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
	IL6013106	A. BUILDING: ______ B. WING ______	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF COLUMBIA	253 BRADINGTON DRIVE COLUMBIA, IL 62236

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Licensure Vioaltions 300.610a) 300.1210b) 300.1210d)2)5) 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. 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/31/19

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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.
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.

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 evidenced by:

Based on observation, record review and interview, the facility failed to implement pressure relieving interventions, prevent infection and the worsening of pressure ulcers for one of 4 residents (R17) reviewed for pressure ulcers in the sample of 37. This failure resulted in R17's facility acquired shear pressure injury deteriorating with the need for surgical debridement (removal) of necrotic (dead) tissue.

Findings include:

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The Minimum Data Sets (MDS) dated 7/01/19 and 10/01/19 documents R17 is severely impaired with cognition, requires extensive assistance with bed mobility, transfers, personal hygiene and is incontinent of bowel and bladder. R17's MDS, dated 10/01/2019, documents R17 was still at risk for pressure ulcers, but has none. This MDS documents R17 has "open lesions."

R17's Initial Skin Alteration Record, dated 6/24/19 documents-"Healed/closed." There is no documentation of pressure ulcers for R17.

R17's Weekly Skin Record, dated 7/9/2019, documents a facility acquired, "PU (pressure ulcer) 2.0 cm (centimeter) X (by) 4.3 cm, open area to coccyx (tailbone), left buttock 1 cm X 1 cm, beefy red in color, free of drainage." There was no documentation of the Stage of the ulcer.

R17's Care Plan, revised 8/13/2019 documents, in part, "potential for pressure ulcer development related to incontinence and need for staff assistance to remain clean and dry and free from odors. Wound to coccyx." The Care Plan documents, "follow facility policies/protocols for the prevention/treatment of skin breakdown for (R17)."

A Physician's Order (PO), dated 8/19/2019 documents, "Refer to wound DR (doctor) for eval (evaluation)and tx (treatment). Wound to coccyx".

V21's, Wound Physician, Initial Wound Evaluation and Management Summary for R17, dated 8/26/2019 documents R17 was first seen and assessed by V21. The Summary documents, in part, "(R17) has a shear wound of the left buttock for at least 3 days duration. There is moderate serous (clear, thin, watery) drainage. Site 1-Shear

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wound sacrum (a large wedge-shaped vertebra at the end of the spine) measuring 2.5 X 4 X 0.2 cm, 50 % (percent) thick adherent devitalized necrotic tissue. Alginate calcium apply once daily for 30 days, Dry protective dressing once daily for 30 days, Santyl, apply once daily for 30 days. Limit sitting to 30 minutes. Off load wound. Reposition per facility protocol. With clean surgical technique, curette (a surgical instrument) was used to surgically excise 5.0 cm2 (squared) of devitalized (dead) tissue and necrotic muscle and surrounding fibers were removed at a depth of 0.3 cm." V21's documented R17 had a shear wound to the left buttock measuring 1.5 cm x 1.5 cm with depth not measurable. The treatment and surgical debridement for the left buttock is the same as the sacral/coccyx ulcer.

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as "localized damage to the skin and underlying soft tissue over a bony prominence related to a medical or other device." NPUAP continued "The Injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear."

The Initial Wound Evaluation and Management Summary for R17, dated 8/31/2019, from V21 documents R17's sacral ulcer measured 3.5 X 5.0 X 0.5 cm, again with 50% necrotic tissue, surface area 17.5 cm2, and had deteriorated. The treatment remained the same. The Summary further documents, "Site 1-Curette was used to surgically excise 8.75 cm2 of devitalized tissue and necrotic muscle and surrounding fascial fibers (fibrous connective tissue containing collagen).
Site 2-Shear wound of left buttock-2 X 2 cm, surface area 4.0 cm2, 40% necrotic tissue. Curette was used to surgically excise 1.6 cm2 of

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devitalized (dead) tissue and necrotic subcutaneous fat and surrounding connective tissue." The treatment remains the same. Once again, V21 recommended "Limit sitting to 30 minutes, Offload wound, reposition per facility protocol."

