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
	IL6008866	A. BUILDING: ______ B. WING ______	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NSG & REHAB CTR	767 30TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Complaint Investigation: 2328910/IL165915	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)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	S9999	Attachment A Statement of Licensure Violations	

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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.

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:

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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.

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 Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow its policy of assessing a resident's skin condition using a standardized assessment, failed to implement interventions to prevent the development of pressure wounds, for a resident that was at risk for developing pressure wounds and failed to monitor a resident's skin for the development pf pressure wounds. These failures resulted in R1 developing an avoidable, infected, unstageable wound that resulted in surgical amputation of R1's, first metatarsal and the development of osteomyelitis.

FINDINGS INCLUDE:

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S9999	Continued From page 3 The (reviewed 08/20/2021) facility policy, Pressure Ulcers/Skin Integrity/Wound Management, directs staff, "A system is in place for the prevention, identification, treatment and documentation of pressure and non-pressure wounds. Upon admission: A Braden skin assessment be completed upon admission. Those residents who represent a high risk will have further preventative interventions put in place. Weekly: A weekly skin check will be conducted and documented for at-risk residents. This is a hands-on, direct visual assessment. Assessment information should identify specific factors that might increase the risk of pressure ulcer development such as: Decreased mobility, Cognitive impairment, Significant weight loss in a resident who also has mobility/positioning concerns, impaired nutrition of history of impaired nutrition, altered sensory perception, incontinence. Care Planning: For the resident at risk for developing a pressure ulcer or who has a pressure ulcer, an individualized care plan will be developed per care plan timelines. The care plan should address prevention of any skin breakdown including, sheering or friction, repositioning, pressure relief equipment and the care and treatment to be provided to the resident. Daily and/or routine ongoing documentation should be conducted by the licensed nurse related to the resident's response to the care and treatment of the skin." R1's facility Face Sheet documents that R1 was admitted to the facility on 9/12/2023 with the following diagnoses: Cerebrovascular Disease with Aphasia, Dysphasia and Hemiplegia, Type 2 Diabetes Mellitus, Quadriplegia, Retention of Urine, Severe Protein-Calorie Malnutrition, Contractures of Muscle.	S9999		

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S9999	Continued From page 4 R1's baseline Care Plan, dated 9/12/23 documents, "(R1) NPO (Nothing Per mouth), Tube Feeding, Non-verbal, Total Dependence on staff for ADLs (Activities of Daily Living), Tracheostomy, Incontinent of Bowel, Foley Catheter." No interventions to prevent/minimize the development of pressure wounds are included. R1's electronic medical record contains R1's Braden Scale, dated 9/12/2023, that is incomplete. R1's September and October 2023 Treatment Administration Records for 2023 contain no documentation that R1's skin was assessed weekly and documented, as required. R1's individualized care plan, developed 10/2/2023 contains no reference to R1's risk for development of pressure wounds nor interventions to prevent/minimize the development of pressure wounds are included. R1's Nursing Progress Notes, signed by V3/Wound Nurse and dated 10/23/23 at 3:21 P.M. document, "(R1's) sister reported to nurse that (R1) had an open wound on his right foot. Upon examination of the foot, it was (an) ulcer on his bunion the size was 6.5 x 2.5 and on the lateral side of his great toe measured 4.0 cm x 2.0 cm. Both wounds were 80% yellow and 20% pink in color. A call was placed to NP (Nurse Practitioner) to get orders for the treatment: Ordered: Cleanse with normal saline, apply (enzymatic debrider) to the wound bed, apply Z-guard to the peri-wound, cover with 4x4's, wrap with gauze daily. (NP) also ordered an air mattress. The dressing was applied as ordered. (NP) ordered Doxycycline (antibiotic)100 mg	S9999		

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S9999	Continued From page 5 (milligrams) BID (twice daily) x 14 days for the infection of the wound." R1's Nursing Progress Notes, dated 10/24/2023 at 9:48 A.M. document, "(R1)'s sister came in and requested (R1) to be sent to the hospital to have the Dr. (Doctor) look at the wound on (R1's) foot and bottom to make sure we are cleaning his wounds and doing the proper treatment. (R1) sent by ambulance." R1's Emergency Room Report, dated 10/24/2023 documents, "Chief Complaint Patient presents with Wound Check. 60 y.o. (year old) male presenting to the ED (Emergency Department) by ambulance for a wound check. Sister reports that she noticed a wound to the medial aspect of patient's right foot yesterday. She explains that patient has been living in a nursing home for the past month. In addition to patient's wound, sister claims that patient has lost a significant amount of weight and has had a "nonstop" cough for the past week. Sister states that (R1) has 'not been acting like himself' recently. Brother voices that (R1) has a history of diabetes. Sister reports that (R1) is non-verbal at his baseline. They deny that (R1) has had any recent episodes of fevers. Feet: Right foot: Skin integrity: Ulcer (Ulceration to the medial aspect of the first MTP joint measuring approximately 3 cm in length and depth to the subcutaneous layer) present. Disposition: Admit. Clinical Impression and Disposition: Ulcer of right foot, unspecified ulcer stage." R1's Hospital Note documents, "Date of Service: 10/25/2023. Procedure(S) Arthroplasty Right First Metatarsal. Preop Diagnosis: Decubitus ulcer right foot first metatarsal, osteomyelitis first metatarsal. Postop Diagnosis: Same. Procedure Performed: Resection right first metatarsal head.	S9999		

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(R1) was brought to the operating room placed in a supine position. Anesthesia via the trach (Tracheostomy). The right lower extremity was scrubbed prepped and draped in the usual aseptic technique. A standard timeout was performed. An incision was made on the dorsal medial first metatarsal. Dissection was carried down to the first metatarsal head. The first metatarsal head was dissected free and then a sagittal saw was used to perform a transverse cut through the neck region of the first metatarsal. The head of the first metatarsal was then surgically removed from the operative field. A rongeur on the back table was used to harvest a sample of bone for aerobic and anaerobic culture. The metatarsal head itself was also sent for gross. The operative site was then flushed with saline, and 3-0 nylon was used for skin closure. The right foot was washed with saline. Xeroform 4 x 4's Kerlix and an Ace wrap was applied to the right lower extremity. Patient tolerated this procedure well. There were no known complications. (R1) will be discharged back to hospitalist care for further treatment."

On 10/30/23 at 8:50 A.M., V4/LPN (Licensed Practical Nurse) stated, "I was the nurse that admitted (R1). I didn't do a Braden Scale (assessment) on the day (R1) was admitted. (R1) would be considered high risk for pressure wounds due to his immobility, incontinence, decreased sensation and poor nutrition."

On 10/30/23 at 12:24 P.M., V3/Wound Nurse stated, "A Braden Scale (skin assessment) is supposed to be done upon admission to assess whether a resident is at risk for skin breakdown. I can't find a completed Braden Scale for (R1) when he was admitted. He was at high risk for breakdown because of his immobility and

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S9999	Continued From page 7 incontinence. When a resident is at risk for skin breakdown, they are supposed to have a care plan to address their skin and weekly skin checks by a nurse. The weekly skin checks get documented on the TAR (Treatment Administration Record). I don't see any weekly skin checks for (R1)." At that time, V3/Wound Nurse confirmed that R1's care plan did not address R1's skin risk and no interventions were in place to reduce/modify the risks. (A)	S9999		