

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003073</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/14/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PARK PLACE OF BELVIDERE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 5TH AVENUE BELVIDERE, IL 61008</b>
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S 000	Initial Comments  Complaint Investigation Survey #1913462/ IL112146	S 000		
S9999	Final Observations  Licensure Violations  300.610a) 300.1210a) 300.1210b)3 300.1210d)2)3)4) A)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  a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	<p><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  06/02/19
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S9999	<p>Continued From page 1</p> <p>resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections.</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>2) All treatments and procedures shall be administered as ordered by the physician.</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</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:</p> <p>A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.</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.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to identify three pressure ulcers on a resident's buttocks and sacrum and left heel prior to being classified as Stage 3 and Unstageable. The facility also failed to put interventions in place to prevent worsening of the</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>wounds and to assist with healing. These failures resulted in R1 developing an unstageable discoloration to her Left heel on 5/1/19, an unstageable open wound on her right buttocks on 5/4/19, and a stage 3 pressure ulcer on her sacrum on 5/6/19. The facility also failed to ensure a resident's heel lift boots were applied correctly to prevent his heels from resting on the bed. Facility also failed to ensure that a resident with a history of urinary tract infections and current skin breakdown received pericare after fecal incontinence in a manner to prevent infection.</p> <p>This applies to 2 of 3 residents (R1, R2) reviewed for pressure ulcers in the sample of 3 and 1 of 3 residents (R1) reviewed for pericare in a sample of 3.</p> <p>The findings include: 1. R1's May 2019 Physician's Order Sheet shows that R1 has diagnoses including Bipolar Disorder, Anxiety Disorder and Vascular Dementia with Behavioral Disturbance.</p> <p>R1's Minimum Data Set (MDS) of 4/6/19 shows that R1 scored a 3 on her BIMS (Basic Interview for Mental Status) showing severe cognitive impairment. This same document shows that R1 is always incontinent of bowel and bladder and requires extensive assist of 2 staff for bed mobility and transfers.</p> <p>R1's Skin Observation Form dated 5/1/19 shows an area to left heel 4.7 x 6.4cm described as discoloration.</p> <p>R1's Skin Observation Form dated 5/4/19 shows an open area to right buttocks measuring 1.5 x 1.0 x 0.1cm. (There is no further description of</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>the wound).</p> <p>The Specialty Physician Wound Evaluation and Management Summary dated 5/6/19 shows that R1 received an initial evaluation of 3 wounds: Site 1: Unstageable Deep Tissue Injury of the Right Buttocks measuring 1.8 x 0.9 x 0.1cm. It is described as 40% Thick adherent devitalized necrotic tissue, 20% slough and 40% skin. Treatment for this wound included surgical excisional debridement. Recommendations include Off-load wound and reposition per facility protocol. Site 2: Stage 3 Pressure Wound Sacrum measuring 0.8 x 0.4 x 0.1cm. It is described as 100% granulation tissue. Recommendations include Off-load wound and reposition per facility policy. (This wound was not previously identified by facility staff) Site 3: Unstageable Deep Tissue Injury of the left heel measuring 4.3 x 6.5 x Not Measurable cm. It is described as Unstageable deep tissue injury with intact skin. Recommendations include Off-load wound, reposition per facility protocol and sponge boot.</p> <p>The Specialty Physician Wound Evaluation and Management Summary dated 5/13/19 shows that R1's right buttocks wound, and sacrum wound have had no change.</p> <p>Throughout the survey on 5/14/19, R1 did not have any type of pressure reducing mattress on her bed nor was there a pressure reducing cushion in her wheelchair.</p> <p>On 5/14/19 at 10:15AM, V7 (CNA Supervisor) assisted R1 after R1 was incontinent of bowel and bladder. V7 completed the care without any other staff assisting her. When trying to turn R1</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>onto her right side to perform pericare, R1 pushed her hand against the wall not allowing V7 to turn her off of her right buttocks. V7 stated, "She is pushing back, I can't turn her." As R1 was turned partially on her right side it was observed that there was no dressing covering R1's sacral wound. While holding R1 partially over on her side with one hand, V7 used the end of a dry towel to wipe the fecal matter from R1 anal area and buttocks. V7 then folded the towel over 3 more times and wiped the area again. V7 then wet the end of another towel and used the wet towel to wipe R1's peri area one more time. No soap or skin cleanser was used to clean R1's skin. R1's right buttocks wound was not able to be visualized at this time. V7 stated she was not aware that R1 had wounds on her buttocks. R1 was also observed to have multiple quarter-sized, deep red areas of petechiae (pinpoint round spots) on her left buttocks. V7 stated she was not sure what that was caused by and proceeded to position R1 onto her right buttocks by placing a wedge cushion under her left hip.</p> <p>R1's Urine Culture dated 3/19/19 shows that R1 was diagnosed with a Urinary Tract Infection caused by Escherichia Coli- ESBL (Extended-spectrum beta-lactamase) (A bacteria commonly found in the gastrointestinal tract). R1 required treatment with antibiotics for 10 days following this diagnosis.