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
	IL6014658	A. BUILDING: ______ B. WING ______	C 01/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

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S 000	Initial Comments	S 000		
S9999	Final Observations	S9999		

S 000 Initial Comments

Original complaint investigation survey.

1717339/ IL# 98889

S9999 Final Observations

Statement of Licensure Violations

300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210c)
300.1210d)2)3)4)A)5)
300.3220f)
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,

Attachment A
Statement of Licensure Violations

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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.

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 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. (Section 3-202.2a of the Act)

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

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following procedures:

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 resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

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

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services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

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 were not met as evidence by:

Based on observation, interview, and record review the facility failed to document initial skin assessments upon admission, failed to measure identified wounds upon admission, failed to conduct weekly measurements and assessments of pressure ulcers, failed to document dressing changes on the treatment record, failed to implement preventative measures for a resident admitted with pressure ulcers, failed to obtain physician orders for a new admission with a Stage 2 pressure ulcer, failed to develop and implement individualized care plans for residents with known pressure ulcers and the facility failed to identify a pressure ulcer prior to a Stage 4. R4 was found to have a Stage 4 pressure ulcer under a leg immobilizer. The facility failed to perform an initial assessment of the wound when

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it was reported by the Nurse Practitioner, including obtaining measurements and description of the wound. R4's pressure ulcer risk assessment was last completed on June 16, 2016 (over one year ago). R4's care plan does not indicate use of a leg immobilizer or interventions to prevent pressure ulcers. The care plan interventions for a Stage 4 pressure ulcer were not implemented. This applies to 3 residents (R1, R2, R4) reviewed for pressure ulcers in the sample of 9 .

The findings include:

1. R4's undated care plan showed R4 is at risk for alteration in skin integrity due to limited mobility. R4 is alert, but confused and forgetful and requires assistance with all ADL's (activities of daily living).

The May 13, 2017 nursing notes document R4 was found on the floor and sustained a distal femur fracture. The nursing notes show an immobilizer was placed on the right knee to restrict movement. The May TAR shows on May 18, 2017, R4 had an order to keep (leg) immobilizer on and only remove for hygiene and dressing. The order was listed as a "for your information" only and no nurses initialed or acknowledged the order.

The nursing notes for R4 were reviewed from May 13 to May 19, 2017 and found no documentation of removal of the leg immobilizer, or skin assessments. R4 had no nursing progress notes from May 19 to June 6, 2017. The May TAR shows R4 was scheduled for a weekly skin check on May 19, and was not completed or initialed by the nurse.

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R4's pressure ulcer risk was completed June 16, 2016 (over one year prior) and showed R4 to be a moderate risk for pressure ulcers. On December 19, 2017 at 3:40 PM, V2 DON (Director of Nurses) said the risk assessment should be completed weekly for new admissions for 4 weeks, then at least quarterly.

On June 14, 2017 NP (Nurse Practitioner) documented R4 was laid down after lunch and found to have open weeping wound to the right lower, lateral leg. The wound measured approximately 8 cm long, unable to assess wound base due to slough and eschar tissue to the wound base. The nursing notes for June 14, 2017 had no identification of a new wound, or any assessment related to a new pressure ulcer. The June TAR had no wound dressing orders for June 14, 2017.

On June 15, 2017 R4's primary physician documents R4 was seen due to report of a new wound, related to the friction between knee immobilizer edge and skin. The physician documents an ulceration of 10cm x 3 cm of (merging) blisters on the right leg, and a 13 cm x 2 cm wound with necrosis and slough, on the right leg.

The June 15, 2017 nursing notes do not indicate any new wounds were identified or had any documentation to describe the new wounds. The wound documentation form dated June 15, 2017 show 2 wounds to the right lower calf. The wound listed as #1 is assessed to be a Stage 4 pressure wound measuring 7cm x 2cm x 0.2cm. Wound #2 measures 6cm x 2cm x 0.2cm and was not staged by the nurse.

The June 2017 TAR showed daily

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treatment/dressing orders were ordered for the right lower calf and a different treatment order for the right upper calf. The TAR shows the treatment ordered for the right lower calf was only completed on June 16, 2017. The order was not discontinued until June 21, 2017.

On June 21, 2017, the nursing notes show the wound physician evaluated the wounds to R4's right lower leg. The wound documentation showed the right upper lateral ankle (lower calf) to measure 10cm x 2.5cm x 0.2cm, the wound is a Stage 4 with 80% necrotic tissue. The physician listed the second wound as a deep tissue injury of the right proximal dorsal foot as 1cm x 3.5cm.

