Illinols Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6005615 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD LUTHERAN HOME, THE **PEORIA, IL 61614** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 Initial Comments S 000 First Probationary Licensure Survey Final Observations S9999 Statement of Licensure Violations 300.1210 d)5) Section 300.1210 General Requirements for Nursing and Personal Care 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. This REQUIREMENT was not met as evidenced by: Based on observation, Interview, and record review the facility failed perform hand hygiene after removing a soiled wound dressing, and Attachment A failed to cleanse a soiled wound bed prior to Statement of Licensure Violations performing new wound treatment for one (R3) of one wound treatment reviewed for pressure ulcers in the sample of seven.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6005615 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6901 NORTH GALENA ROAD LUTHERAN HOME, THE PEORIA, IL 61614** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 Findings include: The NPUAP (National Pressure Ulcer Advisory Panel), dated 2009, documents "Wound cleansing is the process of using fluids to remove surface contaminants, bacteria, and remnants of previous dressings from the wound surface and its surrounding skin... 1. Cleanse the pressure ulcer and surrounding skin at the time of each dressing change." The facility's Clean and Sterile Dressings policy and procedure, revised 9/20/22 documents "Clean Dressings. Steps in the Procedure... 5. Perform hand hygiene. 6. Put on clean gloves. Loosen tape and remove solled dressing, 7, Pull glove over dressing and discard into plastic or biohazard bag. 8. Perform hand hygiene, 9. Open dry, clean dressing (s). 10. Using clean technique, open other products. 11. Perform hand hygiene. 12. Put on clean gloves. 13. Assess the wound and surrounding skin for edema, redness. drainage, progress of tissue healing, and wound stage, 14. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward), 15. Use dry gauze to pat the wound dry. 16. Remove gloves, Perform hand hygiene, Apply gloves, 17. Apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initials to top of dressing, 18. Discard disposable items into the designated container. 19. Remove disposable gloves and discard into designated container, 20, Perform hand hygiene," The facility's Hand Hygiene policy and procedure, revised 9/23/22, documents "Policy Interpretation

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6005615 B. WING 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6901 NORTH GALENA ROAD LUTHERAN HOME, THE PEORIA, IL 61614** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 2 S9999 and Implementation... 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... 7. Use an alcohol-based and rub containing at least 60% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:... g. Before handling clean or soiled dressings, gauze pads, etc; h. Before moving from a contaminated body site to a clean body site during resident care; 8. After contact with a resident's intact skin; j. After contact with blood or bodily fluids: k. After handling used dressings. contaminated equipment, etc.; I. After contact with objects (e.g., medical equipment); m. After removing gloves;... 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing health care associated infections." The Physician Orders for R3, documents a Physician Ordered Treatment, dated 6/20/23 as: "Santyl 250 unit/gram topical ointment... enzymatic debridement. Apply thin layer of Santyl to base of wound, pack with alginate rope, cover using foam with border once daily. On 6/22/23 at 10:34 am, R3 was lying in bed on his left side. V3 RN (Registered Nurse) /Wound Nurse and V4 LPN (Licensed Practical Nurse) assisted R3 onto his right side. V3 RN/Wound Nurse unfastened R3's brief, pulled the brief away from R3's buttocks, revealing an intact coccyx wound dressing, dated 6/21/23. Without performing hand hygiene, V3 RN/Wound Nurse applied gloves, removed R3's soiled foam

dressing, reached into R3's wound bed, grasped

PRINTED: 08/03/2023 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6005615 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD **LUTHERAN HOME, THE PEORIA, IL 61614** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 the pink and tan saturated soiled dressing from R3's wound and placed the soiled dressing on a paper towel on R3's bed. With same soiled gloves V3 RN/Wound Nurse assessed and touched R3's wound edges and using soiled gloved finger ran finger under edge of R3's coccyx wound bed. V3 RN/Wound Nurse then picked up the new tube of Santyl from R3's bed sheet, unscrewed the top, turned the cap over and punctured a hole in the opening of the tube. and placed the tube on R3's fitted bed sheet. V3 RN/Wound Nurse picked up a sealed package of cotton swabs and with same soiled gloves opened the package and placed it on R3's fitted bed sheet. V3 RN/Wound Nurse removed her soiled gloves and without performing hand hygiene, applied new gloves, V3 RN/Wound Nurse picked up the tube of Santvl and a cotton swab, from R3's bed sheet, squeezed a small amount of Santyl onto the cotton swab and began to rub the swab around in R3's soiled wound, V3 RN/Wound Nurse reached for second cotton swab from R3's bed sheet and repeated the same process. V3 RN/Wound Nurse then opened a package of calcium alginate rope, pulled the rope from the package and began packing R3's wound, grabbed the foam bordered dressing and applied it over R3's wound, positioned and fastened R3's brief, pulled up and straightened R3's bedding, picked up the soiled supplies from R3's bed, pushed the privacy curtain back and placed soiled supplies into a garbage bag.

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hallway.

removed her gloves and stepped out into the

On 6/22/23 at 10:45 am, V3 RN/Wound Nurse stated she was told by V1 DON/Director of Nursing to follow the physician orders and R3's coccyx treatment order did not say to clean R3's wound or she would have. V3 RN/Wound Nurse

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6005615 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6901 NORTH GALENA ROAD LUTHERAN HOME, THE PEORIA, IL 81814** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 stated "V6 (R3's) Wound Doctor may not have wanted R3's wound bed cleaned so not to destroy the wound bed." V3 RN/Wound Nurse stated she changed her gloves after she removed R3's old dressing and did not need to perform hand hygiene because R3's old dressing was a dakins (bleach) solution dressing so R3's wound was already clean. On 6/22/23 at 10:48 am, V4 LPN stated she follows whatever the physician order reads and also would not have cleaned R3's wound bed prior to putting the new dressing on because there was no order to clean it. On 6/22/23 at 12:37 pm, V6 (R3's) Wound Doctor stated it is the standard of care and practice to cleanse a soiled wound prior to doing the new treatment and they shouldn't need a physician order for it. V6 also stated he expects the Nurses to cleanse a wound before doing the treatment and should be in the facility's protocol to do so. On 6/22/23 at 1:30 pm, V2 DON (Director of Nursing) stated he did advise V3 RN/Wound Nurse to follow R3's Physician Orders for wound treatment and he (V2) was going to call V6 (R3's) Wound Doctor and get a clarification order to include the cleansing of R3's Wound. V1 Administrator and V2 DON confirmed V3

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RN/Wound Nurse should have performed hand hygiene in between glove changes, performed hand hygiene after touching R3's contaminated wound, should have cleansed R3's wound prior to applying new treatment and should not have placed clean treatment supplies on R3's bed sheet and should have placed the soiled treatment supplies in the garbage.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING \_ IL6005615 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6901 NORTH GALENA ROAD LUTHERAN HOME, THE PEORIA, IL 61614** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) S9999 Continued From page 5 S9999 (B)

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