

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6015523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>01/06/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ARDEN COURTS OF GLEN ELLYN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2 SOUTH 706 PARK BLVD GLEN ELLYN, IL 60137</b>
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S 000	Initial Comments  First Licensure Post Visit to Survey of November 3, 2016- Repeat 330.1710 f) 1), Repeat 330.2010 Survey was done in conjunction with: Complaint Investigation: 1676183/IL89492- Repeat 330.1710 f) 1)	S 000		
S9999	Final Observations  STATEMENT OF LICENSURE VIOLATIONS 330.1710f)1) Section 330.1710 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident ' s condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. This requirement is not met as evidenced by: Based on record review, observation and interviews, the facility failed to obtain Physician ' s Orders for a heel ulcer. The facility failed to assess and initiate a plan of care for a resident who developed/acquired a pressure ulcer to the right hip and a resident who acquired an unstageable ulcer to the left heel while in the facility. The facility failed to provide off loading for a resident with an ulcer to the left heel. The facility failed to initiate skin risk assessments for residents with ulcers. The facility failed to follow Physician ' s Orders when providing treatment to an unstageable ulcer. The facility failed to follow their Plan of Correction regarding wound care. The facility failed to follow their policy for Wounds. This failure led to R2 developing an unstageable heel ulcer while in the facility.	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>This applies to 2 of 3 residents (R2, R3) reviewed for pressure and other than pressure ulcers. Findings include:</p> <p>1). On January 3, 2017 the facility was asked to provide a list of residents with all ulcer types. Instead, the facility provided nursing notes for R1. No list was provided. At 2:50pm, E2 (Director of Nursing) stated that the facility does not take care of wounds beyond stage 2.</p> <p>R2 ' s Face Sheet documents that he is 84 years old admitted on August 29, 2016 with the following diagnoses: Dementia, hyperlipidemia, hypertension, presence of pacemaker, diabetes mellitus type 2, major depressive disorder, and suicidal ideations. R2 ' s January 2017 MAR (Medication Administration Record) and TOS (Telephone Order Sheet)/POS Physicians Order Sheet documented the following orders: December 31, 2016 Cleanse open area on left heel with normal saline and cover with gauze/tape.</p> <p>January 4, 2017 Medihoney gel, cover with foam dressing, then cover with gauze wrap, change 3 times a week. Heel lift while in bed. The Physician signature section of the telephone order sheets was blank.</p> <p>January 4, 2017, Levaquin 750mg, 1 tablet daily for 10 days.</p> <p>On January 5, 2017 at 11:00am, R2 was rolling down the hall in his wheelchair. R2 had no leg rest on his wheel chair. R2 ' s left foot had a heel protector; however, he was using his feet to propel himself. The heel protector was made with a hole in the bottom. R2 ' s left foot was edematous and contained a gauze wrap dressing. Blood could be seen on the bottom of the dressing. E6 (Caregiver) stated the wound has been there a week. E6 stated " I noticed it Monday and told the nurse (January 2, 2016). E7 was also on the unit and stated that the wound</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>has been on R2 ' s heel for a week. E2 (Director of Nursing) stated she does wound measurements. E2 provided treatment for R2 ' s wound. The wound was observed from the lateral aspect (outer side) to the medial aspect (inner most side) of his heel. There was black unstageable necrotic tissue in the center with yellow slough around the edges. Just below that was brown necrotic tissue. The peri-wound was open and reddened. E2 removed foam dressing which contained a large amount of brownish yellow drainage. E2 stated she will not change the dressing because it was placed yesterday. E2 was asked to perform a complete dressing change/treatment for R2. E2 stated I have to check the book for the order. The surveyor stated " ok. " E2 did not check the book. E2 placed the same dirty dressing on R2 ' s heel. E2 did not cleanse the wound or apply medihoney. E2 wrapped R2 ' s heel with a new gauze wrap and placed the same soiled dressing onto R2 ' s draining heel. E2 also stated that the facility cannot take care of residents who have wounds that are greater than stage 2. E2 stated that R2 ' s wound is facility acquired.</p> <p>R2 ' s Nursing Notes from December 31, 2017-January 3, 2017 contained no documentation about the wound to his left heel. The last entry for R2 ' s progress notes for December 2016 was on December 21, 2016. The next entry in R2 ' s progress notes was January 4, 2017 (Day after survey started). There were no measurements or description of the wound in R2 ' s Medical Record. R2 ' s progress notes on January 4, 2017 documents that the wound is 5.0 by 6.0 cm with necrotic tissue in the center measuring 1.5X3cm, the tissue is red and moist and skin rolled at the edges. There ' s no documentation of progression or regression of the wound as the</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>Medical Record does not document what it looked like on December 31, 2016. There was also no skin risk assessment in R2 ' s medical record. The last Physician ' s Progress note in R2 ' s medical record (provided by E2) was dated December 15, 2016 which documented: no edema.