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
	IL6000103	A. BUILDING: ______ B. WING ______	C 05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ALMA NELSON MANOR	550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108

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S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)3)
300.1210d)5)
300.1210d)6)
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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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

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S9999	Continued From page 1	S9999		

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:

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.

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.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) 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)

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S9999	Continued From page 2 These Requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to identify a deep tissue injury and pressure ulcers prior to a stage 3 for residents assessed as mild to moderate risk for skin breakdown. The facility failed to ensure a resident's wound dressing was in place to prevent wound contamination to a stage 4 pressure ulcer. This failure contributed to R6 developing a stage 3 pressure ulcer to his coccyx and sacrum and a deep tissue injury to his right heel on April 23, 2015. This applies to 3 of 3 residents (R4, R5, R6) reviewed for pressure ulcers in the sample of 18. The findings include: 1. The Medication Administration Record dated May, 2015 shows R2's diagnoses to include schizophrenia, diabetes mellitus type II, difficulty walking and muscle weakness. The Braden Scale for predicting skin breakdown dated March 23, 2015, shows R6 is a mild risk for skin breakdown. On May 5, 2015 at 10:25 AM, E15 (Registered Nurse) changed R6's dressings to his coccyx/sacral area and right heel. R6's right heel is approximately the size of a quarter with irregular borders. It is a deep red, purple color, looking like a blood blister. The coccyx/sacral area is now one area. It is open and approximately dime size with irregular borders. The wound is a whitish gray color. The facility's wound assessment initiated April 23, 2015, shows that a Stage 3 pressure ulcer was found on R6's coccyx and sacral areas. The coccyx wound measured 1 x 1 x 0.2 centimeters (cm). The sacral wound measured 4.5 x 4 x 0.2	S9999		

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S9999	Continued From page 3 cm. The same assessment shows R6 also developed a deep tissue injury to the right heel measuring 4 x 3 cm found with 100% eschar (black tissue). On May 5, 2015 at 9:05 AM, E19 (Behavioral Health Director) stated, "R6 got the two pressure ulcers because he was in bed all the time." E19 also stated that R6 was on the behavioral health unit when he developed the pressure ulcers and deep tissue injury. E19 stated, that the unit's goal is to have independent residents. They have a minimum of one staff which does not have to be nursing staff. E19 confirmed that they do not use turn schedules with residents on that unit. 2. The Medication Administration Record dated April, 2015 shows that R5 has diagnoses including osteoarthritis, diabetes and cerebral artery occlusion with infarct. The Physician Wound Care Evaluation dated April 16, 2015 shows that R5 has a new Stage III pressure ulcer measuring 2 x 1.8 x 0.2 centimeters(cm) with 30% scattered slough (devitalized tissue) identified on April 16, 2015. On May 4, 2015 at 2:30 PM, E3 (RN) stated, "A CNA reported it and I looked at it that same morning. I really don't know her that well. Sometimes you find them (pressure ulcers) at a Stage III." On May 4, 2015 at 11:50 AM, R5 was laying in bed with a pillow slightly tucked under her left hip. At 12:00 PM, E20 (CNA) pulled back the dressing on R5's left sacrum and revealed a dime sized open area with a yellow tissue present and a red center. E20 stated, "We usually try to get her up for meals but we haven't had time to get her up yet today. We are going as fast as we can but there are only 2 of us down here." On May 5, 2015, R5 was positioned on her back in the bed with her head elevated. R5 stated, "I'd really like to get on my side."	S9999		

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S9999	Continued From page 4 The Medication Administration Record dated April, 2015 shows an order initiated on January 29,2013 for R5 to have a head to toe body assessment for skin alteration. R5's care plan dated May 10, 2013 states, "Inspect skin with cares daily." The facility policy entitled Prevention and Treatment of Skin Breakdown dated June, 2013 states, "The facility will properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers. The facility will implement preventative measures and provide appropriate treatment modalities for skin impairments according to industry standards of care." 3. The Minimum Data Set of April 2, 2015 shows that R4 is dependent on 2 or more staff for transfers and requires extensive assist of 1 staff member for personal hygiene. This same document shows that R4 is occasionally incontinent of bowel. On May 4, 2015 at 11:15 AM, E9-Licensed Practical Nurse (LPN) stated, "I have to call over to the sub-acute and find out where the wound is because I didn't see anything." The Nurse's Notes dated May 4, 2015 show that E9 assessed R4's buttocks around 6:45 AM and was unable to locate the wound. At 11:30 AM, E9 assisted R4 to turn onto her side to allow surveyor to observe R4's wound. R4 was incontinent of stool. R4's wound was not covered with a dressing and was caked (filled) with stool. E9 cleaned R4's periarea with disposable wipes to expose the wound. There was a dime sized " hole " on R4's coccyx between her buttocks. E9 cleansed R4's wound with normal saline, packed it with Mesalt (absorbent dressing), covered the wound with 4x4 gauze square and attempted to secure it with paper tape. The tape did not adhere to R4's skin but E9 continued to reposition R4	S9999		

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S9999	Continued From page 5 onto her right side. On May 4, 2015 at 11:45 AM, E10- Certified Nursing Assistant (CNA) stated that she had cleaned R4's periarea about 10:00 AM after an episode of bowel incontinence and there was no dressing in place at that time. The facility provided an admission wound assessment dated April 16, 2015 that shows R4 has a Stage 4 pressure ulcer on her coccyx. The next facility wound assessment is dated May 4, 2015 (18 days later) and shows that R4 has a Stage 4 pressure ulcer to her coccyx measuring 1.2 cm x 0.8 cm x 4.3 cm. The Physician's Order Sheet dated May , 2015 shows R4's treatment order as, "Clean coccyx with normal saline. Pat dry. Apply Mesalt to wound depth and undermining. Cover with ¼ abdominal pad. May use transparent film to secure dressing in place." R4's care plan initiated May 4, 2015 states, "Keep skin clean and dry, Weekly wound progress assessment by nurse and as ordered by doctor." The facility policy entitled Prevention and Treatment of Skin Breakdown dated June, 2013 states, "Carry out treatments as per physician's orders and complete weekly documentation regarding progress of skin impairments." (B)	S9999		