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
	IL6012827	A. BUILDING: ______ B. WING ______	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

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S 000	Initial Comments	S 000		

S 000 Initial Comments

Annual Licensure and Certification Survey

S9999 Final Observations

Statement of Licensure Violations.

300.610 a)
300.1210 a)
300.1210 b)
300.1210 c)
300.1210 d) 2) 3) 5)
300.3240 a)

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to

Attachment A
Statement of Licensure Violations

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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S9999	Continued From page 2 resident's medical record. 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 regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure pressure ulcers were identified, changes in existing wounds were assessed and physicians were notified, and prevention interventions were in place for residents at risk for developing pressure ulcers. This failure resulted in R46 developing multiple unidentified, untreated pressure ulcers to R46's left foot and a worsening pressure ulcer condition which was not assessed and not reported to the physician on the right foot. Applies to 3 of 11 residents (R24, R46, and R55) reviewed for pressure in the sample of 22. The findings include:	S9999		

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1. Face sheet, dated 6/11/19, shows R46 was admitted to the facility on 4/8/19 and diagnoses included protein-calorie malnutrition, anxiety, non-Hodgkin lymphoma, Type 2 diabetes, dementia, Parkinson's disease, and metabolic encephalopathy.

MDS (Minimum Data Set), dated 5/6/19, shows R46's cognitive status was severely compromised and R46 required the extensive assistance of two staff for bed mobility, transfers, and toileting. The MDS shows R46 was totally dependent on staff for bathing. The MDS shows R46 was at risk of developing pressure ulcers/injuries and R46 did not have an pressure ulcer/injury at that time.

ADL (Activities of Daily Living) care plan, initiated 4/8/19, shows R46 required the assistance of two staff to reposition and turn R46 in bed. Pressure ulcer care plan, initiated 5/14/19, shows R46 had a pressure ulcer to the right heel and R46's goal was to have intact skin free of redness, blisters, or discoloration by the next review. R46's goals also included the pressure ulcer will show signs of healing and remain free from infection.

Hospice Aide Care Plan, undated, shows "check pressure areas for sores."

POS (Physician Order Sheet), dated 6/11/19, shows R46 had physician orders for the following:
- Skin assessment weekly on shower day as needed and every day shift every Wednesday (ordered 4/8/19)
- Skin check daily every evening shift (ordered 4/8/19)
- Treatment to left heel: Apply aquaphor for protection every evening shift (ordered 4/9/19)
- Compression wraps for compression to bilateral lower extremities on in AM and off at HS (before

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bedtime) (ordered 4/9/19)
- Heel protector boots while in bed every shift for protection (ordered 4/9/2019)
- Hospice services (ordered 4/19/19)
- Betadine anti-septic paint to right heel and cover with dry dressing / Kerlix daily every evening shift (ordered 5/14/19 and discontinued 6/10/19)
- Clean left toe with normal saline and apply dry dressing until healed (ordered 5/14/19)
- Off load heels with pillows when in bed as preferred by resident every shift (ordered 6/10/19)
- Wound physician for evaluation and treatment (ordered 6/10/19)

Hospice nurse visit communication, dated 5/21/19, shows "Blister on right heel, cleaned, betadine applied, and covered with dressing." Hospice nursing note, dated 5/22/19, shows R46 had a skin tear on his hands, no blisters/open areas on skin including heels were identified. Hospice nurse visit communication, dated 5/29/19, shows "Right heel blister still being treated."
Hospice visit communications, dated 6/10/19, 6/6/19 6/4/19, 5/30/19, 5/28/19, 5/20/19, and 5/13/19 all show R46 was given a bath by aides and no wounds on R46's heels were identified. The 6/6/19 documentation identified dressings on both arms, no other dressings were mentioned.