</p> <p>On January 5, 2016 at 9:42am, E2 stated that R2 ' s wound is facility acquired. E2 stated " we don ' t do any skin assessments, this is not skilled. We don ' t do skin risk assessments. " E2 stated that R2 has diabetes mellitus. At 10:24am, E2 stated that the wound nurse saw R2 last night. When asked to present the assessment for R2 ' s wound on December 31, 2016 and subsequent documentation that led up to January 4, 2017, E2 stated " the nurse missed the documentation of the wound on his foot. " E2 stated that the wound was initially noted on December 31, 2016, but the facility did not call the home health nurse until January 3, 2017. E2 stated " we are missing the charting from when the wound was noted. "</p> <p>On January 5, 2016 at 1:07pm, Z1 (Covering for Z2, while on vacation) stated that the facility informed him on yesterday (January 4, 2017) of the wound to R2 ' s heel and mentioned something about December 31, 2016. Z1 stated he saw the wound yesterday and informed the facility to offload R2 ' s heel. Z1 stated " I started him on anti-biotics because that wound doesn ' t look good. Z1 stated " if the home health nurse can ' t do it daily, he has to go, " Z1 was asked if he was aware that the facility had a policy not to take care of wounds greater then stage 2. Z1 stated " if the facility can ' t manage him there, surely he has to go because that wound doesn ' t look good. "</p> <p>On January 5, 2016 at 1:25pm, Z3 (Home Health Care Nurse) stated that the policy at the facility is</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>that they can apply Band-Aids or bacitracin to wounds but can ' t apply medihoney, tegaderm or even duoderm. When asked if she had seen R2 ' s wound, Z3 stated " I saw it once (January 4, 2017). Z3 stated that she is mainly seeing R2 for psych. Z3 stated " he ' s being seen 3 times a week. " When informed of Z1 ' s statement about Home healthcare taking care of R2 ' s wound, Z3 stated that home health care can see him daily for one week only. But according to Z3, R2 is not currently being seen daily. Z3 stated that she was informed of R2 ' s wound on December 31, 2016 but did not see him as the wound was described as a blister. Z3 stated that she was not made aware of R2 ' s wound having necrotic tissue prior to January 4, 2017. Z3 stated that she can start sending someone to assess R2 ' s wound daily starting today. R2 ' s medical record contained no documentation of a blister or when the wound started to regress. The facility ' s policy for wounds documents: Each facility will ensure that a wound/skin evaluation is initiated on any resident when a wound or skin condition is identified upon move in or at any time during their stay. The wound/skin assessment will be documented in the Clinical Evaluation in PCC (Computerized charting) and a Body Assessment Tool will be used to document this evaluation. The facility will ensure that no wounds and/or skin conditions beyond a stage II or unstageable are admitted and/or retained in our facilities.</p> <p>Procedures: The RSC (Resident Service Coordinator) will conduct a wound/skin evaluation within 24 hours of move in. Weekly progress notes will be documented on the resident ' s Individual Service Notes maintained in the Resident Information Book.</p> <p>Indications: To ensure that no wounds and/or skin conditions receiving treatment at Facility are</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>greater than a stage 2.</p> <p>Level of Responsibility of RN/LPN: Obtain a Body Assessment Tool and a Wound Measurement Tool; Identify the wound and/or skin condition area on the Body Assessment Tool; Measure the size of the wound and/or area of skin condition; Document the first day the wound and/or skin condition was first observed; Document the anatomical site of the wound and /or skin condition, the type, the size, dept, color, amount and type of drainage, and odor if present; Document treatment ordered by physician; Continued documentation to include all of the above plus progress or lack of progress of the wound.</p> <p>Wound Stages: In stage II wounds, the top most layers of the skin is severed (epidermis and dermis). Unstageable wounds are classified when full thickness tissue loss in which the base is covered by slough (yellow, tan, gray, green, or brown) and/or Escher (tan, brown, or black) in the wound bed.</p> <p>On January 5, 2017 at 1:53pm, E1 stated " we don ' t have a skin risk assessment policy. At 3:39pm, E2 stated that she is the RSC (Resident Service Coordinator).</p> <p>On January 6, 2017 at 8:30am, E2 presented the surveyor with Nursing notes dated January 5, 2017 documenting: Late entry- On December 31, 2016 noted resident ' s left foot heel with popped up blister measured at 5cm X6cm with necrotic tissue on center of wound. The Nursing notes contained at least 7 documented late entries from December 31, 2016-January 3, 2017, all dated January 5, 2017. E2 stated that R2 was sent to the hospital last night because the Physician sent him out. E2 stated " because we can ' t take care of a wound greater than a stage II. "</p> <p>On January 6, 2016 at 10:56am, E1 stated that the wound nurse came to the facility on January</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>5, 2017 and evaluated R2 and confirmed that the wound was unstageable. R2 ' s Medical Record contained an order from Z1 dated January 5, 2017 to send R2 to the hospital. 