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
	IL6003834	A. BUILDING: ____ B. WING ____	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HEALTH CARE CENTER	1425 WEST ESTES AVENUE CHICAGO, IL 60626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations	S9999		

Statement of Licensure Violations

300.610a)
300.1010h)
300.1210 a)
300.1210b)
300.1210d)3
300.1210)d)5)
300.3240a)
300.1220b)3)

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 accident,

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/10/15

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injury or change in condition at the time of notification.

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 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)

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:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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S9999	Continued From page 2 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. 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) 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	S9999		

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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.

These requirements were not met as evidence by:

Based on observation, interview and record review, the facility failed to notify a physician after identifying a worsened pressure sore, provide adequate pain medication and relief prior to wound treatment and follow physician's orders when treating a pressure sore. These deficient practices resulted in a decline in condition of pressure ulcer for one resident (R6) of two residents reviewed for pressure sores in a sample of 24.
Findings include:
On 3/23/15, the facility provided a document dated 3/23/15 and titled, "Residents with Decubitus Ulcers." R6 was listed as a resident with left heel and right heel decubitus ulcers that were facility acquired. R6's "Other Skin Condition Weekly Status Report" dated 3/20/15 documents the following identification dates: 'mid back wound 12/26/14, right heel 2/12/15 and left heel 2/12/15".
On 3/24/15 at 9:35am, E3 (Assistant Director of

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S9999	Continued From page 4 Nursing-ADON) stated, "The mid back is a skin tear, left heel is unstageable and right heel is unstageable. Standardly, the night nurses do the treatments. But I'm the treatment nurse for day shift. I assess weekly and do rounds with the nurses." E3 indicated the wound care doctor does the measuring of the wounds every Friday. E3 performed R6's wound care to her mid back on 3/24/15 at 9:40am. R6's Resident Medication Administration Record (MAR) documents that she received Acetaminophen 325 mg (milligrams) two tablets by mouth on 3/24/15 at 9:15am. As E3 removed the dressing on R6's mid back, R6 complained of pain. R6 grimaced and stated, "Oh my god that hurts." E3 did not acknowledge R6's verbal expression of pain. E3 continued to cleanse the mid back wound with normal saline. R6 continued to complain of pain, bringing her right hand up to her face. E3 confirmed that R6's mid back wound is classified as a skin tear. E3 stated, "We identified her mid back as a pressure area but classified due to root cause which was a skin tear." There was visible tunneling noted in the wound. E3 stated, "That tunneling is new." E3 indicated that the wound did not look like that on the previous Friday. E3 confirmed that R6's wound care is performed daily. E3 stated, "The night nurse did not tell me about any change in condition. But, that is a change." As E3 applied the Santyl and Bactroban to R6's mid back wound, R6 verbally complained of pain. E3 asked, "Are you okay?" R6 shook her head no. E3 continued to finish up the wound treatment. At 9:53am, E3 unwrapped R6's right heel dressing. The wound was pink with granulation tissue and a small area of slough. R6 stated, "Oh my god" and then started to cry. R6 stated, "It's hurting so bad." R6 started to shake her right hand in the air. E7 (CNA-Certified Nurse	S9999		

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Assistant) stated, "It's ok. We're almost done." At 9:54am, R6 asked E7, "When will it stop hurting?" E7 replied, "I don't know." E3 stated, "Sorry, Ms. (R6)" and continued with the wound care treatment on her right heel. E3 then turned to the surveyor and stated, "It's bad. It's continuously declining." As E3 applied the Santyl and Bactroban to R6's right heel, R6 started to cry. E7 again replied, "It's almost done." E3 stated, "She was already medicated with Tylenol. You have to consider her age when ordering pain medication." E3 stated, "She always complains like this during treatment."

At 9:59am, E3 unwrapped R6's left heel dressing. R6 did not complain of as much pain. R6 stated, "This one doesn't hurt as much. " The left heel wound had eschar that covered the wound. E3 painted the wound with Povidine/Iodine swabs, first around the perimeter of the wound and then on the wound bed.

R6's Physician Order Sheet (POS) documents an order dated 3/20/15: Apply skin prep to left heel after normal saline cleanse daily and cover with dry dressing daily on 11p-7a shift.

R6's Left Heel Care Plan dated 2/16/15 documents: Interventions: Nursing to do treatment as order(ed). Treatment as ordered per wound doctor.

