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
	IL6001028	A. BUILDING: _____ B. WING _____	C 12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

(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 Statement of Licensure Violation: 300.1210b) 300.1210d)2)5 300.3240a) 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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	S9999	Attachment A Statement of Licensure Violations	

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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)

These requirements are not met as evidenced by:

Based on interview, observation and record review, the facility failed to ensure treatments are done according to physician's orders, failed to coordinate pressure ulcer care with wound clinic and failed to follow prevention plans including timeliness in turning and repositioning for 2 of 4 residents (R3 and R4) in a sample of 11. This failure resulted in a decline in wound status for R3 on 12/17/15 which the facility was unaware of.

Findings include:

1. R3's Minimum Data Set (MDS) dated 10/1/15 documents R3 has no cognitive impairment and requires extensive assist of two staff for bed mobility and transfers. The MDS documents R3 to have a colostomy and urinary catheter along with having 1 stage III pressure ulcer and 2 stage IV pressure ulcers she was admitted to the facility with. The December 2015 Physician's Order Sheet (POS) documents R3 goes to the Wound Clinic Weekly for management and includes orders for a pressure relieving cushion in wheelchair, up in W/C (wheelchair) 2 hour intervals, one hour intervals before and after meals and from 7pm to 9pm along with orders for Prostat 30cc BID (two times daily), Vitamin C 500mg bid, and Arginaid 1 packet BID. Labs dated 12/22/15 document R3's Pre-Albumin as low at 15 (Normal 20-40.) R3's Braden score

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dated 8/24/15 score her at moderate risk of 14 with 12 or below considered high risk. The care plan dated 10/18/15 identifies R3's risk adding "prefers to sit up in chair at bedside all day and is uncooperative with laying down." Interventions include: may be up for meals and therapy only, assist with repositioning and pressure relief at least every one to two hours, provide diet and nutritional supplements as ordered, and treatments as ordered to left and right buttocks. The care plan failed to address R3's refusals of timely repositioning with alternate interventions to ensure R3 stays off her coccyx area as ordered by the physician.

On 12/22/15 at 10:35am, R3 was sitting in her wheelchair at bedside. R3 stated she has been in her wheelchair without repositioning since before breakfast about 8:30am. R3 stated she had a dressing on her "bottom" and that it had not been changed since "yesterday afternoon." R3 stated the dressing orders were changed and it was now suppose to be done twice daily. R3 stated the facility nurses do not always follow the wound clinics orders.

On 12/22/15, R3 remained in her wheelchair from 10:35am through lunch until 2:55PM. At 2:55pm, R3 was transferred to bed by E7 and E8, Certified Nurses Aides (CNA's.) E6 Licensed Practical Nurse (LPN) entered the room to do the treatment change. Both CNA's confirmed that R3 had been in her wheelchair since early in the morning. When R3 was rolled to her right side, her coccyx dressing had drainage visible across the entire dressing and the entire lower edge of the dressing was loose with the wound bed gaping and visible. The packing was balled up saturated with gray drainage. The wound bed had large patches of grayish yellow material present.

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The left buttock dressing was intact but also had drainage visible throughout the dressing. When E6 removed the left buttock dressing, the wound bed also had some gray matter over the base of the wound. No odor was noted.

Z1, R3's daughter in law was present during the dressing change and stated "compared to the last time I saw it, it looks worse." R1 replied "Yes, that's what the wound clinic says." R1 stated the wound clinic has complained that the facility does not follow physician's orders or always use the appropriate supplies.

Wound Care documentation dated 12/3/15 documents orders for 2 larger pressure ulcers. Wound #3 is identified as the Midline Sacrum which measured 10.5 centimeters (CM) long x 11.5 cm wide x 3.2 cm deep, undermining at 1 o'clock to 3 0' clock with a maximum distance of 2.8cm. The note identifies a large amount of purulent drainage noted with a large amount of necrotic tissue within the wound bed including adherent slough. Wound #4 location is noted on the left ischium measuring 4.8cm x 2.7cm x 0.8cm with bone exposed, large amount of purulent drainage and medium amount (34-66%) of necrotic tissue within the wound bed including adherent slough." Orders given the facility for the Sacrum ulcer were "santyl - nickel thick to the wound bed (the wound vac (vacuum) is on hold for the sacral wound - do not apply the vac to the sacral wound this week", The orders for the left ischium were "Wound Vac to wound continuously at 125mm/hg pressure, black foam - purocol AG (may use plain purocol), then adaptic (sent with patient), then green foam to wound bed, frame the wound with wound vac drape, track the suction pad out and away from wound and bony prominence, do not place suction directly over the