The nursing weekly wound documentation for the Stage 4 pressure ulcer to the right upper lateral ankle was last documented on August 16, 2017, and the wound was 9.5cm x 9.5 cm. The nursing progress notes do not show any further assessments of the wounds from August 16 to present day.

On December 6, 2017, the wound physician documents R4 continues to have a Stage 4 wound measuring 7.8cm x 2.0cm on R4's right ankle.

On December 19, 2017 at 2:00 PM, R4 was lying in bed with R4's feet/ankles on the bed. R4 had socks on and had no pressure relieving interventions in place.

On December 15, 2017 at 9:40 AM, V2 said weekly skin assessments of the wound are completed by wound care, and the wound physician is in the facility every week and he completes the measurements of the wounds at

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that time. V2 stated the wound nurse would be responsible for measurements, and when the facility does not have a wound nurse the floor nurses should be doing weekly measurements.

On December 26, 2017 at 1:30 PM, V2 removed R4's dressing to the right ankle. The wound was located on the outer right ankle and the area above the ankle. The wound appeared to have some reddish drainage on the towel under R4's foot.

On December 26, 2017 at 2:00 PM, R4 had both ankles on the bed, and no pressure relief under the wounds. V6 was asked about the dressing and pressure relief and V6 stated V2 had completed R4's dressing. V6 stated R4 should have some type of pillow or blanket under R4's feet to keep the pressure ulcer off of the bed.

R4's undated care plan documents R4 has a skin alteration to right upper lateral ankle at a Stage 4. The interventions include weekly skin assessments and checking for pressure areas. And to use pillows to reduce pressure on heels and pressure points. The wound is to be assessed weekly by nursing to monitor for signs of infection, provide treatments as ordered. Consider etiology of the wound and implement appropriate interventions to prevent further wounds.

The updated weekly pressure ulcer list was requested from the facility and V2 stated V2 could not locate the report.

On December 26, 2017 at 1:30 PM, V2 said V2 did not know how R4 acquired the Stage 4 wound.

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S9999	Continued From page 8 On December 27, 2017 at 10:20 AM, V12 (Nurse Practitioner) said R4's immobilizer was the length of R4's leg, from the thigh to her ankle. V12 said she found the pressure injury, no facility staff had reported any open areas to her, and the wound was located directly under the immobilizer. V12 said the wound was clearly caused by the immobilizer and the wound followed the seam on the brace. V12 said she reported the wound immediately to the wound nurse and a dressing was applied. V12 described the wound as linear and was located at the ankle and continued up toward the calf. V12 clarified the wound physician documentation of the right upper lateral ankle is a more specific location of the wound and is the same wound she had initially identified on June 14, 2017. V12 said the wound was caused by pressure and was a Stage 4. V12 said the leg brace (immobilizer) should have been removed at least daily, and the wound should have been found when it became reddened, before it was a Stage 4. The facility's October 2004 policy for wound management documents the nurse will: 2. Document the size and description of the wound in the nurse's notes. 3. Initiate a wound documentation form, identifying the type of wound, the size, the location, and the status of the wound. 5. Implement appropriate pressure ulcer prevention protocols. 7. Complete skin assessments on all residents weekly after showers or as assigned to check for new skin integrity impairment. Document results in the nurses notes. 10. Perform treatments as ordered. The facility's March 2003 policy for prevention of pressure ulcers shows the rehab/restorative nurse will 3. Repeat the pressure ulcer risk assessment quarterly or when a resident has significant changes in condition,	S9999		

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and make re-evaluation appropriate.

2. The face sheet for R1 shows R1 was admitted to the facility on August 16, 2017 from the local hospital. The face sheet shows R1 was admitted with multiple diagnoses including pressure ulcer of sacral region at Stage 4, and paraplegia.

The October 3, 2017 admission MDS (Minimum Data Set) showed R1 was totally dependent on staff for transfers. The MDS showed R1 required extensive assist of 2 staff for bed mobility.

The admission nursing assessment dated August 16, 2017 shows R1's general skin condition as pale, dry, warm and had one Stage 4 wound. There were no location or measurements documented for a Stage 4 wound. The body diagram on the nursing assessment sheet had 8 circled areas noted. There was no indication of the type of skin problem on the noted areas. The nursing assessment sheet indicates the nurse is to document all body marks such as scars, bruises, discoloring, abrasions, pressure ulcers or any questionable markings. The instructions for pressure ulcers documentation should include the size, depth, color and drainage for each wound.

