

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/08/2017
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NAME OF PROVIDER OR SUPPLIER WASHINGTON CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 NEWCASTLE WASHINGTON, IL 61571
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S 000	<p>Initial Comments</p> <p>Complaint Investigation</p> <p>1720557/IL91392</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999	<p>Attachment A</p> <p>Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/06/17

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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. <p>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)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure a hypotensive resident was not administered antihypertensive medications, and blood pressures were monitored for that hypotensive resident which affected one of nine residents (R2) reviewed for medication administration parameters in a sample of thirteen.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>These failures resulted in R2 developing severe hypotension, requiring emergent hospitalization, sustaining Cardiac Demand Ischemia following the antihypertensive medication administration.</p> <p>Findings include:</p> <p>A Medication Orders - Not Controlled Substances policy dated 12/21/09 states, "Standard Protocols written by the physician will name the condition and prescribe the action to be taken in caring for the patient, including the dosage and route of administration for a drug..."</p> <p>A Following Physician Orders policy (undated) states that staff, "Cannot change a physician order without another order from the physician...Orders to be carried out as written...Notify the physician when you are unable to carry out the orders as written."</p> <p>A Lippencott, Williams and Wilkins Nursing Drug Handbook dated 2011 instructs to monitor blood pressure frequently while taking Clonidine Hydrochloride.</p> <p>A Holland Nursing Guide (undated) documents that an adverse effect of administering Moexipril is hypotension.</p> <p>R2's Change in Condition Evaluation dated 12/18/16 at 3:45p.m. documents R2 had a change in condition related to abnormal vital signs, food and/or fluid intake was decreased, nausea and vomiting. The Change in Condition Evaluation documents R2's blood pressure (BP) was 93 systolic blood pressure (SBP) and 48 diastolic blood pressure (DBP) or 93/48mmhg (millimeters of mercury), heart rate 117 bpm (beats per minute), and respirations were 50</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>breaths per minute all of which was reported to Z1 (R2's physician).</p> <p>A nurse's note dated 12/18/16 at 4:49p.m., states, "New orders...hold B/P med (medication) if SBP is less than 120 and DBP is less than 60."</p> <p>A nurse's note dated 12/18/16 at 9:30p.m. document R2's physician was notified that R2's family was requesting intravenous (IV) fluids for R2.</p> <p>R2's Blood Pressure log dated 12/18/16 documents that R2's blood pressure was still 93/48mmhg at 10:27p.m.</p> <p>R2's physician's order (POS) dated 12/18/16 documents R2 was ordered to have two liters of Normal Saline IV fluids to infuse at a rate of 75cc (cubic centimeters)/hour.</p> <p>R2's nurse's note dated 12/18/16 at 11:27p.m., documents that R2 had an IV catheter inserted into R2's left arm which was infusing IV fluids at a rate of 75ml (milliliters) per hour.</p> <p>R2's nurse's note dated 12/19/16 at 3:31a.m., document that R2's IV catheter infiltrated (stopped functioning) and, "RNs (Registered Nurses) tried six times to start another. Sent fax to Z1 (R2's physician) to state RN cannot get anoather IV started...awaiting reply." The nurse's notes do not document that Z1 was called in addition to sending a fax to Z1's office.</p> <p>R2's nurse's note dated 12/19/16 at 7:00a.m. documents R2's IV and IV fluids were restarted at that time.</p> <p>R2's Blood Pressure log dated 12/18/16 and</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>12/19/16 does not document R2 had blood pressure monitoring from 10:27p.m. on 12/18/16 to 7:52a.m. 12/19/16 at which time R2's blood pressure was 108/56mmhg.</p> <p>R2's MAR dated 12/19/16 documents that at 8:00a.m. E7 (Registered Nurse) administered R2's blood pressure medications Moexipril Hydrochloride 15mg and Clonidine Hydrochloride 0.1mg despite R2's blood pressure of 108/56mmhg and Z1's order to hold B/P medications for SBP less than 120 and a DBP less than 60</p> <p>R2's Blood Pressure log dated 12/19/16 at 9:46a.m. documents R2's blood pressure at that time was 114/78mmhg.