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
	IL6003305	A. BUILDING: _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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
S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.1010h) 300.1210b) 300.1210d)2, 5 300.1220b)3 300.1620a) 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 300.1010 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,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 injury or change in condition at the time of notification 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 services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 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,	S9999		

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S9999	Continued From page 2 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. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. 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 and record review the facility failed to identify pressure ulcers before deep tissue injury and stage II wounds developed and failed to ensure pressure reduction interventions were in place. The facility failed to perform a wound care treatment as ordered and failed to notifiy a physician of a wound decline. The facility failed to perform complete wound assessments, failed to monitor an area of skin concern identified on admission, and failed to ensure	S9999		

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reddend skin areas were reported to the nurse. This applies to 2 of 8 residents (R1, R6) reviewed for pressure in the sample of 17.

The findings include:

1. R1's MDS of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting. The MDS shows R1 has 1 unstageable pressure ulcer with slough.

R1's admission assessment for predicting pressure sore risk dated January 25, 2016 shows R1 was at a mild risk for pressure ulcers, and showed that R1 had no sensory impairment, was able to respond to verbal commands, and had no sensory deficit which would limit her ability to feel or voice pain or discomfort.

R1's admission assessment dated January 25, 2016, shows she was chair ridden, required help with feeding, and was forgetful and confused. This assessment showed R1 was admitted with a "1 cm reddened area" to her right buttock. The next wound assessment completed on R1 was February 5, 2016 and showed a "4cm x 3 cm stage 2" pressure ulcer to R1's coccyx. There was no description of R1's wound bed, surrounding tissue, drainage, or odor.

R1's Emergency Department visit records dated February 2, 2016 shows R1 had a stage II pressure ulcer to the sacrum present during the visit, and R1 would require a wound care nurse consult, and frequent adjustments of position to help with her history of a pressure ulcer while she was at the hospital.

R1's February 8, 2016 assessment shows the

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S9999	Continued From page 4 wound increased to 6.8cm x 4.9cm x Unable to Determine the Depth, the wound bed declined, and was 100% covered with yellow/white slough and the wound was unstageable. R1's wound care clinic assessment dated February 23, 2016 shows the original cause of R1's wound to her coccyx was from a pressure injury. This assessment shows R1 had a deep pressure ulcer wound that measured 4.5cm length x 2 cm width x 0.5 cm depth with exposed muscle, a medium amount of necrotic tissue within the wound including slough, and a large amount of necrotic foul smelling material in the wound (dead tissue). R1's skin condition report dated March 8, 2016 (return to facility from surgical debridement) shows R1's wound measured 7cm x 5.5cm x 6cm (length, width, depth), with 30% slough. R1's wound care clinic documentation dated March 2, 2016 shows R1's wound was malodorous with dark necrotic tissue visible around the entire region ,with purulent drainage. This assessment shows R1 was admitted to the hospital (from wound clinic) for a bacterial infection, and stage 4 pressure ulcer of the sacral region. R1's wound care clinic orders dated February 23, 2016 shows an order to clean the wound twice daily (and more if needed) with Dakin's (bleach based wound cleanser) or soap and water, then rinse with Dakin's, and cover with dry gauze, and moisten gauze with Dakin's sol then apply to open area and cover with gauze. R1's Pressure Ulcer care plan dated February 23,	S9999		

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S9999	Continued From page 5 2016 shows an intervention for "treatments as ordered." R1's Treatment Administration Record (TAR) shows R1 did not receive any dressing changes with Dakin's on February 23, February 24, and the first treatment was not completed until the evening of February 25. R1's wound culture dated February 25, 2016 shows the wound had gram negative rods, E. Coli, and Extended spectrum Beta Lactamase (ESBL - bacteria) present in the wound. On March 10, 2016 at 1:30 PM, E19 (CNA-Certified Nurse Assistant) and E26 (Wound Care Nurse) positioned R1 on her left side in bed. E26 removed the dressing to R1's sacrum, and R1 had a large, grapefruit sized , deep open pressure ulcer to her sacrum. E26 cleaned the wound with saline, and a strong foul odor was present. R1's wound bed had gray, tan strands of slough present throughout, and bone was present to the center of the wound. E26 pointed to open areas around the outside of the wound on the left side and said R1 had new breakdown that wasn't there when she returned from surgery. E26 said she knows the wound is "deep" and described the wound odor as "rotting", and said there was an increase in slough to the wound bed compared to when R1 returned from the hospital after the surgical debridement. E26 pointed to a dark circular spot inside the wound and said it was R1's exposed bone. E26 placed a 4x4 gauge pad, covered with Santyl inside the wound, and then placed 4 (4x4) Dakin's soaked gauze pads, over the gauze with Santyl, inside R1's wound, and taped a gauze pad over the top of the wound. On March 9, 2016 at 1:30 PM, Z1 (Family	S9999		

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Member) said R1's pressure ulcer was found when she was in the ER (emergency room) at the hospital. Z1 said when R1 got to the ER, and they rolled her over, the staff found the pressure ulcer. Z1 said R1 had it prior to going to the ER but the facility did not know it.