The August 16, 2017 nursing admission progress note documents 4 pressure injuries with measurements, no wound bed descriptions, presence of any drainage, and no description of the peri wound areas. The notes document presence of a wound vac but does not include the location of the wound vac or settings. The note showed R1 had Stage 2 wounds on both heels, no measurements or wound descriptions were documented.

The nursing progress note (wound charting)

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dated August 24, 2017, 8 days after R1's admission, shows R1 had a wound vac on two Stage 4 wounds and had multiple Stage 4 wounds and a total of 16 wounds of various stages. No measurements or assessments were documented until September 8, 2017.

A list of R1's wounds, any healed areas since admission, and current open wounds were requested from the facility and V2 stated V2 could not find any such report. A copy of R1's last visit to the wound clinic was provided.
October 31, 2017, R1 was last seen at the wound healing center. 9 pressure ulcers are documented, including four Stage 4 wounds, two Stage 2, two unstageable, and one skin tear.

R1's nursing progress notes for November 25, 2017 documents R1 was out of the facility from November 14, 2017 until November 25, 2017.

The November 25, 2017 admission nursing assessment for R1 showed no skin condition or assessment. The body diagram is blank and none of R1's pressure ulcer areas are listed, no vital signs or diagnosis are listed on the form. The initial nursing progress note for November 25, 2017 lists the general location of R1's wounds but does not describe the specific locations or stages of the wounds. The nursing assessment was not signed by any nurse.

The facility nurse admission checklist for R1 on November 25, 2017 shows the nurse is to complete nursing assessments including a thorough body audit, complete pressure ulcer risk assessment, complete wound documentation form for wounds, and schedule weekly skin assessments on the TAR based on the shower schedule. All areas are not checked off on R1's

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list, and the form is not signed by the nurse.

The November 25, 2017 wound documentation forms list 4 wounds. The nurse did not indicate the type of wound, or staging. The form lists a wound description for 1 of the 4 wounds and no other documentation was provided. The facility could not provide weekly documentation for each of R1's wounds.

The December 2017 TAR does not show any scheduled weekly skin checks. The dressing changes listed on the TAR show changes are to be done on Monday, Wednesday, and Friday. For December, no dressing changes are documented on December 1, 4, 8, or 15. The TAR does not show the resident refused or out of the building, the day is blank.

The December 15, 2017 care plan for R1 shows R1 has skin integrity changes and lists 13 wounds at various stages, and the interventions listed include: treatment as ordered, position changes at frequent intervals, protect skin at all times, sleeves for upper and lower extremities and pad wheelchair. The care plan does not note the use of/or location of the wound vac, any visits to the wound healing center or need for wound specialist. The care plan shows R1 requires assessment and management of skin integrity and the skin condition is to be assessed upon admission and weekly.

R1's December 19, 2017 visit to the wound healing center shows R1 had decline in 5 of the pressure ulcer wounds with an increase of necrotic tissues. On December 20. 2017 at 3:20 PM, V10 (wound healing center coordinator) said the facility should be monitoring R1's wounds and updating the wound clinic of any decline. V10

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said V10 was not sure why there was a gap in R1's visits to the clinic, R1 could have been seen sooner if the facility had called to schedule.

3. On December 15, 2017 at 9:10 AM, R2 was laying in R2's bed on R2's back watching television. R2 had a pillow behind R2's head and a regular mattress on R2's bed. R2's heels were lying flat against the mattress. R2 stated R2 is in the facility for rehabilitation and to receive intravenous antibiotics for an infection to left hip. R2 stated R2 had a hip replacement in R2's left hip that was removed due to acquiring a severe infection which was causing R2's kidneys to fail. R2 stated R2 has not been able to bear R2's full weight on R2's left leg because R2 only has antibiotic spacers in the hip until R2 is well enough to get another hip replacement done. R2 stated because of the wounds R2's bottom is uncomfortable and staff have not spoken to R2 about repositioning to avoid pressure to these areas.

On December 15, 2017, at 10:40 AM, V5 LPN (Licensed Practical Nurse) performed a dressing change to the areas on both of R2's buttocks. There were no positioning devices or pillows in place to offload pressure. There was an undated dressing in place on both the left and right buttocks. V5 LPN removed R2's dressing and exposed an open area to the left buttock and a circular reddened area to the right buttock. V5 LPN then placed new dressings and pulled R2's pants back into place. R2 was then returned to R2's previous position on R2's back.

