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 _____	10/25/2019

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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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 are not met as evidenced by: Based on observation, interview and record review the facility failed to follow its policy and wash hands in between glove changes, avoid	S9999		

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S9999	Continued From page 2	S9999		

touching clean items with soiled gloves, and avoid direct contact with a wound for one resident (R288) and failed to identify and assess a pressure ulcer wound for one resident (R31) of four residents reviewed for pressure wounds in the sample of 39. This failure resulted in a decline in R31's coccyx wound from incontinent dermatitis to an unstageable ulcerated wound.

Findings include:

1. Physician Order Sheet (POS) dated 10/2019 indicates R31 was admitted to the facility on 8/7/19 with diagnoses that include Brain Tumor, Debility and Severe Muscle Deconditioning.

POS indicates order initiated on 10/8/19 to start Santyl (chemical debriding agent) to coccyx wound bed, apply Calazyme (protective cream) to periwound bed and cover with Xeroform (petroleum coated dressing) daily and as needed.

On 10/24/19 at 9:40am V3 (Assistant Director of Nursing/Wound Nurse) changed the dressing on R31's coccyx. Coccyx wound was larger than a fifty cent piece, ulcerated with defined edges and thick layer of adherent yellow slough in the wound bed. After the wound was cleaned with normal saline, the layer of slough remained intact in the wound bed. At that time V3 stated "(V11) is calling this incontinent dermatitis; that's not slough in the wound bed - it's Calazyme." V3 stated they are not staging or calling the wound "a pressure ulcer."

Weekly Pressure Ulcer Tracking Log does not include R31's ulcerated coccyx wound.

Braden Score - Pressure Sore Risk Assessment dated 10/3/19 indicates R31 at "High Risk" for

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S9999	Continued From page 3 developing pressure ulcers. On 10/25/19 at 8:50am V11 (Nurse Practitioner/Wounds) stated R31's coccyx wound started out as incontinent dermatitis and has declined to the wound it is now. V11 stated that the adherent coating in R31's wound bed is slough, which is why he ordered the Santyl, stating "The appropriate treatment to debride the layer of slough." V11 stated that pressure is part of the problem as well as moisture. V11 stated that he has detailed typed notes after each wound round that include notes indicating that if the ordered treatment was in place and done as it should be the wound would not have declined as it did. V11 stated he has seen several times during rounds that R31's dressing was not in place and positioned off of the wound. V11 stated that it was "avoidable" for the wound to decline from dermatitis to what it is now. V11 agreed the wound is not stageable at this time due to the thick layer of adherent slough in the wound bed. None of V11's detailed wound notes were presented by the facility or found as part of R31's medical record. V3 presented unsigned, handwritten, abbreviated notes that V3 stated were written by V11. No weekly wound notes were presented documenting assessments of R31's coccyx wound. Facility Policy/Pressure Ulcers/Wounds (undated) indicates: Wound nurse will generate weekly wound report. Facility Policy/Wound Care dated 2010 indicates: The following information should be recorded in the resident's medical record: 6. All assessment data (i.e., wound bed color,	S9999		

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S9999	Continued From page 4	S9999		

size, drainage, etc.)obtained when inspecting the wound.

2. The facility's "Wound Care" policy, revised October 2010, states, "4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves... 7. Use no-touch technique... 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound."

The facility's "Standard Precautions" policy, revised December 2007, states, "Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments."

R288's current Physician Order Sheet states, "Cleanse coccyx wound daily and prn (as needed), apply collagen to wound bed, cover with foam dressing."

On 10/22/19 at 01:32 PM, V2 (Director of Nursing) entered R288's room to change a coccyx wound dressing. V2 removed R288's coccyx wound dressing, removed V2's soiled gloves and then placed on clean gloves with no handwashing occurring prior. V2 then cleansed the coccyx wound with gauze pads and normal saline. V2 removed V2's soiled gloves and placed on clean gloves, with no handwashing occurring prior. V2 then applied the Collagen powder with V2's gloved hand directly to R288's wound bed. After touching R288's wound bed directly, V2 reached into V2's right pocket with same soiled

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S9999	Continued From page 5 gloves to locate a marking pen to date R288's wound dressing. V2 again changed gloves without handwashing and disposed of R288's biohazard bag. V2 then washed V2's hands in the nearby sink. On 10/22/19 at 01:49 PM V2 (DON) stated, "That would have been better; I should have washed (my hands in between glove changes). I shouldn't have reached into my pocket (with soiled gloves on). I hadn't used that powder. I used my fingers and probably shouldn't have. That makes more sense." (B)	S9999		