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
	IL6009740	A. BUILDING: ______ B. WING ______	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON SENIOR LIVING	1201 NEWCASTLE WASHINGTON, IL 61571

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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

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Based on observation, interview and record review, the facility failed to recognize, treat and perform ongoing monitoring and assessment of a pressure ulcer and failed to change gloves and perform hand hygiene during pressure ulcer care for two of four residents (R53 and R330) reviewed for pressure ulcers in the sample of 35. These failures resulted in the development of R53's pressure ulcer on 9/4/19 which did not have immediate interventions and treatments implemented resulting in the deterioration of R53's pressure ulcer to an unstageable pressure ulcer on 10/30/19.

Findings include:

1. R53's Skin and wound evaluation dated 9/4/19 documents the following: "Type: pressure, Stage: Stage 2: Partial-thickness skin loss with exposed dermis, Location Sacrum, In-House Acquired, Exact date: 9/5/19, Wound Measurements, Area 0.4cm (centimeters), Length 0.9 cm, Width 0.5 cm, Not Applicable for Depth, undermining and tunneling. No evidence of infection. Other, pink or red. No exudate drainage or odor. Surrounding Tissue: Erythema, Treatment: none."

The facility's Wound Care Guidelines document the following: Supportive Interventions: "To utilize the supportive interventions, determine the etiology of the wound on the left and consider the supportive interventions listed. Evaluate need for Turning and Repositioning devices, nutritional supplement."

On 11/7/19 at 2:20 p.m. V2 (Director of Nursing) stated when this wound was documented on 9/4/19 the Wound Care Guidelines should have been followed. V2 stated the Wound Care Guidelines are standing orders that the nurses

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can use to treat wounds. V2 was unable to find documentation that the facility's wound care guidelines were implemented on 9/4/19. V2 verified there was not a treatment implemented on 9/4/19 until 9/23/19 when preventative cream was ordered. V2 stated the preventative cream order was ordered as needed and did not document it was to treat R53's buttock wound.

R53's progress notes dated 9/4/2019 at 9:32 p.m. documents the following: "CNA (Certified Nursing Assistant, unidentified) reports pressure sore on resident's sacrum." R53's medical record did not contain documentation addressing R53's Sacral/Coccyx wound between 9/5/19 and 9/20/19.

On 9/21/2019 at 12:44 p.m. R53's Progress Nursing Note documents the following: "(R53) He is complaining of back, buttocks and foot pain."

R53's progress nursing note dated 9/23/2019 at 9:06 p.m. documents the following: "Resident (R53) is starting to develop redness on his bottom." R53's medical record does not contain a progress nursing note describing R53's sacrum/coccyx or buttocks wound.

R53's progress nursing note dated 10/24/2019 at 8:46 p.m. documents the following: "On pain management. Dressing changed to Pressure wound at his coccyx area, Prescribed cream applied."

R53's progress nursing note dated 10/25/2019 at 9:05 p.m. documented the following: "(R53) He had loose stool this morning. Placed him on bed and he had 1 episode of watery diarrhea foul smell. Ordered to place on Contact Isolation Precaution as ordered. Wound cleansed and

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covered with skin prep, and kept open. Resident is complaining of pain while cleaning his wound."

On 10/26/2019 at 12:08 p.m. R53's progress Nursing Note documents the following: "(R53) Resident laid down in bed after meals d/t (due to) wound on coccyx area. Area open et scant amount of blood coming from wound."

R53's Skin and Wound evaluation dated 10/28/19 documents the following: "Type: Moisture Associated Skin Damage (MASD), In-House acquired." The section of this form titled "How long has the wound been present," "exact date" is blank. This same form documents the following: "wound measurements, area-3.5 cm (centimeters), length-3.9 cm, width 1.2cm. (depth, undermining and tunneling documents not applicable). Wound bed Epithelial, 10% of wound covered, Granulation 70% of wound filled, Slough 20% of wound filled. Exudate Light, Serosanguinous and no odor. Surrounding tissue: Erythema and Fragile." The sections titled wound pain and goal of care are blank. This same form documents the progress of this wound is deteriorating.

R53's Skin/Wound Note dated 10/29/2019 at 9:51 p.m. documents the following: "Stage 2 pressure sore to coccyx, skin remained open, redness noted around the wound."