On 3/24/15 at 4:15pm, E21 (LPN-Licensed Practical Nurse) stated, "I worked the 11pm-7am shift on Monday night (3/23-3/24). (R6's) dressing change was done at 4:30am. Wound looks like it was healing. No drainage. In the middle was a very small hole. So I put cream on it as ordered. My job is to just do the treatment. I think the supervisor knows. I told (E3) what it looks like. I told her there was a hole. If change in wound, call the doctor. Tell them the status of the wound. May change wound treatment. Yesterday night was the first time I saw the dot. I

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S9999	Continued From page 6 just do the dressing. I don't know if I document it." On 3/25/15 at 10:10am, E3 stated, "If a significant change occurs, then they notify me. (The tunneling) had to have developed in the last shift. I was not aware of the tunneling." On 3/25/15 at 10:28am, E3 stated, "If she (night nurse) assessed any changes, she should have documented it then let me know. She reported to me yesterday (3/24) that the wound was healing fine. I had no knowledge of the wound decline." E3 continued, "Yes, I heard her (R6) say, "I wish I had cancer. I wish I could die. I have pain." But she was already medicated. Based on the wound care observation, the doctor changed her pain medication to Motrin 600 mg by mouth three times a day." E3 indicated that E21 did not document the wound treatment in a progress note. E3 indicated that E21 just signed the Treatment Administration Record indicating that the treatment was performed. On 3/25/15 at 3:45pm, Z1 (Wound Care Physician) stated, "No, I was not notified until yesterday in the afternoon. If I was aware of the tunneling, would have started packing with calcium alginate." Z1 continued, "The wounds get better and worse. Tunneling is a decline in the condition of the wound. If pain, she should definitely be on medications that help. If crying or expressing pain, treatment should be stopped and her pain reassessed. Give pain med and then go back and finish dressing. She should be medicated before each wound treatment. Not notified that pain was ever an issue." Z1 stated, "Skin prep forms another barrier. Skin prep is not Betadine. My current order is skin prep for her left heel." On 3/26/15 at 11:00am, E3 stated, "Our facility skin prep is Povidine/Iodine, Betadine." E3 confirmed that the physician order is for skin prep to the left heel and not Povidine/Iodine. E3 could	S9999		

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not confirm the staging of the mid back, left heel and right heel at this time. E3 indicated that the wound doctor is the person that stages the wounds.
R6's MAR for January 2015, February 2015 and March 2015 document that she receives Acetaminophen sporadically and not daily prior to wound treatments. R6's Physician Order Sheet indicates that R6's wound care is performed daily.
On 3/25/15 at 1:38pm, E7 (CNA) stated, "I usually always help with wound care. She always complains of pain. Especially with dressing changes." E7 confirmed that R6 is very alert.
R6 discussed the pain on 3/25/15 at 1:39pm. R6 stated, "It hurts all the time. Even if they give me plain Tylenol, it still hurts. Tylenol doesn't help me one bit. The right heel hurts more than the left heel when they do my treatment. I didn't know that pain in that right foot until I came here. Pain is pain. When I complain of pain, they never stop. They keep going. I cannot explain the pain, so sharp. When they're done doing the treatment, the pain goes away. If they get stronger pain medication, I would be so grateful. Sitting here, right now, I have no pain."
R6's Minimum Data Set (MDS) dated 1/24/15 documents a Brief Interview of Mental Status (BIMS) score of 12 out of a possible score of 15. This indicates that the resident is alert.
R6's Pain Management Care Plan dated 3/10/15 documents: Resident will have pain managed to a tolerable level of as evidenced by pain rating of (blank) on a scale of 1-10. Interventions:
On-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating an(y) aggravating factors.
A facility policy dated 9/20/12 and titled, "Pressure Ulcer Prevention and Guidelines" documents: Procedure: A. (2) Any changes in the

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S9999	Continued From page 8 skin integrity will be recorded on the skin check assessment tool. (3) The skin check assessment tool will be referred to the treatment nurse for follow up with the Physicians as indicated. A facility policy with a revised date of 1/2/14 and titled, "Pain Assessment Management" documents: "Purpose: 1. To ensure that resident with complaints of pain are properly identified and assessed. 2. To ensure that appropriate pain management is provided. Procedure: 4. Residents identified to need pain management will be referred to MD and corresponding care plan will be followed." (B)	S9999		