate use of personal protective equipment (PPE), failed to implement their infection prevention control program and provide appropriate infection surveillance for staff, failed to provide continued staff education related to the COVID-19 pandemic, and failed to establish an effective isolation wing to prevent cross contamination between COVID-19 positive residents and persons under investigation. These failures resulted in an outbreak of COVID-19 among staff and residents that resulted in 49 residents being evacuated to an alternate long term care facility. This applies to all 85 residents</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>in the facility reviewed for infection control.</p> <p>The findings include:</p> <p>This facility data sheet dated 10/14/20 showed 85 residents residing in the facility. On 10/15/20, the facility provided a roster of residents evacuated which include R13-R61.</p> <p>1) On 10/14/20 at 8:30AM, V2 (Director of Nursing) stated, "We have 14 residents and 8 staff members currently positive for COVID-19. We are on our 3rd week of employee testing. We think our initial COVID-19 case came from a staff member. She just finished her 14 day quarantine. Last Friday (10/9/20) was the first positive COVID-19 case with residents."</p> <p>On 10/14/20 at 12:15PM, V1 (Administrator) stated, "We have decided to evacuate. Our human resources department and office personnel are contacting the families to let them know that they either need to take their family member home or we have to transfer them to an alternate facility. This is an emergency transfer, there is no other choice besides home at this point. We are declaring an internal disaster. All staff have been separated. Staff have been pulled from the non-COVID unit to the COVID unit but then they must stay on COVID unit. They are not allowed to cross back over to the non-COVID unit."</p> <p>On 10/14/20 at 9:00AM, V5 (Certified Nursing Assistant) stated, "Today is my first day working on the COVID unit. I am still learning all of the processes and what I'm supposed to be doing. I didn't get training for this unit, I usually work on the persons under investigation (PUI) unit."</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>On 10/14/20 at 9:10AM, V3 (Infection Control Nurse/Licensed Practical Nurse) stated, The dietary staff are not required to wear PPE when delivering meal trays. The dietary staff deliver the meal cart to both the COVID and PUI unit. To get to the PUI unit, the dietary staff must first pass through the COVID unit (without PPE on). To retrieve the meal carts, dietary staff must go back through the COVID unit and wheel the cart back through the COVID unit to the kitchen.</p> <p>On 10/14/20 at 11:20AM, V3 (Infection Control Nurse/Licensed Practical Nurse) took off her dirty PPE, left the COVID unit and entered the non-COVID area of the facility where staff are not allowed to cross over after working on the COVID unit.</p> <p>On 10/14/20 at 11:30AM, V9 (housekeeping/maintenance director) was standing at the nurses station on the COVID unit with his bare hands touching surfaces on top of the nurses station. V9 did not have gloves or an isolation gown on. V9 left the COVID unit without performing any hand hygiene and proceeded out into the receptionist area of the facility.</p> <p>On 10/14/20 at 2:00PM, V4 (Registered Nurse) was applying PPE at the entrance of the COVID unit. V4 stated, "I normally work on the non-COVID unit, that's where I am working today. I just came over here to draw blood on a resident then I'm heading back to finish my shift on the non-COVID unit." (Crossing from non-COVID unit to COVID unit and back to non-COVID unit). R5-R11 all reside on the COVID-19 positive unit. Progress notes for R5-R11 were reviewed and showed V4 (Registered Nurse) documented that she performed blood draws on R5-11 on</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>10/12/20. (while she was working the non-COVID unit)</p> <p>On 10/14/20 at 2:12PM, V5 (certified nursing assistant) came out of the soiled utility room on the COVID unit without a mask or PPE on. V5 walked around the nurse's station, made eye contact with surveyor, and then attempted to cover her mouth and nose with the edge of her shirt.</p> <p>On 10/15/20 at 10:55AM, V7 (admissions/marketing director) was observed at the nurses station on the COVID unit. V7 was leaning over the desk, putting her hands in direct contact with the desk and then proceeded to leave the unit. During this observation, V7 was wearing a surgical mask but no gown, gloves, or N95 mask. V7 did not perform hand hygiene upon exiting the COVID unit.