R46's facility Admission Skin Assessment and Weekly Wound Progress Notes show the following:
5/14/19 right heel Stage 2 pressure ulcer, 5.0 cm (centimeters) length, 5 cm width, no drainage/odor, no undermining, and intact.
5/21/19 no changes
5/28/19 no changes
6/3/19 right heel blood blister popped open, unstageable, 4.0 cm length, 5 cm width, bloody

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wound bed due to fresh sore, moderate serosanguineous drainage, no odor, erythema, edematous, open. "For Wound MD (Physician) referral."

Late entry Skin/Wound Note, written 6/10/19 and backdated 6/3/19 in the facility EMR (Electronic Medical Record), shows "Right heel blister popped open, dry dressing applied, for referral to Wound MD."

Wound Summary, dated 6/6/2019, shows R46's wound as an active unstageable blood filled blister, no exudate, 4 cm length, 5 cm width, and showing probable improvement.

On 6/11/19 10:39 AM, V6 (Wound Nurse) stated R46's heel blister popped open on 6/3/19 but R46 had not yet been seen by V26 (Wound Physician).

On 6/12/19 at 12:00 PM, copies of all of R46's physician/nurse practitioner/physician assistant notes were requested from the facility. The facility provided progress notes dated 6/7/19, 5/21/19, 5/20/19, 5/6/19, and 4/28/19. None of the records showed a physician assessment of any of the pressure ulcers.

On 6/10/19 at 10:24 AM, during initial tour of the facility, V27 (Registered Nurse) stated V27 had no residents with pressure ulcers on V27's assignment which included R46.

On 6/11/19 at 1:20 PM, V7 (Registered Nurse) stated V7 had not changed R46's right heel dressings because evening shift completes the dressing changes. V7 stated V7 was not aware of any open areas on R46's left heel or toes.

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On 6/11/19 at 01:28 PM, R46 was lying in bed, feet were on the bed, knees were elevated. R46 was sporadically sliding left and right heels back and forth on R46's mattress halting with heels resting on the mattress. The mattress was a standard mattress and there were no pillows under R46's legs or feet and a white blanket covered R46's legs. V7 (Registered Nurse) entered R46's room and removed the covers on R46's legs. R46 had no protective footwear or boots on R46's feet. R46 had non-skid socks on both feet and a white dressing on right foot under the sock. A strong, foul odor was present. V7 stated R46 should have had protective boots on R46's feet, but the boots were in R46's closet. There was a spot of bright, red, fresh blood , measuring approximately 1.5 cm (centimeters) in diameter, on the white fitted sheet over the mattress. V7 removed R46's socks and there was blood on the left sock. R46's left foot had four smaller black circular areas with red boarders around the ulcers (two on the lateral side edge of the foot, one on the lateral malleolus, one on the medial malleolus), and one larger, open circular wound with a black center on the lateral side of the left heel. V7 and V6 (Wound Nurse) stated V6 had not previously seen any wounds on R46's left foot and was not aware of the wounds until that time. V7 and V6 removed the dressing on the right foot and a strong, foul odor was present. The bandage was heavily saturated with drainage from the wound. The wound was open and had yellow, purulent, thick drainage. The center of the wound had circular, hardened, dark purple tissue and the surrounding tissue surrounding was absent up to the perimeter of the wound.

On 6/11/19 at 1:54 PM, V6 stated "We don't date" when asked to identify the date on the right heel dressing. V6 stated R46's original wound was an

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intact blister on R46's right foot. V6 looked at the left foot/heel, and stated, "This, actually, I have not seen yet. This is the first I have seen of this one." V7 and V6 verified R46's mattress was a standard mattress and not a pressure relieving mattress or a low air loss mattress. V6 stated R46 did not have a low air loss/pressure relieving mattress because "he doesn't have anything on the bottom, so we are doing the offloading." V7 stated, "Even when R46 has the pillows, R46 constantly moves and they aren't under R46 anymore." V7 stated R46 also constantly kicks off pressure relieving boots. There were three pressure relieving boots in R46's closet.