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S9999	Continued From page 4 wound." December 2015 Treatment Administration Records (TAR) reflects the orders correctly for the Ischium but there is no initials or documentation on the TAR that shows the treatments were actually done except on 12/6/15 with "HOLD" written in on 12/10. Wound Clinic notes dated 12/10/15 identify decline documenting "Sacral wound appears larger, several areas of edges and base are necrotic - blue, purple, burgundy, not bleeding when cut, other areas are sloughy, entire area debrided today." Treatment order changes were made for the left ischium - change dressing every other date - Wound Vac change on Monday, Wednesday, and Friday. Hold Vac today and tomorrow, place Saturday 12/12/15, until Saturday, follow same orders as sacrum. Orders for the Sacrum - Change outer dressing twice daily (Leave Acticoat in place until Saturday,then change whole dressing) DO NOT USE TELFA ON ANY WOUNDS." December TARs for treatment changes dated 12/10/15 shows the dressings were not changed according to orders dated 12/10/15 with the Acticoat boxed off for 12/13-12/14 and 12/16-12/17/15 with no initials present. The TAR shows no initials on 12/12/15 for the Wound Vac being placed with the order on the TAR documenting "wound vac on hold til Sat (no date)." This order had HOLD written in for 12/10/15 and 12/11/15. There are no initials for treatments being done to the Sacrum or ischium even though an arrow is drawn to 12/10/15 for the start of the treatment. Wound Care Progress notes dated 12/17/15	S9999		

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document "My orders were not transcribed correctly last week. The wound Vac was not stopped on the ischium, nor was it started on the sacrum. All of the ulcers are worse today. The sacral wound is as necrotic as it was last week." The note also documents R3 telling the wound clinic that she did not have dressing changes for 2 days.

The POS 12/17/15 reflects orders from a Wound Clinic dated 12/17/15 to hold the wound vac treatment and start treatments of cleansing the wounds with Normal Saline (NS), cut Aquacell AG to size, cut Mepilex transfer dressing to fit over wound wedge, fill wound with gauze, cover with 4 x 4 ABD BID (Twice daily.)

December TAR documents these treatments were done on the 3-11 shift on 12/17/15 and on 7-3 shift daily from 12/18/15 thru 12/22/15 but no other times. Nurse Progress notes document treatments done 12/19, 12/20, and 12/22/15 on 3-11 shift that are not initialed off on the TAR. No treatments are documented as being done on the 3-11 shift 12/21/15

On 12/23/15 at 1pm, Z2 Wound Clinic Manager stated they see R3 on a weekly basis and have had problems with communications with the facility. Z2 stated following orders for dressing changes are a problem adding there have been times when R3 has come into the clinic with the wrong treatment on or they've used dressings they specifically are not to use. E2 stated the clinic will send new orders for supplies the facility does not have and then they'll change it without contacting them in a timely manner without notification to the clinic.

Z2 stated the Wound Physician, Z3, would say

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the facility was not following physician's orders for wound treatment has contributed to the decline or lack of improvement in R3's wound. Z2 stated the facility has never contacted them in regards to obtaining wound status documentation and have never contacted them in regards to not following physician's orders when supplies are not available.

On 12/23/15 at 2pm, E1 Administrator and E2, Director of Nursing confirmed they have no documentation from the wound clinic except orders and have requested them numerous times. E2 stated R3 will return from the clinic with new orders but have no other information such as wound status /measurements etc with it. E2 stated the Facility has it's own wound nurse (E5 Registered Nurse RN) who does measurements on a weekly basis. E2 stated the facility nurses have called the wound clinic numerous times to clarify orders and agrees that documentation on the TARs could be better stating that some nurses may document treatments in the progress notes. Both E1 and E2 state R3 is resistant to timely repositioning and refuses often to go to bed for dressing changes.

On 12/29/15 at 10:53am, E2 stated Z3, Primary Physician made arrangements for R3 to go to the Wound clinic and that there are times when the facility does not have the clinic's supplies as ordered and they will use comparable supplies they have.

There is no coordination of care between the wound care clinic and the facility according to E5 Registered Nurse/Wound Nurse who agreed on 12/22/15 that she does not get any information from the wound care clinic in regards to the status of the wounds ie improvement, decline. E5

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S9999	Continued From page 7 stated she does her own weekly measurements but follows the wound clinics orders. E5 stated she felt R3's wounds are looking better and often after debriding, they will get larger. E5 stated she doesn't really want to compare her wound assessments with the clinic due to them debriding them and added it depends on how someone measures as to whether the measurement findings would be the same. Weekly Skin alteration records completed by E5 dated 12/11/15 for the sacrum pressure ulcer fails to identify the area as being larger with necrotic tissue recorded by the wound clinic on 12/11/15 but documents the wound base being "yellow" with 25-50% beefy red. E5 documented "no change" for the healing process even though the wound physician documented a decline in the wound which required debridement. On 12/17/15, E5 again document "no change" for wound healing with no necrotic tissue identified or declined as documented by the wound care physician. The weekly Skin alteration records for the left ischium also shows conflict between the two evaluations. E5's report dated 12/11/15 fails to reflect the area as being larger as documented by the wound clinic yet identifies an improvement in the wound status. E5 failed to document any necrotic tissue prior to R3 going to the wound clinic. There is no evidence the facility identifies the necrotic tissue and adherent slough the wound clinic documents even though they see R3's wounds more frequently. On the 12/17/15 report, R5's wound report documents 100% beefy red wound bed with no change to the wound status although the wound clinic documents "all ulcers are worse today" on 12/17/15.	S9999		

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S9999	Continued From page 8 The facility policy dated 1/2014 entitled "Decubitus Care/Pressure Areas" documents it is the policy of the facility to ensure a proper treatment program has been instituted and is being closely monitored to promote healing of any pressure ulcer, once identified." (B)	S9999		