</p> <p>On 10/15/20 at 3:00PM, V15 (registered nurse) was observed on the COVID unit putting on her N95 mask and commented to the surveyor, "I have no idea how this mask goes on, does this look right? It feels weird. Oh well, I guess its right. I came in today and was told all of my residents moved to another facility. I'm not sure what I am going to be doing tonight because I have never worked over here (PUI unit)."</p> <p>On 10/15/20 at 7:00PM, V6 (Registered Nurse) was observed sitting at the nurses station on the COVID unit. V6 did not have a mask, gloves, or gown on. V6 continued to sit at the nurse's station for 5 minutes without PPE on. V6 then stood up, went into the soiled utility room on the COVID unit, and walked out with a clean N95 mask and face shield in his hands.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 10/20/20 at 11:07AM, V12 (certified nursing assistant) stated, "I tested positive for COVID-19 when I tested last week. I had a headache last Wednesday or Thursday and called the facility and they told me to come in and get a COVID test done. I walked into the facility with a surgical mask on and went down to the soiled utility room on the COVID unit and got my test done there. You have to walk through the reception area and down one hallway to get to the soiled utility room on the COVID unit. I got my positive results that Friday. The N95 masks that they gave us to wear didn't fit right. That bothers me because I didn't really feel 100% protected. Also, the COVID unit nurses station was deemed "clean" so we were told we could hang out and sit there with just a mask on. I don't feel comfortable with that because we have 2 overflow patients that are COVID positive in rooms near the nurse's station. I remember getting educated on the use of our personal protective equipment but I don't recall any recent in-services or updates on COVID-19. Once positive tests started rolling in everyone just kind of panicked."</p> <p>On 10/20/20 at 11:40AM, V13 (care plan coordinator/registered nurse) stated, "I tested positive a week ago today. I had a few symptoms, cough and nasal congestion. I tested negative the day before that and the Friday before that as well. (The facility was unable to provide documentation of the 2 previous negative test results). Then I had a rapid test done on the 13th. I'm still having the cough. They told me that we could put our personal protective equipment on at the nurse's station on the COVID unit because it was brand new out of the package. We were tested weekly for a little bit, then had 2 weeks of negatives, so we went monthly. Then when we did that monthly test is when we ended</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>up with a positive staff member on September 29th. It had really only been 2 weeks since we had done a weekly test. Then it started to be everybody testing positive. I'm not sure why. The last days I worked on the COVID unit were October 10th, 11th, 12th and 13th. I got sent home on October 13 after I tested positive. October 9th was the first time we made a COVID unit. It was just a regular unit prior to the 9th."</p> <p>On 10/20/20 at 11:10 AM, V11 (activity aide) stated, "At the time of the test I was having a cough, body aches, sore throat, runny nose and loss of taste. I called in and asked if I could come in and be tested. On Monday the 12th I got tested at the facility and received positive results. I was working on the PUI unit. To my knowledge the outbreak is on the PUI unit. We were doing activities in small groups up until about a week or week and a half before the outbreak. It was rumored that there were a couple of people positive, so we stopped doing the small groups of 4-6 and went back to doing activities on the televisions. The last group was 3 weeks ago. I worked all day on October 9th.</p> <p>On 10/20/20 at 11:20AM, V14 (certified nursing assistant) stated, "I was tested at the facility, I remember feeling chest tightness and congestion and had a really bad headache. I came in to work on 10/7/20 at 6:45AM and didn't feel well so I ended up going home at 8:00AM. They had me sit at the nurse's station because I wasn't feeling well. I tested positive for COVID-19 on 10/9/20. I was working on the PUI hall and we didn't have any positive cases besides staff so we just wore surgical masks. Only one staff member had tested positive on 9/29/20 so we thought we just had to wear the surgical masks and gloves when we were doing patient care. I don't recall hardly</p>	S9999		