</p> <p>R2's MAR dated 12/19/16 at 12:00p.m., documents that E7 administered R2's Clonidine Hydrochloride 0.1mg despite R2's blood pressure of 114/78mmhg and Z1's order to hold B/P medications for SBP less than 120 and a DBP less than 60.</p> <p>R2's Blood Pressure log dated 12/19/16 documents R2 did not have another blood pressure taken until 2:56p.m., five hours later, which was 68/40mmhg.</p> <p>R2's nurse's note dated 12/19/16 at 3:38p.m. and 4:15p.m., documents that Z1 was notified of R2's condition and ordered for R2 to be transferred to the emergency room for evaluation and treatment.</p> <p>On 2/2/17 at 3:06p.m., E7 (Registered Nurse) verified that E7 administered R2's blood pressure medication Moexipril Hydrochloride 15mg and Clonidine Hydrochloride 0.1mg at 8:00a.m. on</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>12/19/16 despite R2's blood pressure of 108/56mmhg and also administered Clonidine Hydrochloride 0.1mg at 12:00p.m. despite R2's blood pressure at 9:46a.m., of 114/78. E7 stated that, before administering the antihypertensive medications she was sure she had taken R2's B/P stating, "It was OK, but I don't remember what it was." E7 stated that there were no physician notifications made because R2 was, "doing well, up in the chair, and eating and drinking."</p> <p>R2's hospital Critical Care physician's History and Physical progress note dated 12/19/16 documents R2 was admitted to the emergency room where laboratory (lab) tests were performed. The progress note documents R2's lab results for a Troponin level (a protein released when heart muscle is damaged) was elevated which was, "Likely caused by demand ischemia. Plan: Will hold antihypertensive medications."</p> <p>A Disciplinary Report dated 12/28/16 documents that E2 (Registered Nurse) increased R2's IV fluids infusion rate from the ordered 75cc/ hour to 150cc/ hour for approximately 45 minutes prior to R2's transfer to the hospital on 12/19/16.</p> <p>On 2/6/17 at 2:25p.m. E2 (Director of Nurses) verified that on 12/19/16 at approximately 3:00p.m. E2 increased R2's IV fluid rate to 150cc/hr for about 45 minutes. E2 also stated that Z1 (R2's physician) should have been notified by the nursing staff that R2 had received antihypertension medications when R2's blood pressure was already low and stated, "If a resident has a low BP, I would think you would monitor it more frequently. But, I wasn't there that day."</p>	S9999		

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S9999	Continued From page 6 On 2/2/17 at 11:35a.m., Z1 (R2's physician) stated, "When Z2 (Nurse Practitioner) was called on the afternoon of 12/19/16, when R2's B/P was 68/40, that nurse told Z2 that she had increased the rate of the IV fluids to 150cc/hour. I would have expected the nurse to infuse R2's IV fluids at the ordered rate and not change the rate without calling me first. Also I would have expected the nurse would call me when R2 received her antihypertensive medications when R2's blood pressure was less than 120SBP and less than 60DPB. If staff had notified me that R2 received her blood pressure medications against my orders to hold for SBP less than 120 and DBP less than 60, when her B/P was already low, I would have sent her to the hospital for evaluation and treatment sooner. R2's B/P may have already been severely low during that five hour period when no blood pressures were taken. But since Z2 and I were not notified until R2's B/P was 68/40 on 12/19/16 at approximately 3:00p.m., R2 had to be sent to the hospital emergently. R2's elevated troponin level with diagnosis of 'demand ischemia' was the result of R2's severe hypotension caused by the facility administering antihypertensive medications outside of the ordered parameters, not monitoring the blood pressure closely, and not notifying me the medications were given." (A) 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5)	S9999			

