

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011597</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/22/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LOFT REHAB &amp; NURSING OF CANTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2081 NORTH MAIN STREET CANTON, IL 61520</b>
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S 000	Initial Comments  Original Complaint Investigation: #2027456/IL126974	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.3240a)  300.610a) 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.  300.1010h) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/08/20
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S9999	<p>Continued From page 1</p> <p>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 of notification.</p> <p>300.1210b) 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.</p> <p>300.1210d)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.</p> <p>300.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Regulations are not met as evidenced by:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Based on observation, record review and interview, the facility failed to thoroughly assess a resident's skin while using compression wraps to splint a femur fracture, notify the Physician after a pressure ulcer/injury was identified to obtain treatment, and failed to accurately assess and identify the stage of multiple pressure injuries, for one of one residents (R1) reviewed with pressure ulcers/injury, in a sample of three. This failure resulted in R1 developing an unstageable pressure ulcer on the right inner knee and a unstageable pressure injury to the back of the left knee.</p> <p>Findings include:</p> <p>The facility policy, titled "Wound Treatment Management (08/01/19)," documents "To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and Physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with Physician orders, including the cleansing method, type of dressing and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify Physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse." The policy further documents, "5. Treatment decisions will be based on: a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Surgical. iii. Incidental (i.e. skin tear, medical adhesive related skin injury). iv. Atypical (i.e.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>dermatological or cancerous lesion, pyoderma, calciphylaxis). b. Characteristics of the wound: i. Pressure injury stage. ii. Size-including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of tissue in the wound bed. vii. Condition of peri-wound skin."</p> <p>A Nursing Note dated 9/10/20 at 4:22 pm by V2 (Director of Nursing) documents, "(R1) returned to facility. (V8 - Physician) notified and orders received to admit with transfer order, hospice (services), regular diet, resume previous medication. (Indwelling) catheter in place and draining yellow urine. (Compression) wrap to lower extremities to splint left to right leg due to fracture and non-surgical candidate. Family aware of diagnosis and hospice referral. Resident assist to bed and skin check performed. Reddened area noted on outside of left great toe, IV (intravenous) site left wrist."</p> <p>Admission Physician's order given by V8 (Physician/Medical Director), on 9/10/20 at 4:15 pm, input by V2 (Director of Nursing), documents, "(Compression) wrap with towels between skin and wrap to prevent breakdown to buddy splint the legs together. Check (every) shift and PRN (as needed)." The Treatment Administration Record for September 2020 does not indicate that this order was processed to be included in the scheduled treatments for R1.</p> <p>A Braden Skin Assessment For Predicting Pressure Sore Risk tool, dated 9/10/20, identifies R1 as being high risk for skin breakdown.</p> <p>The Nursing Progress Notes do not document</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>any information regarding any ongoing assessments of R1's legs and use of compression wraps. The first documented assessment of R1's legs is on 9/14/20 at 12:02 pm, when V2 documents in the nursing notes, "Resident resting in bed with (compression) wraps to bilateral legs at the knees. Hospice nurse in facility and (compression wraps) removed. (Right) anterior knee area (#1) - (4.5) x 1.5 (centimeters). (#2) area 12 x 1.5 (centimeters). (#3) area 0.7 x 1 (centimeters). Outer aspect of right knee 3.7 x 2 (centimeters). (Left) heel 1.5 x 2.7. Left anterior knee 6.5 x 5 (centimeters). Left knee posterior 2.5 x 8.5 (centimeters) with open area surrounding bruised area. (Left) hip 4 x 4 centimeters. Posterior left knee skin is pushed back (no measurement of area). (V8) notified of skin issues and waiting orders." The documented measurements fail to identify the specific characteristics of the pressure injury, including Stage, shape, color or condition of wound bed and there are no further documented skin assessments through 9/18/20, the day R1 expired.</p> <p>On 9/17/20 at 11:30 am, R1 was sleeping in bed and being assessed by V11 (Hospice Registered Nurse). At that time, V11 removed the blanket covering R1's legs, which were not bound with a compression wrap, but open to air. R1's right anterior knee had a dark red and black circular area on the bony prominence, measuring 6.0 x 4.3 centimeters and a large open, weeping, red area the shape of a rectangle directly behind the left knee at the crease, measuring 14 x 7 cm. V11 stated she would consider these wounds to both be unstageable pressure injuries. V11 stated she first saw the wounds on 9/14/20, when she was doing her hospice rounds. On that day, V11 stated she observed R1's legs to be bound</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>together with a compression wrap, and once she removed it, she found "a diaper folded in between her knees," a large reddened area on the inner right knee over the bone where it would touch the left inner knee, and a large open area behind the left knee where the wrap had been. V11 stated that V2 measured all of the abnormal findings on R1's skin and indicated she would get treatment orders. V11 confirmed at that time that Hospice had not given any orders regarding the compression wraps used to splint R1's legs together.