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
	IL6002539	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCTORS NURSING & REHAB CENTER	1201 HAWTHORN ROAD SALEM, IL 62881

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S 000	Initial Comments Complaint Investigation 2355617/IL161793	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)5) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 of 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to notify a resident's Primary Care Physician of a worsening wound, failed to ensure ordered weekly wound care physician visits were done, and failed to notify the resident's Primary Care Physician of the lack of a wound care	S9999		

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S9999	Continued From page 2 physician for 1 of 3 residents (R1) residents reviewed for pressure wounds in the sample of three. These failures resulted in R1's wound worsening to a Stage 4 that developed an infection requiring hospitalization, Intravenous (IV) antibiotic therapy, and surgical debridement. Findings include: R1's Face Sheet documented an Admission Date of 5/1/23, and Diagnoses including Hemiplegia/Hemiparesis following a Subarachnoid Hemorrhage affecting the non-dominant left side, Aphasia, Morbid Obesity, a pressure ulcer to the sacrum, and Diabetes Type 2. R1's Minimum Data Set, dated 6/4/23, documented R1 was totally dependent on at least two staff for transfers, toileting, and bed mobility, had an indwelling urinary catheter, a gastrostomy tube with enteral feedings, a tracheostomy with mechanical ventilation, and a Brief Interview for Mental Status Score of Zero, indicating R1 had severe deficits in cognitive functioning. R1's Care Plan, with a start date of 5/1/23, documented a problem area, "Resident is at risk of skin breakdown or pressure ulcers," with a corresponding intervention, "Report changes to MD (Medical Doctor) and obtain treatments as ordered as indicated." R1's Braden Scale for Predicting Pressure Sore Risk, dated 6/19/23, documented R1 was at moderate risk for the development of pressure ulcers. R1's June 2023 Physicians Order Sheet documented an order, "Cleanse coccyx wound	S9999		

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S9999	Continued From page 3 with wound cleanser, apply (trade name alginate dressing) and cover with bordered gauze dressing daily." R1's Nursing Wound Assessments documented the following (all the following measurements are in centimeters): 5/1/23: "Initial wound observation: (Wound location) Coccyx, two open areas, (area) measures 2 by 4 with a depth of 0.1, light clear serous drainage, well defined edges, with 100 percent of the wound covered by granulation tissue, (stage not documented)." 5/10/23: "(Wound measures) 6.2 by 6.5 by 0.1, moderate serous drainage, stage 3, 20 percent epitheliazation tissue, 80 percent granulation tissue. Wound status: Stable." 5/15/23: "4.5 by 5.6 by 0.1, stage 3, 20 percent epitheliazation tissue, 80 percent granulation tissue. moderate serous clear drainage. Wound status: Improving." 5/22/23: "4.3 by 5.5 by 0.1, stage 3, 30 percent epitheliazation tissue, 70 percent granulation tissue, moderate serous clear drainage. Wound status: Improving." 5/30/23: "4.3 by 5.5 by 0.1, stage 3, 20 percent epitheliazation tissue, 80 percent granulation tissue, moderate serous amber clear drainage. Wound status: Declining." 6/5/23: "4.5 by 5.5 by 0.1, stage 3, 70 percent epitheliazation tissue, 30 percent granulation tissue, moderate serous amber clear drainage. Wound status: Stable." 6/12/23: "4.3 by 5.5 by 0.1, stage 3, 70 percent epitheliazation tissue, 30 percent granulation tissue, moderate serous amber clear drainage. Wound status: Stable." 6/19/23: "4.3 by 5.5 by 0.1, stage 3, 70 percent epitheliazation tissue, 30 percent granulation tissue, moderate serous amber clear drainage.	S9999		

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S9999	Continued From page 4 Wound status: Stable." 6/26/23: "4.3 by 5.4 by 0.1, stage 3, 70 percent epitheliazation tissue, 30 percent granulation tissue, moderate serous amber clear drainage. Wound status: Stable." Physician Wound Evaluation and Management Summaries, authored by V5 (Wound Care Physician), documented the following: 5/10/25: "At the request of the referring provider (V7, R1's Primary Care Physician), a thorough wound care assessment and evaluation was performed today. Stage 3 pressure wound to the sacrum for at least 45 days duration. Wound size (in centimeters) 6.2 by 6.5 by 0.1. (Follow up) in seven days." 5/15/23: "Stage 3 pressure wound to the sacrum. Wound size: 4.5 by 4.6 by 0.1. Wound progress: Improved. Follow up...within seven days." 5/22/23: "Stage 3 pressure wound to the sacrum. 4.3 by 5.5 by 0.1. Wound progress: Improved evidenced by decreased surface area, increased epitheliazation. Follow up...within seven days." 5/29/23: "The patients visit has been rescheduled. No nurse available for rounds." There was no further documentation by V5 in the record. R1's TAR (Treatment Administration Record) for May and June 2023 documented from 5/1/23 to 5/9/23, the coccyx wound was treated every 48 hours with moistened (trade name collagen matrix) covered with a (trade name foam dressing). From 5/10/23 to 6/19/23, the wound was treated daily with calcium alginate with a trade name bordered gauze dressing. From 6/20/23 to 6/28/23, which included the day R1 was sent to the hospital, the area was treated daily with hydrogel followed by (trade name	S9999		