Wound Summary, dated 6/11/19, shows R46's right heel was an unstageable facility-acquired pressure ulcer with 100% slough loosely adherent, moderate serosanguineous drainage measuring 4.5 cm length, 4.5 cm width, 0.0 cm depth. R46's left heel was assessed as an unstageable facility-acquired pressure ulcer, 100% necrotic, hard, firm adherent tissue, 2.5 cm length, 3.5 cm width, and 0.0 cm depth. R46's left medial foot was assessed as a stage 2 pressure ulcer 100% blood-filled blister, 1.0 cm length, 1.0 cm width, and 0.0 cm depth. R46's left foot ankle was assessed as a stage 2 facility-acquired pressure ulcer, 100% blood filled blister, 2.2 cm length, 1.2 cm width, and 0.0 cm depth. R46's left lateral foot was assessed as a stage 2 facility-acquired pressure ulcer, 100% blood filled blister, 6.5 cm length, 1.5 cm width, 0.0 depth.

On 6/11/19 at 03:00 PM, V2 (Director of Nursing) stated all nursing and CNAs (Certified Nursing Assistants) staff are expected to monitor skin daily. V2 stated the nurse signs off on a skin assessment on the treatment record and hospice

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S9999	Continued From page 8 should also report any skin concerns if identified when giving a resident baths twice weekly. V2 stated CNAs should notify their nurse and the wound care nurse if there are any concerns identified. V2 stated the nurse should then notify the physician to evaluate the current treatments for appropriateness or obtain new treatment/care orders for the wound. V2 stated if there is any change in a wound, including signs of infection, the nursing staff were expected to communicate the information to the physician "if the nurse cannot handle it." V2 stated V25 (Wound Physician) comes once weekly on Sundays and as needed. V2 stated V6 (wound nurse) was not wound certified. V2 stated V6 assesses facility wounds and determines the stage/type of wound, and calls the physician to report V6's assessment. V2 stated a resident with a heel pressure ulcer should wear pressure relieving boots, use a pillow under their legs for offloading, and be provided a low air loss mattress. On 6/12/19 at 12:54 PM, V21 (Nurse Practitioner) stated V21 was not aware of the pressure ulcers on R46's right or left heel until 6/11/19 when V21 received a text regarding R46's left foot pressure ulcers. V21 stated V21 remembered a wound on the left toe, but nothing else had been communicated to V21. 2. On 6/10/19 at 10:30 AM, R55 was up in wheelchair in doorway of R55's room. R55's feet were resting on the foot pedals of the chair. R55 was not wearing shoes. R55's left heel had a gauze dressing in place and a sock was covering the rest of the left foot. R55 had only a sock on R55's right foot. R55 was not wearing heal lift boots. At 11:01 AM, V4 and V5 (CNAs) assisted R55 to stand to R55's feet to adjust clothing. V5 attempted to put R55's shoe on R55's left foot	S9999		

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prior to standing and R55 yelled out in pain. R55 then yelled out in pain again while standing up with just R55's socks on. R55's left foot and ankle appeared dry and edematous when sock was removed. R55's bed sheets showed multiple spots of serosanguineous drainage near the foot of the bed.

On 6/10/19 at 11:15 AM, V3 (RN) stated, "R55 has a blister that burst so we are doing dressing changes on it. They are done in the evening and as needed. "

At 2:38 PM, V3 completed a dressing change to R55's left heel. R55 was in bed on a regular facility mattress with a heel lift boot only on R55's left foot. As V3 removed the gauze dressing on R55's left heel the heel showed a large open area about the size of a tennis ball. There was a large area of missing skin over the heel and the edges of the skin still present were white and macerated (looked wet). The center of the wound was a combination of deep red and purple tissue with some yellow strands of tissue present. R55 called out in pain several times throughout the dressing change. There was a slight foul odor present. V3 stated, "I found it like this. It drains a lot. That is why the dressing change is ordered as needed. Found burst open, just like this on the 6th. I documented it." V3 did not address R55's right heel.

