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
	IL6000244	A. BUILDING: _____ B. WING _____	C 12/12/2019

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LOFT REHAB & NURSING OF NORMAL	510 BROADWAY NORMAL, IL 61761

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S 000	Initial Comments Complaint # 1969046 / IL 118228	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)5) 300.3240 a) 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 of care for the care or treatment of such	S9999	**Attachment A** **Statement of Licensure Violations**	

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accident, injury or change in condition at the time of notification.

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.
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

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 are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to prevent the development and worsening of pressure ulcers,

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monitor pressure ulcers, perform physician ordered weekly skin assessments, and obtain and follow treatment orders for residents. This failure affects two of three residents (R5 and R9) reviewed for pressure areas on the sample list of nine. This failure resulted in R5 developing and worsening unstageable pressure areas, and R5 being hospitalized with Sepsis related to pressure ulcers.

Findings include:

1. R5's medical record documents: diagnosis: Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side and Type 2 Diabetes Mellitus.

R5's Minimum Data Set (assessment), dated 9/25/19, documents R5 requires extensive assistance of staff with bed mobility, dressing and toilet use, and total dependence of staff with transfers and locomotion. This same MDS documents R5 is always incontinent of bowel and bladder and "Yes" is checked under - is this resident at risk of developing pressure ulcers/injuries.

R5's care plan, with a revision date of 7/2/19, documents: " Focus: (R5) has potential for pressure ulcer development related to immobility. Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown."

R5's Wound Evaluation and Management Summary, dated 11/20/2019, documents, "Exam: Groin/Buttock coccyx wound resolved with 0.5 cm x 0.5 cm of recent epithelialization visible midline distal sacrum more consistent with recent MASD (moisture associated skin damage) fissure that has healed. Other Diagnosis: Moisture

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Associated Dermatitis. Additional information: No ulcerations present today. There is a 0.5 cm x 0.5 cm area of indentation with thin epithelialization indicating recent healing likely several days ago based on appearance. Treatment: house barrier cream q (every)shift and prn (as needed) after incontinence to buttocks."

R5's Skin Observation Tool form documents, "site: Coccyx, type: pressure, length: 2 cm, width: 2cm, depth: 0.2 cm, stage: two."

R5's Treatment Administration Records (TAR's) documents: "start date: 11/19/19, wound to coccyx: cleanse and apply barrier cream, monitor for s/s (signs and symptoms) of infection/worsening every shift for wound care at 6:15 AM, 2:15 PM and 10:15 PM."

R5's medical record documents, "12/1/2019 at 11:24 PM, Noted with skin care at HS (hours of sleep) res (resident) has a 2 cm (centimeter) open area on coccyx with several tiny open areas surround the coccyx. area was draining a serous pink. Cleansed with wound cleaner and abt (antibiotic) umg (ointment) applied with (guaze pad) and covered with a (waterproof) drsg. (physician) faxed for TX (treatment) orders."

R5's TAR's, dated December 2019, fails to document new physician ordered treatments from 12/1/19 to 12/4/19 after the development of R5's stage 2 pressure area to the coccyx.

R5's progress notes document on "12/2/2019 at 5:19 PM, "New order received to refer to wound clinic and turn and reposition every two hour."

R5's Wound Evaluation and Management Summary, dated 12/4/2019 at 7:00 AM,

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documents, "Focused Wound Exam (Site 1), Unstageable (due to Necrosis) Sacrum (coccyx area). Etiology (quality) Pressure. MDS 3.0 Stage Unstageable Necrosis. Duration > (greater than) 1 days. Wound Size (Length x Width x Depth): 4 x 3 x Not Measurable cm. Exudate: Moderate Serous. Thick adherent devitalized necrotic tissue: 75 %. Additional wound detail: patient with febrile illness now, thought to be UTI (urinary tract infection). Focused Wound Exam (Site 2). Unstageable DTI (Deep Tissue Injury) of the Left Buttocks. Etiology (quality) Pressure. MDS 3.0 Stage Unstageable DTI with intact skin. Duration > 1 days. Wound Size (L x W x D): 1.5 x 2.5 x Not Measurable cm. Focused Wound Exam (Site 3), Unstageable DTI of the Right Buttock. Etiology (quality) Pressure. MDS 3.0 Stage Unstageable DTI with intact skin. Duration > 1 days. Wound Size (L x W x D): 1 x 0.7 x Not Measurable cm."

R5's progress notes document: "12/4/2019 at 8:54 AM, "Resident noted to be hot to touch at time of wound MD (physician) rounds. Resident moaning and crying out at being turned. Spoke with cart nurse, call was placed to (physicians office) for orders due to hyperglycemia, reading of HI on glucometer meaning over 500. Call received back from (physician) received orders to call 911 and send to ER (emergency room) for evaluation and treatment, no coverage for hyperglycemia to be given prior to sending out. Resident left facility at 8:57 AM."