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S9999	Continued From page 5 calcium alginate) covered with (trade name bordered gauze dressing). Nursing Progress Notes for R1 documented the following: 6/20/23 at 3:45pm: "Wound Doctor attempted to be contacted multiple times the last few days...regarding residents worsening wound to coccyx. Wound Nurse finally contacted (V6-Physician/Medical Director) for further instruction, (new treatment order obtained.)" 6/26/23 at 5:36pm: "Wound Nurse assessed and completed residents prescribed treatment order with no issues...Wound edges look to be rejuvinating much better than previous treatment that was prescribed. Wound Nurse attempted to contact Wound Doctor once again regarding (the) center area of the wound that is still not appearing to improve....Still no answer." 6/28/23 at 8:10am: "Night nurse reported...this resident had 104 (degrees Fahrenheit) fever...rechecked at 7:30, still 103.8. Urine in (indwelling catheter) bag noted to be dark and cloudy with small clots observed. (V7) notified at 7:38am and orders are given to send to the hospital." A Hospital Admission Record for R1, dated 6/28/23, documented,".. Admitted (to the ICU (Intensive Care Unit)) with Urosepsis... (Admission) white blood cell count 18.6 (cells per microliter)(reference range: Normal 5-10). Culture from sacrum: Light Proteus miralibis, light polymorphonuclear cells, heavy gram-positive cocci, moderate gram variable bacilli. Assessment: Septic shock secondary to sacral wound. Cefipime 2000 milligrams in 0.9 percent	S9999		

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S9999	Continued From page 6	S9999		

sodium chloride in 50 milliliter IV piggyback given. A Hospital Encounter note dated 6/30/23 documented, "Debridement of infected, necrotic, stage 4 sacral wound...necrotic tissue (present) all the way to the coccyx, fascia, and muscle...Possible need for multiple serial debridements."

On 7/13/23 at 7:35am, V4 (R1's Power of Attorney) stated R1 was admitted to the facility on 5/1/23. V4 stated R1 was admitted to the facility with a coccyx wound. V4 stated on 6/28/23, R1 developed a temperature of 103 degrees Fahrenheit, and was sent to the hospital, where it was discovered R1 had a Urinary Tract Infection and R1's coccyx wound was so deep the bone was exposed, and the wound was infected. V4 stated R1 will need multiple surgical interventions to close the wound. V4 stated R1 will also have to be on intravenous antibiotics, "for weeks."

On 7/13/23 at 2:30pm, V6 (Physician/Medical Director) stated staff had contacted him once in the past few weeks to report R1's pressure ulcer was not improving and they had been unable to reach V5. V6 stated he did not evaluate R1, but did give orders to change the treatment. V6 stated he had heard nothing further about R1.

On 7/13/23 at 2:50pm, V2 (Director of Nursing) stated R1 was admitted with she believed three pressure areas to the sacrum, two of which have healed. V2 stated R1 was getting daily skin checks documented with a check off on the Treatment Administration Record (TAR), with a documented full evaluation of the skin done weekly. V2 stated R1's wound care treatment was being done daily with a check off on the TAR. V2 stated V5 was to see all residents with wounds every Monday. V2 stated over the course of

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S9999	Continued From page 7	S9999		

several weeks in April and May 2023, V5 became less and less available and difficult to reach. V2 stated V5 last saw R1 on 5/22/23. V2 stated she is not sure why any of V5's notes would read, "No nurse available to round," as any of the nurses may round with V5. V2 stated V3 (Licensed Practical Nurse/Wound Care Nurse), tried contacting V5 on multiple occasions after 5/22/23. V2 stated V3 was measuring and staging V5's residents wounds weekly, and was continuing to treat the wound according to V5's 5/22/23 orders. V2 stated about two weeks ago, V2 reached out to V5's contractual employer to ask that they send a different provider, and a Wound Care Nurse Practitioner started at the facility on Monday, 7/10/23. V2 stated on 6/28/23, R1 developed a 103 degree fever and was sent to the hospital for Urosepsis. V2 stated at the time of hospitalization, R1 did not have a wound infection.