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STEPHENSON NURSING CENTER **2946 SOUTH WALNUT ROAD**
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S9999	<p>Continued From page 8</p> <p>any in-services on infection control or COVID-19 except at the beginning of the pandemic. I remember administration started panicking about staffing because we were short on staff."</p> <p>On 10/14/20 at 1:06PM, V3 (Infection Preventionist) stated, "At this time, we are treating the north and south units like 2 separate facilities. Our staff do not cross over from one wing to the other. For the non-COVID units the staff are wearing the blue surgical masks and if they would have someone on quarantine then yes they would do the conventional stuff like put on a mask, gown, and gloves. They wouldn't need a face shield because the residents are negative for COVID-19 and have assessments done every shift. On the COVID positive and persons under investigation (PUI) units we are wearing a gown, gloves, KN95 mask. We are not necessarily mandating eyewear because they are the "monitored" residents. On the COVID unit, staff are wearing N95 mask, gloves, gown, and goggles/face shield. There are 2 residents on the other side of the COVID positive hall with their doors open because that is their preference. I prefer to keep the personal protective equipment at the nurse's station so that way if I have to do something I can get my PPE on quicker. I started doing in-services on Monday and Tuesday (10/13/20 and 10/14/20, after positive COVID-19 test results have been received). I started doing infection control in-services. Prior to the outbreak we had a big flu thing (in-service). That was an all staff meeting and it was a big meeting. The last in-service I did was all about the influenza. They had a lot of questions about COVID. Before the in-services yesterday it was more monitoring, standing back and watching. For the quarantined residents that we've had here and there, I was just watching. Half the time they don't even know</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>I'm paying attention."</p> <p>On 10/14/20 at 2:10PM, V3 stated, "I do not have an employee infection control tracking form prepared, I have a few things written down but nothing formal. I'm not going to give you that because it's not anything formal. We don't really have staff call off for illnesses so it's not that much. Last week is when we really started seeing call offs due to COVID."</p> <p>On 10/21/20 at 10:45AM, V16 (Certified Nursing Assistant) stated, "I worked on 9/28/20. When I went home I felt like I was getting a cold. I didn't feel well when I went in for my shift on 9/29/20 at 6:45AM. At 8:00AM, I reported to management (I can't remember who) that I didn't feel well. They contacted the administrator who then gave me a COVID test and sent me home. I found out on 10/1/20 that I had tested positive for COVID. The facility told me to contact anyone I had been in contact with for the past 48 hours and let them know I tested positive. They didn't ask me who I worked with or what residents I worked with."</p> <p>On 10/21/20 at 11:09AM, V3 stated, "For reusable personal protective equipment (PPE) we are storing goggles and mask in our utility room. It's a clean room. We aren't using that room for anything else right now. When staff are at the COVID nurses station they should be wearing gowns, N95 mask, goggles/face shield, gloves. If staff are not working the staff can come in and get a rapid test in the community room right outside of the front lobby. If staff test positive they are taken off the roster, it is reported to the local health department and the administrator reports it to public health. I don't think there is anything else we do related to positive staff cases. I don't really deal with that part very much. I haven't heard of</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>any staff getting their rapid test in the soiled utility room on the COVID unit. That would be unacceptable because they are walking through the building and could contaminate other people. COVID in-services have not occurred since I came here in July. Nothing formal has happened. I know the administrator has done nurse meetings every other Tuesday and I am off every Tuesday so I'm not sure what has been said in those meetings."