On March 10, 2016 at 4:40 PM, E27 (LPN - Licensed Practical Nurse) said the nurses do not conduct skin assessments on residents unless an area of concern is identified by a CNA, or on admission. E27 said R1 was high risk for skin breakdown on admission to the facility.

On March 11, 2016 at 8:30 AM, E23 (LPN) said the nurses rely on the CNAs to report any reddened areas they see during care to the nurses, and all reddened areas or areas of concern should be reported to the nurse by the CNAs .

On March 11 at 9:00 AM, E26 (Wound Care Nurse) said if a resident has an identified area of concern like R1 did with the reddened area on admission, the site should be assessed by both nursing or the Wound Care Nurse at least twice a week until the area resolves. E26 said a complete assessment should be documented on the treatment assessment sheet. E26 said preventative measures should be put in place, including a soft foam dressing to prevent the area from breaking down. E26 said she determined how to apply R1's treatments, and did not check with the wound care clinic on how they wanted the Dakin's and Sanytl applied. E26 said she should have notified the wound care doctor on 3/10/16 after she noticed the decline in R1's wound with additional slough and breakdown present outside the wound, plus a stronger smelling foul odor. E26 said she did not notify the

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wound doctor of the decline. E26 said a complete assessment should be done on wounds to include size, depth, wound bed, drainage, color odor, and stage. E26 said the CNAs do skin assessments with cares and should report any areas of concern to the nurse. The nurse would then perform and document a complete assessment of that area.

At 9:40 AM, E30 (LPN) said she became aware of R1's pressure ulcer when R1 returned from the hospital on February 5, 2016. E28 said the hospital said R1 arrived to the emergency room with the pressure ulcer, but she (E28) did not know R1 had one.

At 10:10AM, E3 (ADON-Assistant Director of Nursing) said she felt R1 was high risk for skin breakdown on admission to the facility and R1's assessment for predicting pressure sore risk dated January 25, 2016, shows did not accurately assess R1's sensory impairment.

At 10:20 AM, Z2 (Primary Care Physician) said R 1 was at a high risk for skin breakdown on admission to the facility, and the wound to her sacrum was from pressure.

At 10:30 AM, E1 (Administrator) said wound care treatments should be completed as ordered. E1 and E2 said a physician should be notified immediately with a decline in a wound, and all reddened areas observed by a CNA should be reported to the nurse and an assessment completed if the area is pressure related. At 10:40 AM, E2 (DON-Director of Nursing) said R1 did not get a wound treatment with Dakin's solution on 2/23/16, 2/24/16, or in the morning on 2/26/16. E2 said the solution was not available because it was not delivered until later in the day

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S9999	Continued From page 8 on February 26, 2016. E2 said if a treatment square is blank, or initialed and circled, the treatment was not done. 2. R6's MDS of January 2, 2016 shows R6 requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting. On March 8, 2016 at 11:05 AM, E9 (LPN) said R6 had an event this morning in which she had a possible seizure or stroke, and would not be getting out of bed, until she was more alert. On March 9, 2016 at 1:00 PM, E21 and E24 (CNAs) provided care to R6 while she was in bed. E24 said R6 had not been out of bed that day. E21 and E24 had R1 on her left side. R1 had dark red circular area to her right buttock. E24 said the area "wasn't so red" this morning. On March 10, 2016 at 10:00 AM, E24 said R6 had the "same red areas yesterday" to her right buttock. On March 11, 2016 at 8:00AM, R6 was assisted off the toilet by E8 (CNA), and R6 had a dark reddened area to her right buttock. There was no assessment of R6's reddened buttock from March 9, 2016 until March 11, 2016 (3 days after the CNA was aware it was present). The facility "Skin Conditions Policy" dated June, 2014 shows: We strive to attain to maintain intact and healthy skin for our residents through a process of identification, monitoring, preventative and treatment protocols. All direct care staff...will be trained to observe for	S9999		

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S9999	Continued From page 9 and report skin conditions including redness, bruising, and skin tears. (B)	S9999		