V21's weekly treatments for R17's pressure ulcers remained the same until The Initial Wound Evaluation and Management Summary dated 9/16/2019. The Summary documents, in part, "She (R17) has a shear wound to the sacrum for at least 23 days duration. There was no pain associated with this condition. Site 1-Shear wound sacrum, 3.5 X 5.0 X 1 cm, surface area 17.5 cm2, moderate serous drainage, 50% thick devitalized necrotic tissue, wound progress-no change. Site 2-shear wound of left buttock, 2 X 2 X 0.1 cm2, surface area 4.0 cm2, 40% necrotic tissue." Once again, both wounds were surgically debrided to obtain margins of viable (good) tissue. V21's plan of care added the antibiotic, Flagyl 500 mg (milligram) to be crushed and added to the current treatment of Alginate calcium and Santyl, then placed in the wounds.

The Initial Wound Evaluation and Management Summary for R17, dated 9/23/2019, documents Gentamycin (antibiotic) ointment was added to the same treatment regimen as of 9/23/2019.

V21's Initial Wound Evaluation and Management Summary for R17, dated 10/07/2019, documents, in part, "Site 1-shear wound sacrum-3.0 X 5.0 X 1 cm, surface area 15.0 cm2, 50% necrotic tissue. This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of biofilm (slimy film of bacteria that sticks to a surface). Site 2-left buttock, 1.5 X 1.5 X 0.1 cm. surface area, 2.25 cm2, 20% necrotic

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tissue, Wound progress, no change."

On 10/8/19 at 11:53 AM, R17 was in bed on her right side. R17's pressure relieving boots were in the geriatric chair. R17's feet were directly on the mattress. At 12:13 PM, V8, Certified Nurse's Aide (CNA) stated, "She (R17) has a sore on her butt. They turn her from side to side."

On 10/8/19 at 12:19 PM, R17 was positioned on her back in bed. Her heels were directly on the mattress. R17's pressure relieving boots remained in the geriatric chair. At 2:17 PM, R17 remained in bed on her back. She had the pressure relieving boots to both feet; however, the heels of the boots were directly on the mattress.

On 10/10/19 at 9:23 AM, R17 was up in a reclined geriatric chair, placing pressure directly on her coccyx and buttocks. R17 was wearing pressure relieving boots to both feet, but her heels were on the foot rest of the chair. At 9:54 AM, 10:16 AM, 10:21 AM, and 10:38 AM, R17 remained up in the reclined geriatric chair on her back. At 10:45 AM, V16, CNA stated, "I got her (R17) up at 6:30 AM. She eats really good, doesn't talk much. Smiles a lot. She can't T&P (turn and position) herself. I know they repositioned her after her treatment was done this morning."

On 10/10/2019 at 10:50 AM, V17, Licensed Practical Nurse (LPN) reported R17's wound treatments were done by the midnight shift, before she arrived at work.

On 10/10/19, at 11:06 AM, R17 was still in the same position in her geriatric chair, on her back, with pressure on her coccyx. At 11:16 AM, R17 was still in the same position. At that time, R49,

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R17's roommate, stated, "She (R17) was up in that chair before I got up at 6:30 (AM) this morning to shower. I'm worried about her."

On 10/10/19 at 11:20 AM, V17, LPN, stated, "She (R17) got the pressure ulcer here. It's an area that keeps coming and going. She eats good. She has a nonhealing wound. (V21, Wound Physician) has been seeing her for several months, once a week."

On 10/10/19 at 12:11 PM, V1, Administrator and V15, Assistant Director of Nursing (ADON), were in R17's room. R17 was still in the geriatric chair on her back. V15 removed the pressure relieving boot to her right foot. A red, blanchable area, the size of a quarter was on R17's inner right heel. V15 checked for pedal pulses and reported they were present to both of R17's feet. The back of R17's calves had been resting directly on the chair. Indentations were noted to back of both calves, where they laid on the chair. V15 floated her feet on a pillow at this time. V1 stated, "Let me get someone to reposition her. It's time for her lunch."

On 10/10/19 at 12:22 PM, V16, CNA entered R17's room, then went to get a mechanical lift. V16 stated, "We usually feed her, take her to the dining room, and then we will lay her down."