</p> <p>The facility's in-service records for the year 2020 showed the facility provided all nurses with an in-service on COVID-19 resident assessments on 3/18/20. On 4/7/20 the facility provided an in-service to all staff on policies & procedures related to COVID-19 as well as current guidance from local and state authorities. The facility was unable to provide any further in-services from 4/7/20 to 10/15/20 related to COVID-19 guidance given to all staff.</p> <p>The facility's policy titled, "COVID-19 Control Measures for Long Term Care" revised 8/20/20 showed, "It is the policy of Stephenson Nursing Center to develop a COVID-19 plan to minimize the spread of the virus. However, in the event the facility is affected with the virus, the following procedures will take effect: ...Staffing: Managers shall ensure that all clinical and non-clinical staff members including housekeeping, laundry and dietary are familiar with the plan. Staff members will know the symptoms of COVID-19 and understand the transmission and preventative measures ...Education/In-services will be provided for staff ...The following guidance is to help prevent transmission of COVID-19 ...d) consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic patients ...Any residents</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>identified with symptoms of fever and respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both Contact and Droplet transmission-based precautions ...Facilities: Focus on decreased staff rotation and cohort staff who work with symptomatic residents whenever possible ...Employees: All employees must wear a mask (universal masking) during their shift to protect residents. All staff must wear masks when entering the building."</p> <p>The guidance from the Centers for Disease Control updated 4/30/20 showed, "Determine which residents received direct care from and which health care providers (HCP) had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset. Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 personal protective equipment (PPE) until results of HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms."</p> <p>2) R12 was admitted to the facility on 3/15/19 with diagnoses including intracranial injury, dysphagia and systolic & diastolic congestive heart failure. R12 was located on the COVID-19 positive unit on 10/14/20.</p> <p>R12's nursing progress notes for 10/5/20 showed, "Fax sent out to physician. (R12) appears lethargic, keeps dozing off in between activity. Poor appetite. Observed with phlegm in his mouth thick and yellow in color. Bilateral lung sounds wheezing with expiration."</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>R12's nursing progress notes for 10/9/20 showed, "Physician notified of positive COVID test results. Quarantine measures initiated."</p> <p>The facility's daily health assessments for R6, R8, R11, and R12 dated 10/2/20 showed assessments were all within normal limits. The assessments dated 10/5/20 showed R12's lung sounds to be "wheeze". The assessments dated 10/7/20 showed R8 and R11 as "wheezes" and R12 to have "rhonchi" (coarse lung sounds).</p> <p>On 10/20/20 at 11:40 AM, V13 said the COVID Isolation Unit was started on 10/9/20 which is when the PPE (Personal Protective Equipment) requirement changed from requiring a surgical mask to staff needed full PPE including the N95 mask and face shield.</p> <p>On 10/21/20 at 11:09AM, V3 stated, "The symptoms related to COVID vary between each patient, some have been afebrile the entire time, some are running a temperature, some have respiratory symptoms such as rhonchi, wheezes. Audible wheezes are only in those patients with prior respiratory history. Daily monitoring of non-covid is temperatures, oxygen saturations, and respiratory assessments (lung sounds). If there were any changes we were writing that down and informing the director of nursing and possibly let the administrator know. Then they directed us on what to do. Whether or not we would isolate them depends on the situation. We would see if they have a fever, respiratory changes, or maybe it is related to something else. We then would contact the primary care provider to see what they wanted to do and usually they'll order a chest x-ray. If the x-ray came back as something like pneumonia the resident is cleared</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>to come out of their room. Whether or not the resident is isolated is up to the physician. I don't know what our policy is related to residents with COVID symptoms. I don't want to quote the wrong thing. (R12) symptoms indicate he should have been isolated and tested immediately. If there is a roommate then that roommate is moved to another private room. (R62) experienced audible wheezing during my shift on 10/7/20. I know that I notified the physician-even if it's not charted. The physician said she does this randomly and didn't order anything additional."