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
	IL6006175	A. BUILDING: _____ B. WING _____	03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING & REHAB CTR	1136 NORTH MILL STREET NAPERVILLE, IL 60563

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S 000	Initial Comments Annual health statement of licensure violations	S 000		
S9999	Final Observations 300.1210b) 300.1210d)5) 300.2220f) 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. 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/24/16

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Section 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident
These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement preventative measures, follow physician's orders for pressure ulcer treatment and failed to provide wound and incontinence care to prevent infection, promote healing and prevent facility acquired pressure sore from worsening.

This failure resulted in R1 acquiring a stage 2 pressure ulcer in the facility on the right gluteal cleft which progressed into an unstageable pressure ulcer after nine days of developing a stage 2 pressure ulcer.

This applies to 2 of 4 residents (R1 and R5) reviewed for pressure ulcers in the sample of 17.

The findings include:

1. R1 is a 64 year old resident admitted to the facility on October 14, 2015. R1's POS (Physician Order Sheet) for the month of March 2016 showed diagnoses that includes acute MI (Myocardial Infarction), malaise, pressure ulcer unspecified buttock (facility acquired), anemia, diabetes, neuropathy and UTI (urinary tract infection).

The Minimum Data Set (MDS) dated January 11,

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2016 and December 11, 2015 showed that R1 required extensive to total assistance for bed mobility, transfers, hygiene and incontinence care for bowel and bladder elimination. The MDS also showed that R1 was cognitively intact and was not identified with mood or behavior episodes.

The Braden Scale Skin Assessment dated 10/14/2015 showed that R1 scored 17 (at risk for pressure sore development). R1's Braden Scale as of December 16, 2015 showed a score of 12 (High Risk).

The Wound Summary showed that on October 28, 2015, two weeks after R1 was admitted, R1 developed a stage 2 pressure ulcer on the right gluteal cleft. On November 06, 2015, 9 days after developing a stage 2, this pressure ulcer worsened to an unstageable pressure ulcer. The pressure ulcer was unstageable for long period until January 18, 2016. The pressure ulcer turned into a stage 3 on January 25, 2016.

The care plan dated January 12, 2016 showed non specific interventions to address R1's worsened pressure sore. Some interventions included utilizing pressure relieving mattress for pressure relief, assist to turn reposition at least every hour and as needed, treatment as ordered by physician, provide incontinent care including moisture barrier to prevent maceration of skin.

The review of R1 ' s POS showed a physician ' s order dated February 10, 2016 to "cleanse the wound (right gluteal pressure sore) with saline and pat dry. Apply skin prep and allow to become tacky. Fill wound with collagen alginate and cover with foam dressing. Change daily and PRN (if needed) if loose or soiled." There was also an order dated November 12, 2015 for R1 to be turn

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and reposition every hour for off loading pressure.

On March 06, 2016 at 10:00 A.M., R1 was in bed lying on her back. R1 stated "I have pain on my behind, I'm still waiting for the nurse to apply my dressing. I had a very good bed bath last evening, the dressing got wet, (E12, CNA, Certified Nurse Assistant) removed the dressing, and up to now, my dressing was not on. I felt so soaked now, it sting. I also need my diaper changed. It takes a while before my diaper was changed and not always turned as often. I would like to get up but my therapy ran out."

At around 10:20 am, E5 (Licensed Practical Nurse) and E9 (CNA) checked R1 ' s skin. R1 was lying on a under inflated pressure relieving mattress, her buttocks/gluteal were not offloaded from pressure. R1 was also noted with a disposable brief and an incontinent cloth pad and a sheet on a low air low mattress. R1 was heavily soaked with urine. The absorbent padding from the brief had turned into a gel like consistency due to heavy saturation of urine. It was also noted that the urine had leaked through the brief onto the incontinent cloth pad. There was no dressing on the pressure sore to the right gluteal cleft. The pressure sore was exposed to the smeared feces and urine. The pressure sore on the right gluteal cleft was approximately an inch or 1.5 inch deep, 1 x1 inch wide and length. There was redness around the sacrum. While providing incontinence care E9 further exposed the pressure sore to fecal material. E5 also did not completely apply skin prep around the wound. Furthermore, E5 did not cover the wound when she applied the alginate dressing and allowed E9 to change the bed linen before covering the wound.

E9 stated that she had provided incontinence

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care and repositioned R1 at 6:30 A.M. on 3/6/2016. E9 also stated that she noted there was no dressing on the right gluteal pressure sore. E9 also added that she did not inform E5 regarding R1 ' s pressure sore not having any dressing. For three and half hour R1 was not repositioned for pressure relief and incontinence care was not provided.

On March 07, 2016 at 3:30 P.M., E12 (CNA) stated that she had removed the pressure sore dressing at around 8:30 P.M. on 3/6/2016. E12 also stated that she informed E13 (Nurse on 3/7/2016 evening shift) regarding R1's requiring pressure sore dressing. E12 also added that at 10:30 P.M. that evening, R1 still had no dressing on the pressure sore. E12 added, "I guess (E13) was busy."

As a result of R1's stage 3 pressure ulcer was exposed to urine and feces for 13 and 1/2 hours that might cause infection of the pressure sore and will not promote healing.

R1 was not turned and reposition every hour as observed on 3/6/2016 at 12:50 P.M., 1:00 P.M. and on 3/7/2016 at 11:20 A.M., 12:20 P.M., 2:10 P.M., 3:18 P.M. During this time of observations, R1 was lying on her back, with her sacrum/buttocks and heels not offloaded.

On 3/7/2016 at 4:10 P.M., E6 (Wound Care Nurse) stated that R1 should be turned and reposition every hour for offloading of pressure, and R1 should be kept clean and dry from incontinence. E6 also added that there should be no added linen padding on the air mattress such as the incontinent cloth pad since it would defeat the purpose of relieving the pressure. As E6 added, the skin prep should be applied as

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ordered by the physician since the skin prep would help prevent further skin damage.

2. On 3/06/2016 at 10:30 A.M., E10, (CNA, Certified Nurse Assistant) provided incontinence care to R5. It was noted that R5's sacrum area had some redness. R5 was moderately soaked with urine. After the incontinence care, there was no skin barrier applied. There was also no protective dressing on the sacrum for pressure ulcer prevention. R5's heels were noted with foam dressing with a date label of January 28, 2016. For 5 weeks the same foam dressing was on R5's heels.

On 3/7/2016 at 4:00 P.M., together with E8 (License Practical Nurse) and E12 (CNA), R5's heels were checked. R5 has the same foam dressing on her heels with a date label of 1/28/2016. E8 stated that the foam dressing was for pressure ulcer prevention since R5 is a high risk for developing pressure ulcer.

The POS for the month of March 2016 showed a physician order dated 1/28/2016 for R5 to have foam dressing on bilateral heels for pressure ulcer prevention. The order also showed to check the heels every shift and change the dressing every week. There was also an order to apply foam dressing on the sacrum for pressure ulcer prevention.

As observed on 3/6/2016 during the incontinence care, there was no foam dressing on the sacrum.

On 3/7/2016 at 4:10 P.M., E7 and E6 (Wound Care Nurses) had no explanation how come the date label was still 1/28/2016 and how could nurse be checking every shift and had not noticed the date label as to when the dressing was last

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S9999	Continued From page 6 changed. E6 and E7 also stated that the dressing was labeled with a date to show when the dressing was last changed. The POS also showed that R5 has diagnoses that include multiple sclerosis, anemia, and venous insufficiency. (B)	S9999		