R5's Hospital History and Physical, by V28 (Hospital Physician), dated 12/4/19, documents, "History of present illness: Patient began having altered mental status about three days ago. This included a fever of about 102 as well as sleeping a lot throughout the day. Associated symptoms

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include a "fist sized" bed sore described as an ulcer on the sacrum. Assessment/Plan: Sepsis, possibly secondary to UTI (Urinary Tract Infection) or ulcer wound on sacrum."

R5's Hospital History and Physical documents: test 12/4/19 at 11:16 AM, urine color: yellow, urine appearance: cloudy, urine bacteria: mod (none seen).

R5's medical record documents, 12/4/2019 1:42 PM, "Received urine culture results (no significant growth identified)."

R5's Hospital Nursing Assessment, completed by V29 (Hospital Registered Nurse), documents on 12/4/19, "Pressure ulcer present, midline coccyx, Type: pressure, length: 5.7 cm, width: 2.8 cm, depth: 0.3 cm, Pressure Ulcer Classification: full thickness, Pressure ulcer stage: unable to stage, (pressure injury to the coccyx is covered with moist necrotic tissue that is tan with some darker brown soft eschar, wound is acutely tender). Right medial buttock, Type; pressure, Length: 1.4 cm, Width: 0.8 cm, Pressure Ulcer Classification: full thickness, Pressure ulcer stage: deep tissue injury, (area of dark purple discoloration to the right medical buttock which is non blanchable, site is acutely tender). Left medial buttock, Type: pressure, Length: 1.3 cm, Width: 2.2 cm, Pressure Ulcer Classification: full thickness, Pressure ulcer stage: deep tissue injury, (area of dark purple discoloration which is non blanchable to the left medial buttock, site is acutely tender to patient)."

R5's hospital discharge summary, dated 12/10/19, documents, "discharge position: skilled nursing facility. Patient presented with sepsis due to UTI (Urinary Tract Infection) and Pressure

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Ulcer coccyx infection, grew polymicrobial.
Hospital Course: (R5) presented to ED (emergency department) with altered mental status the past three days. Patient was not conscious on initial presentation. Patient's daughter stated the patients condition had been getting worse throughout past three days. Patient also had an ulcer on her coccyx that the daughter described as roughly the size of a "fist". Patient was treated for possible sepsis", dictated by V16, Physician.

R5's Specimen Report documents: "Source: coccyx, ordered: wound abscess, queries: other specimen description wound sacral. Collected: 12/4/19. Wound Culture Final Result: Organism #1: Enterococcus Faecalis, Organism #2: Morg. Morganii ssp morganii, Organism #3: Proteus mirabilis."

On 12/11/19 at 1:46 PM, R5 had a 1.7 cm x 0.6 cm area to right buttock, area was not open but had a dark red/black center, a 0.2 cm x 0.3 cm open area to the left buttock with a pink center, and open area to coccyx/ sacrum measuring 4.3 cm x 2.4 cm with yellow slough to the entire wound bed with another area directly below measuring 1.7 cm x 0.6 cm.

On 12/11/19 at 2:48 PM, V23 (Registered Nurse, Previous Wound Nurse) stated, "R5 has a history of pressure ulcers."

On 12/11/19 at 2:55 PM, V2 (DON) stated, "Staff use their nursing judgement when a wound is identified and apply a treatment, notify the doctor and the wound nurse. Barrier cream is our standing order as a preventative, if the open area is a stage two or higher then barrier cream would not be appropriate and the staff should get an

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order for a different treatment and notify (Wound Doctor)."

On 12/11/19 at 3:02 PM, V2 (DON) stated, "R5's treatment orders did not change after R5's developed a stage 2 pressure ulcer on 12/1/19. Staff continued to apply the barrier cream to R5's open pressure area. R5's physician was not notified that R5's open area had worsened after 12/1/19 and R5 had developed two additional areas. R5 was not seen by the wound doctor until 12/4/19, and was later sent to the hospital 12/4/19."

On 12/11/19 at 3:05 PM, V2 (DON) stated, "Staff should have followed up with R5's physician for a new treatment order for the open area identified on 12/1/19. If the nursing staff noticed a change or worsening of the wound or if the current treatment was not effective the physician should have been notified until R5 could have been seen by the Wound doctor."

2. R9's Face Sheet document R9 was admitted to the facility on 10/31/19.

R9's Admission Progress Note, dated 10/31/19, by V23, RN (Registered Nurse)/Previous Wound Nurse, documents R9 was admitted to the facility with Osteomyelitis to the left foot. Wound Vacuum applied to the left foot and a dry dressing to the right foot.

R9's Minimum Data Set (MDS), dated 12/1/19, documents Brief Interview for Mental Status (BIMS) score of 14, which indicates R9 as cognitively intact. This same MDS documents R9 as requiring extensive assistance of two staff for bed mobility. This same MDS documents that R9 is at risk of developing pressure ulcers.