</p> <p>The facility's resident COVID testing log dated 10/7/20 showed R8, R11, and R12 all tested positive for COVID19.</p> <p>(A)</p> <p>Complaint 2018154/IL127745</p> <p>300.610a) 300.1010h) 300.1210d)2)3)5) 300.3210o) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>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.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician 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. (B)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>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.</p> <p>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.</p> <p>Section 300.3210 General</p> <p>o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. (B)</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to identify a pressure ulcer prior to becoming a stage 2, failed to initiate a treatment for a stage 2 pressure wound, failed to notify the power of attorney of the presence of a new pressure wound, failed to report changes in the pressure wound to the physician, and failed to complete accurate weekly assessments for 2 of 3 residents (R1 and R3) reviewed for pressure ulcers.</p> <p>This failure resulted in R1 developing a pressure ulcer, R1's pressure ulcer deteriorating to an unstageable wound with necrotic tissue and becoming infected, and R1's admission to the acute care hospital for surgical treatment.</p> <p>The findings include:</p> <p>1. R1's Face sheet showed he was admitted to the facility on 5/11/19 with diagnoses to include but not limited to quadriplegia, neuromuscular dysfunction of bladder, chronic pulmonary disease, and chronic respiratory failure. R1's facility assessment dated 8/11/20 showed he is completely dependent upon staff for all cares and has a history of pressure ulcers.</p> <p>On 10/16/20 at 12:30 PM, V10 (R1's Power of</p>	S9999		
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S9999	<p>Continued From page 17</p> <p>Attorney for Healthcare) said R1 was transferred to the hospital on 10/10/20 and is "very sick because of necrotic wounds". V10 said she went to the emergency department with R1 on 10/10/20 and was shocked to see he had 2 wounds. V10 said R1 had a wound the size of her fist on his left buttock and a wound near his coccyx. V10 said the hospital took him into surgery and removed the dead tissue. V10 said the facility never informed her of R1's wounds.</p> <p>R1's complete care plan was reviewed and showed a care plan for a pressure ulcer to his left buttock was created on 9/30/20 (53 days after the wound developed) with a problem start date of 8/31/20 (23 days after the wound was identified) which included an intervention to assess the pressure ulcer weekly.</p> <p>R1's nursing progress note entered on 8/8/20 showed, "observed resident incontinence pad with smear of blood upon repositioning. Noted skin excoriation open approx.. 2.5 cm x 2 cm ... [Physician informed]." R1's nursing progress notes from 8/8/20 to current showed no notification to R1's family regarding the onset of his left buttock wound. The first wound assessment for R1's left buttock was documented by V2 (DON/Wound Care Nurse) on 8/12/20 which showed, "Left buttock ..., stage 2, ... 2.0 cm x 2.5 cm x 0.2 cm ... barrier cream to buttocks and groin (an order which had been on R1's physician order sheet since his admission on 5/11/2019). R1's wound assessment documented by V2 on 8/19/20 showed the wound had increased in size to 6 cm x 6 cm x 0.2 cm and notes the treatment which was initiated on 8/16/20. R1's wound assessment for his left buttock entered by V3 and dated 8/26/20 showed the wound had increased in size again to 7.9 cm</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>x 10.4 cm x UTD (unable to determine), was now unstageable, and the notes the tissue type to be necrotic/eschar. This same assessment notes that the same treatment is in place from the prior assessment. There was no weekly assessment for R1's left buttock wound documented for the week of 9/2/20.