On 7/14/23 at 9:40am, V3 stated R1 was admitted with an area to the coccyx, primarily covered with granulation tissue, with two small unhealed areas within it. V3 stated the coccyx was being treated daily, with V3 doing the treatment on Mondays and Fridays and floor nurses doing the treatment on the remaining days. V3 stated R1 was being seen weekly by V5. V3 stated one area resolved, but V3 did not believe the other area was improving with the treatment V5 prescribed. V3 stated she brought this to V5's attention every time he rounded, but V5 still would not change the treatment orders. V3 stated V5 last evaluated R1 on 5/22/23, and did not show up or call to cancel the following week. V3 stated she kept calling V5, as well as his contractual employer, and about three weeks after 5/22/23, the employer told V3 that V5, "was on an extended medical leave and was not

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S9999	Continued From page 8	S9999		

available." V3 stated at that point, she called V7 to ask if V7 could evaluate the wound, but V7 did not return V3's call. V3 stated on 6/20/23, she contacted V6 to report the wound was declining, and V6 did not evaluate the wound, but did prescribe new treatment orders. V3 stated she last observed and treated the wound on 6/26/23, and she felt the wound was improving. V3 stated around that time, V2 called V5's employer and asked they send a different provider since V5 was not dependable. V3 stated she heard on the morning of 6/29/23 that R1 had been sent to the hospital on 6/28/23 and, "(V1, Administrator) and (V2) said they heard from the hospital that when they got (R1), the wound looked really bad, the wound was infected, bone was exposed, (R1) would have to be on IV antibiotics for four weeks, and she would need to have surgery on the wound." V3 stated she was very surprised to hear this report. V3 stated R1 is the only resident whose wound deteriorated while the facility was without a wound care provider. V3 stated on 7/10/23, V5's employer sent a new mid-level wound care provider, who followed up on all V5's residents, and will see them weekly every Monday.

On 7/14/23 at 12:45pm, V1 stated he heard from a nursing staff member, he could not remember which one, a nurse at the hospital where R1 was, called voicing concerns about the appearance of the wound and questioning the quality of wound care she was receiving at the facility. V1 stated the last staff member to provide R1's wound care prior to her hospitalization was V8 (Licensed Practical Nurse/LPN) on 6/27/23.

On 7/14/23 at 12:50pm, V8 (Licensed Practical Nurse/LPN) stated she did not specifically recall doing R1's dressing change on 6/27/23, but if it

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S9999	Continued From page 9	S9999		

had showed signs of infection or if the bone was exposed she most certainly would have contacted V7. V8 stated she and V3 had discussed the wound several times, and she was aware V3 had been trying to get a hold of V5.

On 7/14/23 at 1:20pm, V9 (Registered Nurse) stated she had discussed R1 with hospital staff during transfer report, but nothing was said about her wound being infected.

On 7/14/23 at 1:30pm, V2 stated she,"Heard in passing at the 6/29/23 Department Head Meeting," that hospital staff called to voice concern about the condition of the wound and the quality of wound care she received at the facility, but she did know who took the call, and she did not follow up with the hospital.

On 7/14/23 at 1:45pm, V10 (Hospital Nursing House Supervisor) stated R1 was admitted on 6/28/23 with an admitting diagnosis of Sepsis due to Urinary Tract Infection versus Osteomyelitis from an infected sacral wound. V10 stated on admission, staff noted the wound was unstageable with necrotic tissue present. V10 stated R1 was on IV antibiotics throughout her stay. V10 stated during the hospitalization the wound had to be surgically debrided. V10 stated R1 was discharged from the hospital on 7/7/23 to a hospital in Missouri, where R1 will get more surgical intervention for the wound. V10 stated R1's hospital chart contained no documentation to indicate their staff talked to the facility about R1's wound specifically.

On 7/14/23 at 2:00 pm, V7 (R1's Primary Care Physician) stated she was aware R1 had been sent to the hospital due to Urosepsis and an infected pressure ulcer. V7 stated she had no

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S9999	Continued From page 10 idea V5 had not been visiting the facility due to being on an extended medical leave. V7 stated the facility did not call to tell her R1 was not being seen, nor that R1's pressure area had worsened. V7 stated she is always available by phone, and additionally she is in the facility rounding every week and nobody said anything to her about this issue. V7 stated had she been aware, she would have evaluated the wound herself. V7 stated R1 has multiple serious health concerns which complicated her care. V7 stated she had counted on the facility to ensure R1's wound was being treated by a specialist. A Wound Management Program Policy dated 1/20/23 documented," It is the policy of (the facility) to manage resident skin integrity through prevention, assessment, and implementation of evaluation and interventions ...Physician orders should be obtained and followed for each resident. The facility will assess residents weekly for current skin conditions ...Physician ...(will be) called.. weekly...with an update of the current wound condition. These calls are documented in the nursing notes." (A)	S9999		