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R9's Physician Order Sheet (POS), dated 10/1/19-12/31/19, documents diagnoses of: osteomyelitis of the left ankle and foot. This POS documents the following physician orders: skin observation tool to be completed weekly, pressure ulcer risk assessment to be completed weekly for four weeks, then monthly unless condition changes such that warrants assessment more often. Apply an absorbent occlusive dressing to the right and left inner buttocks. Change every 3 days, Wound vacuum to the left foot wound with pressure settings: 125 mm/ Hg (millimeters of Mercury) continuous suction. Change the vacuum dressing three times a week and as needed. Monitor the wound vacuum every shift to ensure proper functioning.

Pressure Ulcer Risk Assessments, dated 10/31/19, 11/7/19, and 11/14/19, document R9 is at moderate risk for skin breakdown. There is no Pressure Ulcer Risk Assessment for 11/21/19.

R9's Skin Observation Tool, dated 11/20/19, documents new pressure ulcers to R9's "right and left inner buttocks." There was no description or staging of any pressure ulcers. There were no other Skin Observation Tools completed in R9's medical record.

Wound Assessment Details signed by V27, Wound Physician, document the following: 11/27/19 - R9's right and left foot wounds "increased in size", "nursing home has not changed vac {vacuum} in six days." 12/5/19 - "Stage IV Pressure ulcer of the left heel."

On 12/11/19 at 9:35 AM, V11, RN, entered R9's room to complete R9's ordered treatments. V11 removed the dressings to R9's coccyx and left

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buttocks pressure ulcers. Per V11, R9's coccyx wound measures 3.8 cm (centimeters) long by 2.1 cm wide. This wound was covered in soft white tissue with uneven wound edges, slight noticeable depth and moderate amount of yellow drainage. R9's skin surrounding coccyx pressure wound and left buttock pressure wound was dark red. The pressure ulcer to R9's left buttocks was also covered in white slough. V11 stated R9 had obtained both the left buttock pressure wound and the coccyx pressure wound at facility. At the time, left foot wound had a Wound Vacuum dressing covering the wound, and the machine was set at 120 mm Hg. The Wound Vacuum machine had three settings to choose from: 70 mm/Hg, 120mm/Hg, and 150 mm/Hg.

On 12/11/19 at 9:45 AM, V11 stated R9's coccyx wound had declined and now appears larger and has white tissue covering the wound that it did not have before. V11 stated R9 has had the same wound vacuum machine and set on 120 mm/Hg since admission.

On 12/11/19 at 12:30 PM, V2 stated when a resident is identified to have a new or worsening pressure ulcer, staff should assess the wound, measure the wound, notify the resident's physician and Power of Attorney should be notified and orders obtained. V2 also stated the nurse should obtain a consult for a wound physician. V2 stated nurse should complete the skin observation tool and pressure ulcer risk assessment upon admission, with any new wound or worsening of any wound. V2 stated skin audits and skin observation tool should be completed weekly. V2 stated nurses should carry out and follow physician orders. V2 stated nursing staff should have notified V27 of the wound vacuum settings not being accurate.

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The Facility Policy titled "Prevention of Pressure Ulcers/Injuries", revised July 2019, documents the following: "Purpose: The purpose of this procedure is to provide information regarding indentification of pressure ulcer/injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment 1. Assess the resident on admission for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 4. Inspect the skin on a daily basis when preforming or assisting with personal care or activities of daily living. a. identify any signs of developing pressure injuries
b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser d. moisturize dry skin daily e. reposition resident as indicated on the care plan. Mobility/Repositioning 2. At least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more. Monitoring 1. Evaluate, report and document potential changes in the skin 2.Review the interventions and strategies for effectiveness on an ongoing basis."

The Facility Policy titled "Pressure Ulcer/Injury Risk Assessment", revised July 2018, documents the following: "General Guidelines
6. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. Steps in the Procedure 3. Conduct a comprehensive skin assessment with

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every risk assessment. c. If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin. 4.

Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. a.The interventions must be based on current, recognized standards of care. b. The effects of the interventions must be evaluated. c. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Documentation The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment conducted. 2.The date and time and type of skin care provided, if appropriate. 3. The name and title (or initials) of the individual who conducted the assessment. 4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e. the size and location of any red or tender areas), if identified. 10. the signature and title (or initials) of the person recording the date. 11. initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted. 12. documentation in the medical record addressing MD notification if new skin alteration noted with change of plan of care, if indicated."

The Facility Policy titled "Wound Care", revised October 2010, documents the following: "Documentation The following should be recorded in the resident's medical record: 1. The type of wound care given. 2.The date and time the wound care was given. 3. The position in which the resident was placed. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound."

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