</p> <p>R1's treatment administration record for August 2020 showed the treatment to R1's left buttock was changed on 8/29/20 to "...cleanse with wound cleanser daily, apply Santyl (enzymatic debridement cream) and cover with ABD (non-adhering gauze pad)".</p> <p>R1's left buttock wound assessment entered by V3 on 9/9/20 showed the wound to measure 7.9 cm x 11 cm x UTD, to be unstageable, and the tissue type to be "slough". R1's wound assessment dated 9/16/20 showed the wound had increased in size to 7.9 cm x 12 cm x UTD, to be unstageable, and the tissue type as necrotic/eschar again. This assessment notes no treatment change. R1's left buttock wound assessment dated 9/23/20 showed the wound to measure 7 cm x 12 cm x 0.2 cm.</p> <p>R1's treatment administration record for September 2020 showed the treatment for his left buttock wound was changed on 9/24/20. There were no treatment changes made between 8/29/20 and 9/24/20 despite the wound continuing to increase in size. There was no documentation in R1's medical record between 8/29/20 and 9/24/20 showing notification to a physician regarding the left buttock wound.</p> <p>R1's left buttock wound assessment entered by V2 DON on 9/30/20 showed the wound to be 7 cm x 12 cm x UTD, stage 3, and the tissue type</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>as slough. This assessment noted no changes to the wound treatment. The last documented assessment for R1's left buttock wound before his transfer to the acute care hospital on 10/10/20 was entered by V2 on 10/7/20 and showed the wound to be 6.8 cm x 12.9 cm x UTD, stage 3, and the tissue type to be necrotic/eschar. This assessment noted no change to the wound treatment orders. The wound treatment orders were not changed from 9/24/20 through 10/10/20 when he was transferred to the acute care hospital. R1's nursing progress notes from 9/24/20 through 10/10/20 do not include notification to the physician regarding the left buttock wound.</p> <p>R1's nursing progress note dated 9/29/20 showed, "requested to have clear liquids to drink for lunch stated 'the food is balling up in his mouth not able to swallow it as his mouth is too dry not producing enough saliva". R1's nursing progress note dated 10/7/20 entered by V4 RN (Registered Nurse) showed, "Has been up in wheelchair by desk yelling help, when asked what he needed stated I can't breathe need drink of water. Water given. Within a few min he started yelling again that he couldn't breathe yet was able to talk and yell just fine." R1's nursing progress note dated 10/8/20 entered by V4 showed, "told staff that he wanted to go to the ER. Writer entered room but refuses to answer when questions asked. Lungs clear yet diminished ..."</p> <p>R1's nursing progress note dated 10/9/20 showed, "Resident states he can't breathe but speaking in full sentences ... O2 (oxygen) at 5 LPM via tracheostomy ... state he cannot swallow and drink but was able to take medications without problem and drank water offered after medications." R1's nursing progress note dated 10/9/20 showed, " ...chose to decline to eat</p>	S9999		
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S9999	<p>Continued From page 20</p> <p>breakfast ...states I can't swallow and drink when I am lying down ..." R1's nursing progress note dated 10/9/20 at 11:01AM showed, "Refused scheduled bath. State he wants to go to the hospital. PCP (Primary Care Physician) notified by fax, awaiting advise." R1's nursing progress note dated 10/9/20 at 1:51 PM showed, " ... still awaiting for PCP's advice" R1's nursing progress note dated 10/9/20 at 10:27 PM showed, "Fax received from [PCP], stated he would be in the facility to see this resident over the weekend." R1's nursing progress note dated 10/10/20 at 10:05 AM with an edit time of 11:59 AM showed, " ...Resident alert yet increased lethargy noted. Refused to eat. Did take meds with water no difficulty swallowing. Area to Lt (left) buttock has increase in eschar and active bleeding noted. Surrounding tissue is spongy. Resident request to go to the ER (emergency room) states 'I'm dying'. Call placed to [PCP] update given states to send him to the ER." R1's nursing progress note dated 10/10/20 at 3:29 PM showed, "[PCP] here stated resident is being admitted to the hospital. BGM (Blood Glucose Monitoring) was 407 and has infection. Will see the surgeon in the AM about left buttock."</p> <p>R1's treatment administration record for August 2020 showed no treatment orders started for R1's left buttock wound until 8/16/20.</p> <p>R1's nursing progress note dated 8/16/20 showed, "[R1's Primary Care Physician] here on rounds. Treatment order received for left buttocks ..."</p> <p>R1's nursing progress note dated 8/23/20 showed, "Observed resident left buttock wound is not healing ..."</p>	S9999		

