

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6008304</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALDEN TERRACE OF MCHENRY REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>803 ROYAL DRIVE MCHENRY, IL 60050</b>
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S 000	Initial Comments	S 000		
S9999	<p>Annual Licensure and Certification</p> <p>Complaint Investigation #2017690/IL127245</p> <p>Final Observations</p> <p>Statement of Licensure violations:</p> <p>300.1010h) 300.1210b) 300.1210d)3)5) 300.3240a)</p> <p>Section 300.1010 Medical Care Policies</p> <p>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 of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p>	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/30/20

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>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</p> <p>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>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>These requirements were NOT met evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician, wound care nurse, and director of nursing, upon identification of a new skin concern with redness. The facility also failed to obtain treatment orders, and failed to document a wound assessment for a resident at high risk for developing pressure injuries. These failures led to R37's reddened sacral area becoming an unstageable pressure injury for 1 of 5 residents (R37) reviewed for pressure injuries in the sample of 26. The findings include:</p> <p>R37's admission record shows she was admitted to the facility on 11/10/2018 with diagnoses including Alzheimer's disease, Parkinson's disease and need for assistance with personal care.</p> <p>R37's Braden Scale (risk for pressure injury development) dated 7/16/2020 shows she has a high risk for developing a pressure injury.</p> <p>On 09/28/20 at 10:19 AM V12 Hospice CNA (Certified Nursing Assistant) was performing incontinence care for R37. R37 had a foam dressing to her sacral area that measured approximately eight inches wide by four inches long. There was a small amount of brownish drainage in the middle of the dressing that was visible through the dressing. V12 said that R37 has a new pressure ulcer. The foam dressing was not intact at the bottom towards R37's rectum. Upon review of R37's electronic orders, there were no wound orders noted for R37's</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>sacral area.</p> <p>On 9/29/2020 at 10:39 AM, V13 RN (Registered Nurse)/Wound Care Nurse and V14 ADON (Assistant Director of Nursing)/previous wound care nurse came in to resident's room to change a dressing to R37's right heel. V13 or V14 did not turn or change R37's sacral wound dressing.</p> <p>On 9/29/20 at 11:07 AM, V15 CNA and V6 CNA went into R37's room to perform incontinence care. V15 and V6 turned R37 onto her side and the same foam dressing was noted to R37 sacral area. Brownish drainage was noted from the outside covering the entire foam dressing. This drainage amount increased from 9/28/2020. The bottom of the dressing was still not intact and completely opened towards R37's rectum.</p> <p>On 9/29/20 at 2:00 PM, V16 LPN (Licensed Practical Nurse) said R37 has a dry dressing order for her right great toe, a dressing on her right heel blister, and no other dressings that she know of. V16 said the wound care nurse rounds weekly with the wound doctor on Wednesdays. V16 said the floor nurses do the dressing changes on the other days. V16 said she was not aware of a dressing on R37's sacral area, but V15 reported it to her today (9/29/2020) prior to V13 and V14 entering R37's room to change her heel dressing (at 10:39 AM). V16 said she has not changed the dressing to R37's sacral area. V16 said she didn't see any notes in R37's electronic medical record regarding this sacral dressing. V16 said that if a cna notices something on the residents skin, then the cna reports it to the nurse and the nurse goes in to assess the wound. Residents' skin is assessed on shower days or with increased pain. V16 stated that R37 receives a shower on Tuesday, Friday, and</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Sunday evenings.</p> <p>On 9/29/20 at 2:17 PM V17 Nurse consultant and V14 ADON (Assistant Director of Nursing)/previous wound care nurse went into R37's room. This surveyor entered R37's room and asked if they were aware of a dressing to R37's sacral area. V14 said he was not aware of a sacral dressing on R37. V16 entered R37's room to assist with positioning. V14 removed the dressing on R37's sacral area. The dressing was saturated with dark drainage. The wound was irregularly shaped with the top layer of skin absent and the wound bed was dark in color. V14 cleaned the wound with saline and stated the wound was an "unstageable pressure injury". V14 measured the wound and said it measured 3.3 cm (centimeters) x 5.5 cm with no depth. V14 said he did not know who put the dressing on R37's sacral area. V16 said the nurse will report if there was a new dressing placed on a resident during shift to shift report. At 2:34 PM V14 said when staff sees a new skin alteration they are to let him know, let V2 DON (director of nursing) know, and let wound care nurse know. The nurse that finds the skin alteration will enter a skin note into the electronic medical record and report it to nurse practitioner or the doctor and start treatment right away. The wound care nurse will follow up on the wound and a referral to the wound doctor will be sent if necessary.</p> <p>R37's shower documentation in the electronic medical record shows R37 received a shower on 9/28, 9/24, 9/20, 9/17 with no new skin abnormalities marked. On 9/27 Not Applicable was marked for skin abnormality.</p> <p>On 9/30/20 at 9:29 AM V17 said they interviewed all staff in regards to R37 sacral wound. During</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>the facility's investigation, it was found that V20 RN (Registered nurse) placed the dressing on R37's sacral area on Sunday, 9/27/2020 (two days prior). V15 CNA reported redness to V20 and V20 placed a foam dressing on R37. V20 stated R37 had redness on her sacral area but there were no open areas. V17 said V20 did not document the wound anywhere, did not call the doctor, and did not call R37's family. During this same interview, V2 DON said V20 should have put in wound orders, notified the doctor, and it should be passed onto next shift nurse. The same dressing has been on R37's sacral area from Sunday-Tuesday.</p> <p>On 9/30/2020 at 10:47 AM, V14 ADON/previous wound care nurse said the purpose of dressings on pressure injuries are for protection. The dressings should be changed in order to keep the wound dry because it is a good medium for bacterial growth, help prevent infection, and protect the wound.</p> <p>V18's Wound Care Doctor note dated 9/30/2020 shows R37 has an unspecified stage pressure injury to her sacral area and it measures 3.5 cm X 8 cm with no depth.</p> <p>R37's Medication Admission Record shows her skin was checked on 9/27/2020 and 9/28/2020.</p> <p>V20's counseling and disciplinary action form dated 9/29/2020 shows, "On Sunday 9/27/2020, I was made aware of the fact that (R37) had some skin changes on her buttocks. I went to look at her and the sacrum was only slightly reddened in two small spots. This was new."</p> <p>R37's Care Plan initiated on 11/10/2018 shows, "(R37) has an actual altered skin integrity related</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>to history or pressure injury to the sacrum...inspect skin daily with care."</p> <p>The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations dated 4/2020 shows, " Identify the presence of pressure injuries and/or other skin alteration, implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. Complete a comprehensive pressure injury evaluation for identified pressure injuries. At least daily, staff should remain alert for potential changes in the skin condition during resident care."</p> <p>The facility's Change of Condition policy dated 6/19 shows,"The attending physician or physician on call/nurse practitioner and responsible party will be notified with changes in a resident's condition."</p> <p>The facility's Weekly Assessment of Skin Alteration Form policy dated 4/2020 shows, "The weekly Assessment of Skin Alteration (WASA) Form should be used for the following wound types: pressure. Based on the findings of the completed WASA form determined appropriate interventions/changes and implement as needed, notify as appropriate, interdisciplinary team member, doctor/nurse practitioner, the resident and/or family members."</p> <p style="text-align: center;">B</p>	S9999		