</p> <p>The undated facility policy entitled Perineal Care states, "Apply soap to a clean washcloth or use incontinence wipe/wash. Use a damp cloth if perineum wash is used. Cleanse buttocks and anus washing/wiping from front to back- this decreases potential for infections with female residents. If cloth/wipe becomes soiled with feces, continue with clean washcloth or clean</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>wipe.</p> <p>On 5/14/19 at 10:50AM, V3 (RN) completed the dressing changes on R1's wounds. R1's left outer heel showed a golf-ball sized open area with a moderate amount of serosanguineous drainage. The wound bed appeared beefy red and there was a large fluid fill blister just above the open wound bed. R1's right buttocks showed a deep, dime-sized area with a brownish red center and a small amount of serosanguineous drainage. R1's sacrum showed a pencil eraser sized area with a dry, dark gray wound bed. There was no dressing covering the wound. V3 was asked about the areas of petechiae on R1's left buttocks. V3 did not seem concerned and stated it looked like the scratches on R1's shins. All dressings were completed as ordered then R1 was positioned back onto her right buttocks as V6(CNA) placed the wedge cushion under R1's left hip.</p> <p>At 12:25PM R1 was still positioned on her right side with her head elevated while she was being fed her lunch in bed.</p> <p>At 1:47PM R1 remained positioned on her right side with the wedge pillow under her left hip.</p> <p>On 5/14/19 at 1:00 PM, V2(Director of Nursing) was asked why R1's pressure ulcers were not found prior to becoming unstageable. V2 stated, "I can't answer that for (R1). She gets care every shift, she is incontinent." V2 was asked how often skin checks are done on residents. V2 stated, "In general it is based on risk. The CNAs document on skin every shift. If they see something there is a place that they can document, it in (EMR-Electronic Medical Record) or on the shower sheet. If they see something they should report it to the nurse."</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>The Task Section of the EMR (where the CNAs document) shows a heading of "skin condition". When activated this section shows that barrier cream is to be applied to resident's buttocks following each incontinent episode. The month of May 2019 shows multiple checkmarks daily under the "yes" column. There is no further documentation of R1's skin condition under this area and no documentation related to open areas on R1's buttocks, sacrum or left heel.</p> <p>R1's Shower Sheet dated 5/1/19 shows R1 has redness on her left heel and scratches on shins, the Shower Sheet dated 5/5/19 shows no skin issues, the Shower Sheet dated 5/8/19 shows no skin issues and old wound (there is no documentation of where the old wound is located), and the Shower Sheet dated 5/12/19 shows no issues and scratches on shins.</p> <p>R1's Braden Scale for Predicting Pressure Score Risk dated 1/5/19 shows that R1 scored a 17, At Risk.</p> <p>On 5/14/19 at 1:20PM V5 (Assistant Director of Nursing) stated, "The Braden scale should be done quarterly. It should have been done in March. I must have missed it." V5 also stated, "The air mattresses are better if they have pressure." V5 not sure why R1 did not have an air mattress on her bed.</p> <p>R1's current care plan does not address her pressure ulcers.</p> <p>The facility policy entitled Pressure Ulcer Prevention date 7/25/16 states the following: - All individuals, regardless of mobility must be assessed for pressure ulcer development on</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>admission, weekly for the first four weeks after admission, then quarterly using a valid pressure ulcer risk assessment.</p> <ul style="list-style-type: none"> <li>- An integral part of any skin care program is a systematic skin assessment. It is through these inspections that early skin problems can be detected and intervention started. Assessment must continue according to an appropriate schedule. Staff should evaluate skin condition and should pay attention to bony prominences.</li> <li>- All residents who are in bed and have been assessed to be at risk for skin breakdown should be repositioned at least every two hours...</li> <li>- All residents assessed to be at risk for breakdown should be placed on a pressure reducing overlay.</li> </ul> <p>2. R2's May 2019 Physician's Order Sheet shows that R2 has diagnoses including Obesity, Mild Intellectual Disabilities, Diabetes -Type 2 and Edema. This same document shows that R2 has an order for Pressure Relieving Protection Boots on at all times, every shift for heel protection and order to inspect both feet and heels every HS (Bedtime).</p> <p>The Minimum Data Set of 3/1/19 shows that R2 requires extensive assist of two staff for bed mobility and is totally dependent on two staff for transfers.</p> <p>R2's Braden Scale for Predicting Pressure Sore Risk dated 3/7/18 (provided by the facility when asked for the most current) shows that R2 scored an 18, At Risk.</p> <p>R2's current Care plan states, "At risk for impaired skin integrity related to impaired mobility, friction and shearing and moisture related to incontinence." This care plan does not</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>address R2's use of the Pressure Relieving Protection boots.</p> <p>On 5/14/19 at 12:30PM R2 stated, "I need new boots. These don't do anything. I have told many people but they don't do anything. They should hold me feet straight and they don't do that."</p> <p>R2 pulled the blanket up and showed surveyor his feet. The boots were on but the Velcro straps were not fastened to hold them in place. R2's heels were both resting on the bed. R2's right ankle was turned inward (towards his left foot) and his left ankle was turned outward.</p> <p>On 5/14/19 at 12:35PM, V8 (RN) stated, "(R2) has had foot drop for a long time. The boots are to protect his feet."</p> <p>On 5/14/19 at 12:45PM, V7 (CNA Supervisor) stated, "That is it how the boots are supposed to be on. His heels are resting on the bed. "</p> <p>The facility policy entitled Pressure Ulcer Prevention dated 7/25/16 states, "Residents who are constantly immobile should have pressure reducing devices used to totally relieve pressure on heels and raise heels completely off the bed."</p> <p>(B)</p>	S9999		