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S9999	<p>Continued From page 21</p> <p>R1's emergency department note from the acute care hospital dated 10/10/20 showed, " ...stage IV pressure ulcer on the patient's coccyx, low back, buttocks area ..."</p> <p>R1's acute care hospital operative note dated 10/11/20 showed, " ...admitted to the hospital for large decubitus ulcer in the left buttock and sacrum. The decubitus ulcer measure 10 cm x 13 cm x 2 cm in size dimensions. Half of the surface area of the decubitus ulcer was necrotic and there was a 2nd ulcer over the sacrum measuring approximately 2 cm in diameter and 3 cm deep ...there was a skin excoriation surrounding the decubitus ulcers covering the entire sacral area and the posterior surface of both thighs." The facility was unable to provide any documentation of the second wound to R1's sacrum.</p> <p>R1's surgical pathology report from the acute care hospital dated 10/11/20 showed ... "debridement tissue, left buttock, inflamed and necrotic soft tissue ... it is a piece of necrotic tissue measuring 5.5 cm x 3 cm x 1.3 cm ..."</p> <p>R1's surgery progress note dated 10/13/20 showed ... "patient with fever. Infection Disease on consult. He is currently receiving gentamicin, clindamycin, and aztreonam (all antibiotics) ..."</p> <p>R1's surgery progress note dated 10/14/20 from the acute care hospital showed, "Chief Complaint: ...large decubitus ulcer in the left buttock, stage 3 and a small sacral ulcer penetrating down to the bone, osteomyelitis (infection into the bone) in similar circumstances requires bone debridement and coverage with muscle flap. Antibiotic treatment with exposed bone will not be adequate. Unfortunately this patient is not a</p>	S9999		

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S9999	<p>Continued From page 22</p> <p>candidate for any surgical procedure."</p> <p>On 10/22/20 at 1:00 PM, V2 DON (Director of Nursing) said she is only aware of R1 having one pressure wound (left buttock) but that it is a fairly large one. V2 stated, "The nurses on the floor do the wound assessments, the report is turned into me and then I input it into the system. Typically the nurses tell me what is going on with the wound and then we discuss it, if they want me to look at it I will but I don't look at everyone's. Wounds are assessed with every dressing change but measurements are done weekly by the nurses on the floor. As soon as the nurse sees that a wound is worsening and not responding to treatment, they should be notifying the physician. The nurses know what they want for orders so I'm ok with them just asking for what they want from the physician. If the nurse does not get a response from the physician by the end of their shift they should be contacting them again. Our medical director is always available to get orders from. A week is unacceptable to wait to get new wound care orders because a wound could become infected and become very serious. I'm trying to get a handle on the wounds again, I've been really busy with other positions so haven't had the time to really pay attention to them."</p> <p>The facility policy with revision date of March 2017 and titled, "Pressure Ulcer Prevention Program Policy and Procedure" showed, "... Treatment Procedures ... 3. Assessments of ulcer including staging, description, and measurements will be documented on the weekly Pressure Ulcer Report by the Wound Care Nurse, or assigned Registered Nurse/Licensed Practical Nurse ... 6. The nurse will notify physician when pressure ulcers develop and inform him/her of treatment</p>	S9999		

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S9999	<p>Continued From page 23</p> <p>being currently used. 7. The nurse will notify resident's family ... 12. Monitor pressure ulcer for signs of infection. 13. Report signs of infection to physician, such as, foul odor, excessive drainage, and unusual appearance.</p> <p>2. R3's electronic face sheet printed 10/20/20 showed R3 was admitted to the facility on 8/12/16 with diagnoses of Alzheimer's disease with late onset, dementia without behavioral disturbance, and vitamin B12 deficiency anemia.</p> <p>R3's facility assessment dated 7/29/20 showed R3 has one stage 3 pressure ulcer that was not present upon admission to the facility.