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S9999	<p>Continued From page 7</p> <p>300.1220b)3) 300.3240a)</p> <p>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.</p> <p>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, injury or change in condition at the time of notification.</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>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)</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>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, 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.</p> <p>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)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident at high risk for developing pressure ulcers was positioned to prevent unrelieved pressure, and that incontinence care was performed to maintain clean, dry skin for one of three residents (R1) reviewed for pressure ulcers in a sample of thirteen. These failures resulted in R1 developing a stage 4 pressure ulcer with Osteomyelitis to the coccyx.</p> <p>Findings include:</p> <p>A National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Staging Guide (undated) documents the definition of a stage 4 pressure ulcer as, " Full thickness tissue loss with exposed or directly palpable fascia, muscle,</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury."</p> <p>A Wound Management policy dated 1/14/14 states, "A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s)...Any condition that may contribute to the resident's risk of developing an ulcer and that may affect functional independence or alter the healing process will also be treated."</p> <p>R1's pressure ulcer risk assessment dated 10/11/16 documents R1's ability to respond meaningfully to pressure-related discomfort was very limited. R1's ability to walk is severely limited or non-existent. R1 can make occasional slight changes in body or extremity position, but is unable to make frequent or significant changes independently. R1 has probable inadequate nutritional intake, requires moderate to maximum assistance in moving, and has a potential problem with friction and shear damage to the skin. R1's pressure ulcer risk assessment also documents that R1's skin is not constantly moist, but is often moist requiring linens to be changed at least once per shift.</p> <p>R1's Minimum Data Set (MDS) assessment dated 10/11/16 documents R1 requires the extensive assistance of two people for toileting and bed mobility, and is always incontinent of bowel and bladder. R1's MDS dated 1/11/17 documents R1 totally dependent on staff for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene, and is always incontinent of bowel and bladder. R1's</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>MDS also documents R1 has a functional limitation in range of motion to both lower extremities.</p> <p>R1's care plan dated 10/5/15 documents, "R1 has potential impairment to skin integrity... instructing staff to, identify/document potential causative factors and eliminate where possible. Keep skin clean and dry." R1's care plan intervention dated 10/12/15 documents to, "Check R1 at least every two hours and as required for incontinence."</p> <p>R1's CNA (Certified Nurse Aide) Skin Attention Forms dated 11/15/16 to 11/22/16 document R1's coccyx (At the top and center of the buttocks) had an area that the CNA, "noticed an abnormality or change in color, moisture, temperature, integrity or turgor." That area was marked as an X on the Skin Attention Form. Each of these forms was signed by R1's nurses indicating the nurses completed a "follow up" to the Skin Attention Forms. R1's CNA Skin Attention Form dated 11/29/16 was not initialed by R1's CNA indicating there were, "No skin problems noted."</p> <p>R1's nurses' notes dated 10/30/16 to 1/31/17 show that there were no nurses' notes from 10/30/16 until 11/15/16. The 11/15/16 note states, "no new issues at this time." R1's nurses' note dated 11/18/16 documents that no skin issues were reported. R1's nurses' notes dated 11/27/16 states, "No recommendations," as the only entry. R1's next nurses' note was not until 12/8/16 which documents R1 has a wound to the sacrum. R1's nurses' notes date 1/17/16 states, "IDT (interdisciplinary team) met for quarterly review...Weight has been stable over the last quarter (10/11/16 to 1/11/17)."</p> <p>A Weekly Pressure Ulcer Surveillance Report</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER WASHINGTON CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 NEWCASTLE WASHINGTON, IL 61571
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(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