R53's Specialty Physician Wound Evaluation and Management Summary dated 10/30/19 documents the following: "Patient (R53) presents with a wound on his sacrum. He has an unstageable (due to necrosis) sacrum. There is moderate serous exudate. Wound size (L x W x D): 5.2 x 1.8 x not measurable, moderate serous exudate, 100% thick adherent devitalized necrotic

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tissue."

R53's progress Infection Note dated 10/31/2019 at 10:15 p.m. documents the following: "Started on Doxy (Doxycycline, Antibiotic) 100 mg (milligrams) BID (twice daily) for 7 days for his wound to coccyx area."

R53's progress Infection Note dated 11/2/2019 at 8:55 p.m. documents the following: "On oral antibiotic for pressure sore stage 2 with pain 5/10 and manage with Norco."

R53's progress Nursing Note dated 11/6/2019 at 2:32 p.m. documents the following: "Wound rounds done with wound doctor on unstageable sacrum wound. The wound bed is 100% slough filled. Measuring 5.2 x 1.8. Mechanical wound debridement done to remove necrotic tissue and and establish new viable tissue."

R53's Specialty Physician Wound Evaluation and Management Summary dated 11/6/19 documents the following: "Dressing was absent this afternoon."

R53's current care plan did not document R53 was at risk for a pressure ulcer nor that R53 currently had sacrum/coccyx skin alterations.

On 11/6/19 at 1:36 p.m. V14 and V15 (Certified Nursing Assistants/CNAs) used a mechanical lift to transfer R53 from the chair to the bed. V14 and V15 then removed R53's adult brief and cleaned stool wiping from the front towards the pressure ulcer. When V14 and V15 removed R53's adult brief, R53's pressure ulcer did not have a dressing.

On 11/07/19 at 08:06 AM V5 (LPN/Nurse

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Manager) stated the following: "I follow pressure, venous and arterial wounds. From 9/4 to 10/1 I would not have rounded on R53 unless he had a pressure ulcer." V5 stated she was unable to find a wound/tracking log for R53. V5 stated "I am not sure what other interventions are in place for (R53)'s pressure ulcer other than a pad is in (R53)'s wheelchair." V5 was unable to clarify when or how R53's coccyx/sacral wound started or how it progressed. V5 was unable to identify a staff member that could speak to the development and progression of R53's sacrum/coccyx wound.

2. The facility's Standard Precautions policy (12/2006) documents the following: "Standard Precautions will be used in the care of all residents regardless of their diagnoses of presumed infection status. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. Wear gloves (clean, non-sterile) when touching blood, body fluids, secretions, excretions and contaminated items. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments."

R330's current electronic Physician's Orders document an order for Phytoplex Z-guard paste, apply to buttocks topically every shift for pressure sore to buttocks.

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S9999	Continued From page 7 R330's Nursing Progress Note (11/3/19) documents the following: "(Bilateral) buttocks with pressure sore approximately 1-2 centimeter (cm) diameter, started red to purplish color on admission, currently progressed to Stage II as resident recently sits and sleeps in the recliner, did not want to lay down to bed." On 11/6/19 at 1:45 PM, V13 (Registered Nurse) performed R330's pressure ulcer care. V13 pulled down R330's adult brief exposing R330's buttocks. R330's bilateral buttocks contained purplish scattered discoloration. R330's right buttock contained a small pinpoint, non-blanchable area that contained a red center and scant amount of serosanguinous drainage. V13 cleansed R330's bilateral buttocks and pressure ulcer with a cleansing wipe. V13 then used the same gloves to apply R330's Z-guard paste to R330's bilateral buttocks and pressure ulcer with V13's gloved hand. V13 did not remove V13's contaminated gloves, perform hand hygiene and put on clean gloves after cleansing R330's buttocks and pressure ulcer and prior to applying R330's z-guard paste. On 11/6/19 at 1:50 PM, V13 verified that V13 cleansed R330's buttocks and pressure ulcer and then used the same gloves to apply R330's Z-guard paste to R330's buttocks and pressure ulcer. V13 verified that V13's gloves would be considered contaminated after cleansing R330's buttocks and pressure ulcer and stated that V13 should have removed V13's contaminated gloves, performed hand hygiene and put on clean gloves after cleansing the pressure ulcer and prior to applying the Z-guard paste. (B)	S9999		

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