On December 19, 2017, at 9:15 AM, R2 stated staff have "not touched the dressings on my butt since you were in here and watched on Friday (4 days prior)." R2 stated V2 DON (Director of

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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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Nursing) was in R2's room this morning and changed the dressing over R2's PICC (Peripherally Inserted Central Catheter) line and looked at R2's incision area on R2's hip but did not change the dressings on R2's buttocks. On December 19, 2017, at 9:55 AM, V4 LPN performed dressing changes to R2's bilateral buttocks. Upon exposing R2's buttocks V4 LPN stated the "dressings are doubled up in R2's crack". V4 LPN removed both undated dressings which were not covering the affected areas and were located bunched up between the resident's buttocks. V4 stated the area on R2's left buttock was not an open area and rubbed V4's gloved finger over the area. R2's left buttock began bleeding and V4 LPN cleansed the area with normal saline and applied a foam dressing to cover the left buttock and right buttock areas.

On December 15, 2017 at 9:40 AM, V2 DON identified R2 as a resident who has pressure areas. V2 DON stated on admission a skin assessment is completed by the admitting nurse and then one is done each week for the next four weeks. On December 15, 2017, at 10:27 AM V4 LPN stated the only time the floor nurses are doing wound measurements is when completing a new admission or when there is a new skin concern. V4 LPN stated that they had a wound care nurse before and she took care of the day to day care of wounds and since she left V4 LPN has not been instructed to do any routine wound measurements. On December 15, 2017, at 10:35 AM V5 LPN stated residents who have wounds will have a pink sheet in the TAR (Treatment Administration Record). V5 stated R2 does not have a pink wound sheet started yet but one of the managers, either the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) are probably going to do that today. On

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	IL6014658	A. BUILDING: ______ B. WING ______	C 01/02/2018

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December 19, 2017, at 11:30 AM, V2 stated it is the floor nurse's responsibility to do routine measurements of wounds.

On December 15, 2017, R2's medical record was reviewed and showed R2 was admitted to the facility on December 8, 2017. An undated, handwritten sheet of paper was found in the medical record and V2 DON identified this as the "nurse to nurse report" from the hospital for R2 at the time of R2's admission and was written by V2 himself. The undated and handwritten "nurse to nurse report" identified R2 as having an open area measuring 1cm x 1cm to the left buttock. On December 19, 2017, at 11:30 AM V2 DON stated there should have been an order obtained for treatment of R2's left buttock wound but it was not followed through.

On December 15, 2017, at 10:30 AM, R2's December 2017 TAR (Treatment Administration Record) showed R2 had an order started on December 13, 2017 to "Cover Rt Buttocks excoriation with foam dressing daily". No treatment order was present on the December 2017 TAR for the open area on the left buttock. On December 19, 2017, at 11:30 AM, R2's December 2017 TAR continued to reflect only the one treatment order for the right buttock and no orders for treatment to the left buttock open area. R2's TAR for December showed that no treatments were signed off as completed between the original order date indicated on the TAR of December 13, 2017 and December 19, 2017 at 10:30 AM for the right buttock excoriation.

R2's physician order sheet for December 2017 was reviewed and showed no physician orders for treatment to either buttock. R2's pressure ulcer

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care plan with goal date of January 6, 2018 showed R2 with excoriation to right buttock with no mention of area to left buttock. R2's pressure ulcer care plan shows pressure redistribution as appropriate but does not have specific interventions in place for pressure ulcer prevention. The initial wound assessment dated December 8, 2017 which was supplied to surveyor on December 19, 2017 showed area to left buttock measuring 1cm x 1cm with no further measurements having been done after December 8, 2017.

The facility "Skin Care Pressure Ulcer/Wound Management" policy and procedure revised October 2004 shows on admission the nurse will document the size and description of wound in the nurse's notes, obtain orders for appropriate treatment according to facility protocols or physician's instructions, implement appropriate pressure ulcer prevention protocols per policy, notify rehab nurse and/or DON of residents admitted with pressure ulcers or other wounds, complete skin assessments on all residents weekly after showers or as assigned to check for new skin integrity impairment. Document results in the nurse's notes, perform treatments as ordered, and date and initial all dressing changes on the cover dressing or tape. The facility "Skin Care Prevention of Pressure Ulcers" policy and procedure revised March 2003 shows the nurse will complete a skin assessment of the resident on admission, document skin condition in the nurse's notes, and implement appropriate protocols to prevent impairment of skin integrity, based on Pressure Ulcer Risk Assessment scores. The Skin/Wound Management procedure with revision date of October 2004 shows on page 3 to reassess the wound weekly or more often as necessary to measure progress or decline in wound status.

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