2). R3 ' s Face Sheet documents that she is 81 years old. R3 ' s POS (Physician ' s Order Sheet) documents the following diagnoses: Front temporal lobe degeneration, other frontal temporal dementia. On January 5, 2017 at 8:50am, R3 was sitting in her wheelchair finishing her breakfast. R3 then asked to go to bed. E8 CNA (Certified Nursing Assistant) was asked to check R3 ' s incontinent brief. Noted on R3 ' s right hip was 4X4 foam border gauze dressing. There was no date on the dressing. Upon removal of the dressing there was an open area that was white in the center with reddened edges. E2 (Director of Nursing) was not aware of the wound. E2 then asked E9 (Nurse on Duty) if she was aware of the wound/dressing on R3 ' s hip. E9 stated " no ". E9 stated that she is the only nurse on duty, other than E2. E2 measured the wound at 0.5 X 0.7cm. There was no documentation in R3 ' s medical record related to the wound. There were no assessment, measurements, or description of the wound documented in R3 ' s medical record. E2 stated she has to investigate to find out who put the dressing on R3 ' s hip. R3 ' s POS for January 2017 contained no order for the wound. On January 5, 2017 at 1:07pm, E2 was asked to page Z1 (Medical Doctor). Z1 stated the facility had just informed him of R3's wound (January 5, 2017).</p> <p>(B)</p> <p>330.2010 Section 330.2010 Kitchen Equipment, Utensils &amp;</p>	S9999		
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S9999	<p>Continued From page 7</p> <p><b>Supplies</b> Each facility shall provide an adequate number of dishes, glassware and silverware of a satisfactory type to serve all residents in the facility at each meal. This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure to that dishware was clean and sanitary. This affected all residents in three of the four facility ' s units. The findings include: During the initial tour of the facility on January 3, 2017 from 12:35pm - 1:30pm, dishware in each resident ' s unit were checked for stains and food debris. In Country Lane ' s kitchen, the inside of eight coffee cups taken from the clean dishware rack had brown substances that extended from the bottom of the cup to the perimeter. E3 (Caregiver) stated the brown substance is coffee stains. E3 added that " the cups are clean, they are just stained. " One cup had a brown syrup-like substance on the lid and outside the top of the cup.</p> <p>In Cottage ' s kitchen pantry, six coffee cups taken from the clean rack in the storage area contained the same brown substance and 2 plates had food debris attached underneath. E4 (Caregiver) stated " it is just coffee stains and they won ' t come out. " Underneath one plate contained a dried substance that looked like spinach. The other plate had a substance that looked like a wet bread crumb. E4said, " we receive our clean dishware from the kitchen so I did not wash any of those dishes on the clean rack. " E4 added, " they clean dirty dishes by first hand-rinsing them and then putting them in their dishwasher. " E4 said she had not received an in-service on proper dishwashing in the last</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>month and that the facility inspects their dishes on a regular basis. E4 added " I am not responsible for any of these dishes and if it sounds like I am being nasty, I apologize."</p> <p>In Garden ' s kitchen pantry, coffee cups taken from the clean racks contained what looked like brown coffee stains and a pink substance on one cup. E5 (caregiver) stated that the substances " should be able to come out. " E5 rinsed three coffee cups with water and the inside brown substance washed right out. E5 then washed six cups clean (that seemed to have harder stains) using water, dish detergent and a dish towel. This included the cup with the pink substance on the outer rim. All cups became clean when E5 washed them.</p> <p>Upon returning to Cottage kitchen to check to see if the brown substance inside the coffee cups was washable. E4 successfully washed 5 cups with the coffee " stains " . E4 then washed the inside of a green cup that contained a buildup of brown grainy-like debris. E4 used a textured cloth to wipe the inside of the green cup. The cup became clean.</p> <p>On January 3, 2017, E1 (Administrator), stated that the facility did not provide a dishwashing in-service to the caregivers. However, E1 said they inspect each unit " dishes daily by picking up the dishes and looking at them, like you do at home." E1 added that the brown substance inside the coffee cups were coffee stains that cannot be removed.</p> <p>The facility also failed to follow their policy entitled " Dishwasher Operations House Pantries " Food Services Policies &amp; Procedures sections V " dated June 2013. The policy states " all dishes,</p>	S9999		
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S9999	Continued From page 9  glassware and silverware (tableware) are washed in the House pantries. " Procedure 10 states " product and maintenance needs are reported to the Building Services Coordinator. "  (AW)	S9999		
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