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S9999	<p>Continued From page 12</p> <p>dated 1/25/17 documents R1 developed a facility acquired stage 4 pressure ulcer to the coccyx on 11/30/16.</p> <p>R1's Wound Care Specialist Evaluation dated 11/30/16 documents R1's coccyx wound was the result of shear and measured 4.0 cm (centimeters) long X 2.0cm wide X Not measurable depth on that date.</p> <p>R1's Wound Care Specialist Evaluation dated 12/7/16 documents R1's wound had deteriorated as a result of ineffective pressure relief to R1's coccyx while in the chair.</p> <p>R1's Wound Care Specialist Evaluation dated 12/14/16 states, "Necrosis much deeper now, consistent with pressure injury not shearing." The evaluation also documented R1's wound was considered unstageable on that date.</p> <p>R1's Wound Care Specialist Evaluation Dated 1/4/17 documents R1's Coccyx wound had deteriorated into a stage 4 pressure ulcer measuring 4.5cm long X 4.5cm wide X non-measurable depth.</p> <p>A Hospice Nurse's note dated 1/12/17 states, "to assess coccyx wound. R1 has a stage 4 pressure injury located on the coccyx. The wound measures is full thickness tissue loss with small area of bone exposed...measures 6.8cm X 4.4cm X 1.9cm...Majority of wound bed is covered in slough and eschar."</p> <p>A Hospice Nurse's note dated 1/23/17 at 3:31p.m., states, "Upon arrival...R1's (incontinence brief), draw sheet and bed sheets soaked with urine. R1's top and pants also wet with urine. R1 was also incontinent of small</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>amount of stool...Requested that R1's (incontinence briefs) be checked every two hours and that R1 be turned and repositioned in bed at that time...R1 is dependent on facility staff for all ADL's (activities of daily living)... At 3:55p.m., attended care plan meeting at facility today...Voiced concern that R1's (incontinence brief), clothing, and bed linens were soaked with urine this morning upon arrival. Was informed that these matters would be addressed."</p> <p>A Hospice Nurse's note dated 1/26/17 at 10:00a.m. states, "Upon arrival...Wound draining a moderate amount of serosanguinous exudate that is foul smelling... Z1 (R1's physician) stated that when Z1 saw R1 earlier this morning for assessment Z1 found R1 lying in bed with linens, clothes, and (incontinence brief) soaked with urine. R1 was also incontinent of stool."</p> <p>On 2/1/17 at 10:20a.m. E5 (Registered Nurse/RN) was preparing to change R1's pressure ulcer dressing. E5 and E6 (CNA) removed R1's pants and incontinence brief. R1's incontinence brief as well as R1's stage 4 coccyx pressure ulcer dressing were saturated with urine. R1's wound was a large deep wound approximately 6cm long X 4.5cm wide X 4cm deep with undermining deep enough that bone was visible within the wound.</p> <p>On 2/1/17 at 3:15p.m. E5 (RN) stated, "I've come in to work in the morning before and hospice has come to me stating R1 was soaked, the whole bed and clothing soaked. One time the hospice nurse asked me to help turn R1. We pulled back the covers and R1 was soaked. R1's (incontinence brief) and bottom covers too. Z1, on Wednesday last week, found R1 wet also. Z1 said to make sure R1 was dry, turned, and</p>	S9999		

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S9999	<p>Continued From page 14 repositioned."</p> <p>On 1/31/17 at 10:00a.m., Z1 stated that the facility was not providing R1 with appropriate incontinence care. Z1 stated that (Z1) and R1's hospice nurses have found R1 soaked with urine on multiple occasions. Z1 stated that on 1/26/17, Z1 entered R1's room to do an examination. Z1 stated, "I touched R1's covers and they were saturated from the fitted sheet through to the comforter. R1 also had feces around her mouth and under her fingernails. I told a CNA and she said R1 really wasn't on her hallway but that she could clean R1 up after she finished with her patient." Z1 stated that as a result of R1's poor incontinence care, R1's coccyx pressure ulcer became infected and the bone was infected with Osteomyelitis. Z1 stated that R1's wound had a foul smelling purulent discharge draining from it. Z1 stated that R1's stage 4 pressure ulcer was caused from unrelieved pressure and from R1 laying in her own waste. Z1 stated that as a result of the severity of R1's pressure ulcer and because the exposed bone within R1's wound has developed Osteomyelitis, R1's death is imminent.</p> <p>On 2/2/17 at 10:30a.m. E1 (Administrator) stated that R1 had passed away during the previous night.</p> <p>(A)</p>	S9999		
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