</p> <p>On 9/17/20 at 1:38 pm, V3 (Registered Nurse) stated she worked the day shift on 9/10/20, and was present when R1 was readmitted from the hospital. V3 stated V2 entered in all of R1's admission orders into the computer for her, while she got R1 settled in her room. When R1 arrived from the hospital, V3 observed R1's legs wrapped together with a compression wrap and a towel was between her knees. V3 stated the wrap "looked tight, but was not digging into her skin." V3 stated she did see an order in the Physician's Order Sheet to check the compression wrap every shift, but did not see it on the Treatment Administration Record. V3 stated she was not clear on what that order meant exactly and if the wraps were actually to be removed every shift or just checked for placement.</p> <p>On 9/21/20 at 3:50 pm, V6 (Licensed Practical Nurse) stated she worked the first shift on 9/11/20, 9/12/20 and 9/13/20 and cared for R1. V6 stated she was told in report the morning of 9/11/20 that R1's compression wraps were in place and Hospice staff were supposed to tell them what exactly to do with them, such as removing or cleansing the skin. V6 stated V10 (Hospice Nurse) came in on 9/11/20 and</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>assessed R1, but gave no orders regarding the compression wraps. V6 stated she just checked them for placement and never removed them on 9/12/20 and 9/13/20.</p> <p>On 9/17/20 at 2:10 pm, V4 (Licensed Practical Nurse) stated she worked the second shift on 9/11/20, 9/12/20 and 9/13/20 and cared for R1. V4 stated on either 9/11/20 or 9/12/20, she told V6 about R1's legs being wrapped and V6 did loosen the wraps, but didn't remove them completely. V4 stated she was under the impression V6 was going to get an order for the legs to be unwrapped and cleansed every shift, but that order was never put on the Treatment Administration Record. V4 stated when she came on shift 9/13/20, her CNA (Certified Nursing Assistant) called her into R1's room to assess the compression wrap on R1's legs, because they appeared wet. V4 stated when she removed the wrap there was a towel folded between her upper thighs and R1's inner knees had been touching, bone on bone, with the wrap holding them in place. V4 stated R1's inner knees had obvious areas of purple and redness where they had been touching and described the right inner knee to have a "baseball size open wound with sloughy skin on the bony prominence." V4 stated the area behind R1's left knee had an open area the exact spot of the wrap, with a visible line where the wrap had stopped. V4 stated this area was weeping and had an odor. V4 stated she immediately called V9 (Wound Nurse) and informed her of what R1's legs looked like. According to V4, V9 instructed her to "not chart anything" and V9 indicated she would look at the wounds the next morning (9/14/20). V4 asked about some foam padding to place between R1's knees when she rewrapped them or a treatment order, and V9 informed her the facility did not</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>have anything like that to protect her knees. V4 stated she decided to take a incontinence brief and cut it, folding it so the absorbent/padded part was on the outside of both sides, and placed it between R1's knees as padding, prior to re-splinting the the legs together with the compression bandage.</p> <p>On 9/17/20 at 1:25 pm, V2 (Director of Nursing) stated she had never observed a resident having her legs splinted in the manner R1's were splinted, when R1 returned from the hospital on 9/10/20. V2 stated she would expect staff to obtain orders from the Physician as to exactly how they are to manage that type of splinting/wrap. At 2:16 pm, V2 pointed out that there was an order from the admitting Physician (V8) on 9/10/20, that she entered into the computer system, advising staff to buddy splint R1's legs together with compression wraps and to check them every shift and as needed. V2 stated, regarding that order, "In my mind, I thought the staff would unwrap R1's legs every shift, but (staff) obviously didn't read the order that way." Additionally, V2 confirmed that specific order never made it to R1's Treatment Administration Record. On 9/21/20 at 2:30 pm, V2 stated she would expect staff to measure and document on wounds as soon as they are identified, to obtain a baseline, and call the Physician to get treatment orders.</p> <p>On 9/21/20 at 1:24 pm, V9 (Wound Nurse) confirmed that V4 did call her on 9/13/20 and reported that R1's compression wraps had been wet, so she removed them and found skin breakdown on R1's inner knees and behind the left knee. V9 stated she did not advise V4 as to what treatment could be provided for the wounds at that time, but notified V2 (Director of Nursing)</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>so she could measure the wounds the next day.</p> <p>On 9/21/20, V8 (Medical Director) stated she did give an order on 9/10/20 for staff to check R1's compression wraps every shift, and assumed that staff would be doing some type of skin assessment at that time. V8 indicated she saw R1 on 9/11/20, during a telehealth visit, but R1 was sleeping and V8 did not see how R1's legs were wrapped during that visit. V8 indicated she was under the impression Hospice staff would be addressing how R1's compression wraps were to be managed. V8 stated it was reported to her on 9/14/20 that R1 just had "blistered areas" on her knees and legs, not as a pressure injury, and staff wanted to treat the areas with Silvadene ointment, which she ordered. V8 indicated she was not given measurements or any additional description of the wounds.</p> <p>(B)</p>	S9999		
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