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
	IL6016786	A. BUILDING: ______ B. WING ______	C 01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK	777 DRAPER AVENUE JOLIET, IL 60432

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S 000	Initial Comments Complaint 1979326/IL118534	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 300.1210 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. Restorative measures shall include, at a minimum, the following	S9999	**Attachment A** **Statement of Licensure Violations**	

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procedures:
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.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent deterioration of a pressure sore for a resident who is identified as a high risk for skin breakdown and has an abrasion in the sacrum. This failure resulted to resident (R1) sustaining a stage 4 pressure ulcer in the sacral area.

This applies to 1 of 4 residents (R1) reviewed for pressure ulcer in the sample of 15.

The findings include:

R1's face sheet showed that R1 is a 75-years old who was originally admitted to the facility on

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10/21/19 with diagnoses that included closed right femur fracture with delayed healing, atrial fibrillation, hypertension, dementia, parkinson's disease, anemia and restlesness and agitaion. R1's minimum data set (MDS) dated 11/28/19 showed R1 requires extensive assistance by one to two staff members with transfer, bed mobility, dressing, hygiene, and toileting, and is always incontinent of bowel.

R1's care plan for alteration in skin integrity initiated 12/5/19, showed no updates to intervention even though R1's wound was worsening in the facility.

On 12/24/19 at 10:20am, V6 (Wound Care Nurse) provided wound care to R1. V6 removed the saturated adbominal (ABD) dressing and cleansed the wound with normal saline solution. V6 measured the wound length 7.5 centimeter (cm) x width 7.0 cm x depth 5cm. R1's wound had an undermining at (12 o'clock by 6 o'clock) 3cm and at (4 o'clock) was 5cm deep. The wound has 80% granulation with 25%-75% serosanguinous odourous drainage. V6 applied hydrogel to wound bed and the wound was covered with ABD pad and secured with tape. R1's sacrum wound was classified as stage 4 sacral wound.

On 12/24/19 at 11:21am, V6 stated R1's wound was first discovered 12/5/19 and that at the time it looked like a slit measuring 1cm x 1cm x 0cm. V6 stated V10 (Wound Care Doctor) examined the wound the same day and prescribed hydrocolloid dressing twice a week.V6 stated when she made rounds on 12/12/19, R1's wound had gotten bigger with a measurement of 2.5cm x 3.0cm, scant drainage, with slough and no odor. V6 stated V10 was not available to observe the

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wound on 12/12/19 because he was on vacation. V6 stated when she saw R1's wound on 12/17/19 because R1 was having symptoms of infection-fever, tachycardia and was hypotensive. V6 stated R1's wound was much bigger (6cm x 4.5cm x 0.5cm) with erythema and slough. V6 stated she texted V10 to inform him about the worsening condition of R1's wound. V6 stated V10 ordered to start R1 on (Keflex) an antibiotic three times a day. V6 stated R1 was sent out to the hospital on 12/17/19. V6 stated R1 returned to the facility 12/22/19 with much bigger wound that meausred 7cm x 7cm x 5cm after hospital debridement.

On 12/24/19 at 1:22pm, V10 stated he examined R1's wound on 12/5/19 with V6. V10 stated he did not take a measurement of the wound because he expected V6 to do it. V10 stated he was out of town on 12/12/19 and did not see R1. V10 stated when he came to the facility to round on 12/19/19, he was informed R1 was in the hospital. V10 stated he was not aware of the condition change to R1's sacrum wound. V10 stated nursing staff should have notified him if the condition of the wound changes. V10 further stated he would have ordered other treatments like Dakin solution or hydrogel treatment for R1.

On 12/30/19 at 11:28am, V18 (Nurse Practitioner) stated he would expect R1's wound to improve with treatments. V18 stated he expected nursing staff to notify the physician if there are signs and symptoms of infection to the wound or if the condition of the wound got worse. V18 stated he did not receive a call regarding R1's wound condition.

On 12/23/19 at 11:50am, V2 Director of Nursing (DON) stated R1 was originally admitted to the

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facility 10/21/19. V2 stated R1 was transferred to a Pyschiatry hospital on 10/24/19 and was re-admitted 11/22/19. V2 stated on 12/5/19, R1 developed stage 2 pressure sore on the sacrum area. V2 stated R1 was being managed by V10 and V6 at the facility. V2 stated on 12/17/19, V6 reported to him that R1's wound has gotten worse. V2 stated V10 was notified and anitbiotic treatments were ordered. V2 stated R1 was noted with fevers of 100.0 or more and tachycardia. V2 stated he notified the primary physician's office for R1's change in condition, and was asked to send R1 out to the hospital.

On 12/31/19 at 10:35am, V2 confirmed R1 was high risk for pressure sore from clinical standpoint. V2 further stated the facility put in place interventions to prevent worsening of the pressure sore but failed to update R1's care plan to reflect the changes.

On 12/23/19 at 11:30am, V4 (Family Member) stated depending on the staff on duty, R1 was not being turned and incontinence brief was not changed in a timely manner at the facility. V4 stated she came in to the facility to visit and sit with R1 on a daily basis to feed R1.

R1's weekly skin alteration review by wound nurse dated 12/5/19 showed R1 with an abrasion in the sacrum/coccyx area measured 1cm x 1cm partial thickness.
R1's weekly skin alteration review by wound nurse dated 12/12/19 showed R1 with an stage 2 in the sacrum/coccyx area measured 2.5cm x 3cm with scant serosansuinous .
R1's weekly skin alteration review by wound nurse dated 12/16/19 showed R1 with a nonstageable in the sacrum/coccyx area measured 6cm x 4cm partial thickness with 100%

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slough and purulent drainage. R1 was sent out to the hospital on 12/17/19.

On returning back from the hospital on 12/22/19, R1's treatment nurse initial skin alteration review by wound nurse dated 12/23/19 showed R1 with a stage 4 sacrum pressure injury that measured 7cm x 7cm x 5cm, 80% granulation, 25%-75% moderate serosanguinous drainage.

Hospital record dated 12/19/19 showed R1 was admitted with fever, tachycardia, elevated white blood cell count of 14.4, lethargy, and drowsiness. The hospital record R1 underwent a surgical debridement, wound measurement showed sacrum pressure injury 7.5cm x 6.5cm x 3.0cm, wound edges well defined, erythema with purple discoloration to inferior margin. It also showed large serosanguinous drainage.

Review of facility's policy titled, 'Pressure Ulcer and Skin Condition Assessment' dated 11/19/19 showed, "To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers, and assuring interventions are implemented". The policy also showed, "the resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care".

(B)