On 10/10/19 at 12:24 PM the mechanical lift pad was attached to R17, and she was lifted for less than 3 minutes from the chair. There was no pressure relieving cushion in the geriatric chair. There was a large indentation in the chair where her buttocks were sitting. On 10/10/19 at 12:26 PM, R17 was lowered back into geriatric chair by V8 (CAN) and V15 (ADON). R17 was slightly repositioned to the left side with a wedge cushion

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under her right arm. R17 still remained sitting on her buttocks with the pressure on her coccyx. At 12:28 PM, R17 was wheeled into the dining room for lunch. R17 had been up in the chair over 3 hours, with her heels not floated and without the benefit of being repositioned or offloading her coccyx. R17 had not been repositioned in the geriatric chair since she had been placed in the chair on the midnight shift, over 7 hours, except for the less than 3 minutes before lunch when she was lifted by the mechanical lift.

On 10/10/19 at 1:30 PM, R17 was transferred to bed by V17(LPN) and V20, LPN and her incontinent brief was removed. The brief was wet with urine. V17 removed the dressing dated 6/10/2019 to the coccyx. A large deep, beefy red open area was on R17's coccyx. The center of the wound was white, possibly revealing bone. R17 had a smaller Stage II pressure ulcer on her inner left buttock.

On 10/10/19 at 1:42 PM, V17 stated, "(V21, Wound Physician)) is calling this wound unstageable shearing. We crush the Flagyl (antibiotic), mix with equal parts Santyl and Gentamycin ointment and paint the wound with it. No tunneling that I see." V17 applied the mixture and packed both wounds with Calcium Alginate. V17 covered the area with a non-adhesive, moisture resistant dressing. R7 was pulled up in bed and positioned to the left side. Her buttocks and upper thighs were heavily creased, red but blanchable. V17 reported she did not know what stages the wounds were.

The NPUAP (National Pressure Ulcer Advisory Panel) at https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf

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documents the definition, "Unstageable Pressure Injury: Obscured full- thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed."

On 10/10/19 at 1:48 PM, V17 and V20 positioned R17 slightly to the left side with a wedge behind her back and a pillow between her knees. They covered her and left the room. Both V17 or V20 failed to provide incontinent care at all. R17's feet were directly on the mattress. R17's pressure relieving boots remained on the geriatric chair.

R17's Progress Note, dated 9/27/2019 at 4:34 PM, from V23, Dietitian documents, in part, "Continued to have a deep tissue injury on left buttock per skin record on 9/16-wound showing no change, Megace (appetite stimulant) discontinued on 9/23/2019. She has been consuming 75-100% at meals. Now receiving 2 times protein at meals per previous RD (Registered Dietitian) recommendation. Weight 183.4 pounds as of 8/28/2019."

On 10/11/19 at 10:29, V2 Director of Nursing (DON), stated, "I just started here 10/3/2019. I'm trying to educate staff. I looked at her wound today. There is no necrosis. There is healthy tissue to the coccyx, I would say it's a Stage III, 3 cm X 3 c, X 1 cm, no tunneling, with a Stage 2 to the left buttock-1 X 1 X 0.5 cm. We will be turning her every hour now."

On 10/11/19 at 10:43 AM, when V21 was asked why he does not Stage wounds, V21 stated, "I don't stage wounds. It (R17) started as a shearing to the coccyx. Necrosis will happen. I

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debride the wound every week using a sterile technique." When V21 was Informed of the facility's failure to T&P R17 for over 4 hours, he stated, "They should keep her clean and follow their facility protocol. The wound is improving very slowly. The standard for T&P is every 2 hours. They should not keep her up for over an hour at a time."

The facility's policy and procedure, reviewed 1/2014 and entitled, "Preventative Skin Care Policy" documents, in part, "To provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers. Any resident identified as being a high risk for potential skin breakdown shall be turned and repositioned at minimum of every 2 hours. Slightly elevate bony prominences/pressure areas off the mattress. Pressure relieving devices may be used to protect heels and elbows. Practice care in moving and lifting residents. Prevent shearing forces during moving and transfers. Prevent pulling resident across the sheets. Keep incontinent residents clean and dry."

(B)