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
	IL6001002	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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S 000	Initial Comments Complaint Investigations: 2177059/IL138541	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)5) 300.1220b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide incontinence care in a timely manner and thoroughly cleanse the perineum area during provision of care. This failure resulted in multiple patches and cluster groups of MASD (Moisture Associated Skin Damage) to R1's bilateral thighs and buttocks and caused R1 to suffer pain and aggravation. This applies to 3 of 3 residents (R1, R2, R3) reviewed for skin alteration and incontinence care. The findings include:	S9999		

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1) The Face Sheet showed that R1 was a 40-year-old female with diagnoses that included pulmonary embolism, acute respiratory failure with hypoxia, lymphedema, difficulty walking, morbid obesity due to excess calories, anemia, lack of coordination, major depressive disorder, history of COVID-19 infection, pneumonia due to corona virus disease, muscle wasting and atrophy to multiple sites, muscle weakness and GERD (Gastro-Esophageal Reflux Disease). R1 was admitted to the facility from the hospital on 5/19/2021.

Review of the weight record history showed R1's weights:
-06/18/2021= 629 pounds
-06/25/2021=632 pounds
-07/02/2021=633 pounds
-08/09/2021=633.4 pounds
-09/07/2021=608 pounds
-10/01/2021=600 pounds

On 10/04/2021 at 12:30 P.M., R1 was lying in her bariatric bed. The width's dimension of R1's bed showed that R1's had approximately 4-6 inches space between the side of her body and edge of the bed. The lack of space meant that R1 could possibly end up on the floor if R1 attempted to turn due to lack of space. R1 was alert and oriented times three. R1 said "Don't worry, I cannot turn myself on my own and have to depend on 5 to 6 staff to turn me. If there is a male staff, then 5 staff will do, otherwise 6 staff if all females. The facility does not have enough people to handle me, so my diaper change was only 3 times a day at 10:00 A.M., 4:30 P.M. and 9:30 P.M. I am usually soaked with urine and stool. I have developed more skin sores and the sores do not heal because I am soaked with urine

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most of the time. My position in bed is the same and I am never turned to sides. Last time I was changed today was around 9:30 to 10:00 A.M. I never got out of bed or sat on a chair. It really does sting my skin when my diaper is soaked with urine. They don't apply my wound dressing most of the time to protect my skin from the burning sensation. It is a very aggravating situation."

During this interview, R1 was calm, cooperative and was compliant when asked to check her skin and incontinence care. V5 (LPN/ Licensed Practical Nurse), V6 (LPN); V7 (CNA/Certified Nurse Assistant) were present when R1 talked about her schedule for incontinence care. They validated that R1 was scheduled to be changed 3 times a day. (10:00 A.M, 4:30 P.M. and 9:30 P.M.).

After the interview with R1 on 10/4/21, the following staff were present to turn R1, V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse); V4 (LPN/Wound Treatment Nurse); V5 (LPN); V6 (LPN); V7 (CNA/Certified Nurse Assistant) and V9 (Male Restorative Aide). A total of 6 staff with 1 male and 5 females. R1 had to be moved towards the edge of the bed, to give room for turning to the opposite side. R1 was observed with 2 diapers under her buttocks and 1 diaper on the frontal aspect of her pubis area. R1 was saturated with urine. V7 said she just changed R1's diaper around 10:00 A.M. There was no wound dressing on R1's perineum or thighs. V7 failed to open R1's multiple skin folds, around the groin area and labial folds for thorough cleansing. V7 also failed to wipe and clean R1's buttocks and failed to apply skin ointment barrier. R1 was noted with multiple skin folds that were not easily accessible for visual

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S9999	Continued From page 4 skin inspection. On 10/4/21, R1 was compliant when was asked if we could do a thorough skin check. Same staff, except that this time 2 males were helping V9 and V8 (Restorative Aide). R1 was observed with multiple patches of open skin sores surrounding her posterior thighs (left and right) and left and right buttocks. V4 measured the wounds that V4 categorized it as MASD (Moisture Associated Skin Damage). The following measurements were provided by V4: V4 started measuring the biggest open skin area on the same group of clustered wounds. V4 failed to measure the surrounding open area with same cluster group of wounds. When V4 was asked if that was how she measured wounds (without measuring smaller size wounds and measuring the widest and longest part of wound), V4 said she was new to the job as a treatment nurse and was not trained. V4 then measured the cluster wounds from the longest and widest part of the wounds in a cluster group. 1) Right distal posterior thigh= 4 cm x 4 cm and 1.0 cm. 2) Right proximal posterior thigh= 1 cm x 1 cm. x 1 cm. 3) Left buttock= 1.5 cm. x 1.0 cm. x 0.5 cm. 4) Right buttock= 2 cm. x 1 cm. x 1 cm. 5) Left proximal posterior thigh= 1 cm. x 1 cm. x 0.5 cm. 6) Left distal/inner thigh= 0.5 cm. x 0.5 cm. x 0.2 cm. V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse) stated during the skin check observation that only the MASD (Moisture Associated Skin Damage) on the right proximal posterior thigh was observed on 10/3/2021 and	S9999		

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that V3 applied foam dressing on it at that time. V3 also added that the rest of the MASD were new. V3 and V4 said R1 had history of MASD before but had healed and they were not as much as observed on 10/4/2021.