On 6/11/19 at 8:15 AM, R55 was in R55's wheelchair after receiving a shower. R55 had a heel lift boot on the left foot but not on the right. The right foot had only a sock and was resting on the wheelchair foot rest.

On 6/11/19 at 9:29 AM, V6 (RN) stated, "R55's wounds were acquired here. R55 uses R55's

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heels to propel himself around in R55's wheelchair. The right heel has a deep tissue injury and the left heel had a blister and the skin came off."

R55's Minimum Data Set dated 5/10/19 shows R55 has diagnoses of alzheimer's disease, multiple sclerosis, parkinson's disease and diabetes. This same assessment shows R55 requires extensive assist of 1 staff for locomotion on and off the unit.

R55's Braden Scale (assessment for pressure ulcer risk) dated 6/10/19 shows R55 scores a 13 (Under 20 = high risk).

R55's Skin Alteration Evaluation dated 6/6/19 states, "Superficial/re-epithelialization, regular/well defined edges, surrounding edges intact with scant drainage. No pain and no additional wounds. " There is no assessment documented of R55's right heel.

R55's Left heel Wound Assessment dated 6/6/19 states, "Facility acquired, Pressure, Blister, Stage 2, 100% Beefy red with a moderate amount of serous drainage. Size 6.0 x 6.0 x 0 cm."

R55's Right heel Wound Assessment dated 6/6/19 states, "Facility acquired. Pressure, Erythema Deep Tissue Injury. Non-blanchable, Erythema 30%, Purple Ecchymosis 70% . Size 2.0 x 2.5 x 0.0 cm. Apply foam dressing every three days and as needed. Off load heel, Prevalon boot all the time."

R55's care plan dated 6/6/19 states, "R55 uses R55's feet to manipulate/mobilize wheelchair. Refuses to use leg rests despite explanation that R55 is running feet/heels against surface against

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surface and it will potentially cause breakdown and (R55) requires no shoes: use only non skid socks. Prevalon boots to both feet when in bed."

3. R24's Minimum Data Set dated 4/8/19, showed R24 was severely cognitively impaired and required extensive to total assistance to complete activities of daily living.
R24's Physician Order Review Report dated 5/29/19, showed, "Offload heels when in bed with pillows."
R24's Care Plan dated 5/29/19, showed R24 "has impairment to skin integrity...offload heels with pillows when in bed...".
R24's Skin Assessment dated 6/10/19, showed R24 was at high risk for pressure injuries.

On 6/11/19, at 8:00 AM, R24 was lying supine in R24's fully reclined high back wheelchair with no pillow or pressure relieving device under R24's heels.

On 6/11/19, at 1:30 PM, R24 was lying supine in bed with no pillow or pressure relieving device under R24's heels.

On 6/12/19, at 8:17 AM, R24 was lying supine in R24's fully reclined high back wheelchair with no pillow or pressure relieving device under R24's heels noted. At 8:18 AM, V8 Registered Nurse stated, "Yes, (R24) is at risk for pressure injuries. R24 refuses foam heel protectors. We sometimes put a pillow under R24's heels to offload but not consistently."

On 6/12/19, at 8:48 AM, V6 Wound Nurse stated R24 was at risk for pressure injuries with pressure relieving interventions for R24 including, "offloading heels with pillows and daily skin checks."

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S9999	Continued From page 12 The facility's Wound Care Program Policy dated 8/2013 showed, "It is the policy of this facility to ensure that residents whose clinical conditions and medical diagnosis potentiate the risk for skin breakdown and development of pressure ulcers are properly identified, assessed and managed according to current regulatory guidelines and standard of care...1. Timely identification of residents assessed to be at risk for skin breakdown...d. Facility shall develop a plan of care and implement interventions according to the resident's Braden Score and/or identified individual risk factor...4. Activity, Mobility, and Positioning...k. Elevate resident heels off the bed as indicated...10. Pressure Ulcer Treatment...c. Timely referral to the facilities wound care specialist for stage III/IV pressure ulcers..." (B)	S9999		