</p> <p>R3's care plan dated 7/8/20 showed, "Resident is at risk for infection and increased pain related to pressure ulcer on coccyx. Notify physician of any need to change treatment or worsening to wound bed. Perform weekly skin check and measure wound. Assess wound bed and surrounding skin."</p> <p>R3's wound assessment dated 5/27/20 showed, "Observed Stage 2 pressure ulcer on 5/27/20, measuring 1.0cmx0.6cmx0.2cm."</p> <p>R3's weekly skin check dated 6/9/20 and 9/22/20 signed by V6 (registered nurse) showed, "Skin clear; no open areas, bruises, skin tears, reddened areas, etc."</p> <p>R3's wound care assessment dated 7/1/20 showed, "Stage 3 coccyx wound measuring 1.2cmx0.9cmx0.3cm." (increase in area and depth from 6/24/20 assessment)</p> <p>R3's nursing progress notes dated 7/6/20 showed, "Communication to physician requesting</p>	S9999		
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(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	<p>Continued From page 24</p> <p>new treatment for area on coccyx." (5 days after noting worsening of wound)</p> <p>R3's wound assessment dated 7/15/20 showed, "Stage 3 coccyx wound measuring 1.8cmx1.3cmx0.3cm. (increase in area and depth from 7/1/20 assessment). No call was placed to R3's physician requesting new treatment orders.</p> <p>R3's wound assessment dated 7/22/20 showed, "Stage 3 coccyx wound measuring 2.1cmx1.4cmx0.2cm (increase in area from 7/15/20 assessment). No call was placed to R3's physician requesting new treatment orders until 7/27/20. New orders were received from R3's physician on 8/3/20.</p> <p>R3's wound assessment dated 8/19/20 showed, "Stage 3 coccyx wound measuring 1.8cm x1.0cm unable to determine depth. Undermining (widening of the wound base) now present at 12:00 with a depth of 2.3cm." (worsening of the wound compared to 8/12/20 assessment and no new orders since 8/3/20).</p> <p>R3's wound assessment dated 8/26/20 showed, "Stage 3 coccyx wound measuring 2.6cm x1.2cm x2.1cm. Undermining present at 12:00 with a depth of 2.1cm. (increase in area and depth from 8/19/20 assessment). New orders were not requested from R3's physician until 9/6/20 when a request was made to send R3 to local wound care clinic for evaluation due to R3's wound not responding to treatment. Order was not received until 9/15/20 to send R3 to the wound care clinic for evaluation.</p> <p>R3's wound assessment dated 9/16/20 showed, "Stage 3 coccyx wound measuring 2.9cmx1.7cmx2.0cm. Undermining not present."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2020
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S9999	<p>Continued From page 25</p> <p>R3's wound care clinic visit note dated 9/17/20 showed, "Sacral ulcer stage 3 with black grey bases noted down to bone some undermining noted ...Initial wound encounter measurements are 2.5cm length x 1cm width x 0.5cm depth, with an area of 2.5sq cm and a volume of 1.25cubic cm. Undermining has been noted at 11:00 and ends at 3:00 with a maximum distance of 2.5cm. There is a moderate amount of purulent drainage noted which has a mild odor.</p> <p>R3's wound care orders received by the facility on 9/17/20 showed, "Cleanse area on coccyx with cytotoxic cleanser. Apply enzymatic debriding agent to wound bed. Butter enzymatic debriding agent onto 1/4" plain packing and pack into undermining from 11-3, and pack into wound. Cover and secure with foam dressing. This dressing to be changed daily."</p> <p>R3's treatment administration record dated 9/17/20 showed, "Cleanse area on coccyx with cytotoxic cleanser, apply enzymatic debriding agent to wound bed and cover with dry dressing daily." R3's orders received by the facility from the wound care clinic on 9/17/20 were not initiated until 9/25/20.</p> <p>On 10/14/20 at 11:00AM, V21 (Licensed Practical Nurse) stated, "(R3)'s wound started out as a small slit and just got worse. It's really advanced now. I think (V2-Director of Nursing) is the wound care nurse but I'm not sure. I just do the dressing changes like I'm supposed to."</p> <p>On 10/22/20 at 1:10PM, V2 stated, "(R3) has an area on her coccyx, it was never reported to me or charted that her wound had progressed down to her bone. She goes to the wound clinic now</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2020
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S9999	Continued From page 26 because we weren't able to get the wound to respond to our treatments." R3's wound assessments dated 5/27/20 thru 9/30/20 showed V2 evaluated R3's wounds. (A)	S9999		