The care plan dated 5/19/2021 and 8/19/2021 showed that R1 has alteration in skin integrity and is at risk of deterioration and or additional skin issues related to limited mobility, incontinence with bladder and bowel, morbid obesity, lymphedema, refusing air mattress, refusing peri-care at times. The interventions to prevent deterioration and acquired additional skin alteration included but not limited to: good peri care; apply protective barrier; reposition frequently when in bed, chair, and or wheelchair; pressure redistributing mattress/air loss mattress; off load bilateral heel from pressure with pillow.

Review of the care plan showed that R1's incontinence care to prevent skin sores was not addressed. The limited size of the bariatric bed which had no air mattress and prevented R1 from turning to sides was also not addressed. R1's refusal of treatment on the care plan showed no revised intervention.

On 10/6/2021 at 3:00 P.M., V1 (Administrator) stated that the facility does not accept residents that weigh more than 350 pounds because it lacks staff to provide care.

On 10/6/2021 at 5:00 P.M., V2 (Director of Nursing) added that V4 was new to her position as a wound treatment nurse and was not trained yet. V2 also said that facility does not accept residents that weigh more than 350 pounds. V2 also added that they try their best to provide care to R1 but R1's situation needed additional

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S9999	Continued From page 6 support. On 10/6/2021 at 6:30 P.M., V14 (Wound Care Physician Specialist) said he saw and examined R1 on 10/5/2021. V14 said R1 had multiple patches/clusters of MASD (Moisture Associated Skin Damage) on the posterior bilateral thighs and buttocks area. V14 said R1 was on a bariatric bed but the bariatric bed was only rated for a 350-pound person. R1 weighs ~600 pounds and her bariatric bed cannot accommodate R1 for turning and repositioning. V14 also validated R1 needed to be kept clean and dry from urine and stool and should be checked for incontinence care at least every 2 hours, should be turned every 2 hours to offload pressure and an air loss mattress be implemented to prevent pressure sores, MASD or other skin alterations. V14 also said these preventions should be implemented even if a resident has multiple comorbidities. V14 added that if these interventions were implemented and pressure sores and MASD still existed, then the sores were unavoidable. V14 stated all possible interventions should be provided to determine if sores were avoidable or not. V14 said if R1 had complained of burning sensation due to urine, then a foam dressing should be applied to protect the damaged skin. V14 said "Peri-care that is not done timely, which is at least every 2 hours, causes urine and stool to saturate the skin and not cleansing the perineum thoroughly will cause MASD and pressure sores and even a non-medical person knows that." The undated facility's policy for incontinence care states, "It is the policy of the facility to ensure that resident's receive as much assistance as needed for cleansing the perineum and buttocks after an incontinence episode... Frequency depends on	S9999		

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bladder diary and /or routine of minimal every 2 hours". The policy also showed to...cleanse the peri-area and buttocks wiping from front of perineum toward the rectum. For a female resident, separate the labia and wash area using downward strokes from pubic area to rectal area and to cleanse in skin folds."

The POS (Physician Order Sheet) for the month of October 2021, the facility's policy for incontinence care and the interview with V14 showed conflicting plan of care to prevent skin alteration. The POS showed to "change and clean (R1) daily on this time range 10:00 A.M., 4:30 P.M., and 9:30 P.M." There was no assessment to justify this time range for changing and cleaning R1's incontinence care.

2) On 10/4/2021 at 3:35 P.M., R2 was observed regarding her skin alteration. R2 has a stage 4 pressure ulcer on the sacrum. V4 (LPN/Wound Treatment Nurse) provided wound dressing to R2. R2 was saturated with urine and soft stool. V4 failed to cleanse R2 thoroughly by not cleaning the frontal/pubic area and separating labial folds to clean. V4 provided wound dressing change on R2's sacrum and the foam dressing were loosely adhering to the surrounding skin because it was still wet when V4 cleansed the rectal area. R2 was visibly dripping urine and V4 continued to fasten the incontinence brief with the wound dressing edges not sealed properly to the skin.

The care plan dated 3/9/2021; 6/9/2021 and 9/7/2021 showed that R2 "has alteration in skin integrity and is at risk for deterioration and /or additional skin issues related to limited mobility, incontinence of bladder and bladder." The interventions included but not limited to "good peri

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S9999	Continued From page 8 care and drying of skin, apply protective barrier." 3) On 10/4/2021 at 3:45 P.M., R3 was observed regarding skin alteration. R3 has a stage 4 pressure ulcer on the sacrum. R3 was saturated with urine and liquid stool. V4 failed to provide R3 incontinence care. V4 proceeded to change R3's sacrum wound dressing without ensuring that R3 was clean and dry. V4 said "I will let (V15, CNA) provide incontinence care to (R3)." At this time, V15 was providing hygiene to R10. The care plan dated 9/7/2021 showed that R3 "has alteration in skin integrity and is at risk for deterioration and /or additional skin issues related to limited mobility, incontinence of bladder and bladder..." The interventions included but not limited to "good peri care and drying of skin, apply protective barrier." (B)	S9999		