

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2017
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1095 TWILIGHT DRIVE MORRIS, IL 60450
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S 000	Initial Comments Complaint Investigation 1773074/ IL 94212	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d) 2) 300.1210 d) 3) 300.1210 d) 5) 300.3240 a) 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	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

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

TITLE

(X6) DATE

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S9999	Continued From page 1 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. (B) 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 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.	S9999		

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S9999	<p>Continued From page 2</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 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>Based on observation, interview and record review the facility failed to identify declining wounds, notify the doctor and treat wound deterioration for residents with pressure sores.</p> <p>As a result R1 was hospitalized and diagnosed with severe septic shock due to an infected left heel wound. This applies to 2 of 3 residents (R1, R2) reviewed for pressure sores.</p> <p>The Findings Include:</p> <p>1). Face Sheet documents R1 was admitted on April 28, 2016 with the following pertinent diagnosis Alzheimers.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>On May 23, 2017 at 9:07 AM, Z2 said R1 was admitted with a left heel wound which according to the wound care nurse was healing. Z2 said R1 is now hospitalized with a left heel infected and necrotic wound.</p> <p>Wound Care Notes were reviewed from March 2017 through May of 2017. Wound Care Note dated March 10, 2017 states, R1 was admitted with an unstageable left heel wound on December 16, 2016. Wound Care Note dated May 15, 2017 documents R1's left heel wound was healing, developed 10% necrosis with beefy red granulation tissue and measured 3.0 centimeters in length by 3.0 centimeters in width by .3cm in depth with decreased slough.</p> <p>Physician Orders dated May 5, 2017 states to clean the left heel deep tissue injury wound with normal saline, skin prep, apply medi-honey to area, cover with alginate and secure with kerlix. The physicians order was changed on May 16, 2017 to clean the left heel deep tissue injury with normal saline, skin prep, apply medi-honey to area, cover with alginate and secure with kerlix every 3 days and as needed.</p> <p>The Medication Administration Records's were reviewed from April 1 to May 18, 2017. The records document the last time R1's left heel wound was treated was May 16, 2017. There was no assessment of the wound on the May 17 or May 18, 2017.</p> <p>Nursing Progress Notes dated May 18, 2017 document " R1's roommate alerted staff to R1's loud breathing, R1 observed in respiratory distress, vitals, 79% oxygen saturation on room air, respirations 32, Temperature 104.2 axillary.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Oxygen supplied, Acetaminophen given, cool wash cloth place on forehead, bilateral axillary and in groin area. Medical Doctor paged returned call to send to the emergency room via ambulance. Power of attorney notified.."</p> <p>Emergency Room Record dated May 18, 2017 was reviewed. The Record documents R1 was admitted with Severe Sepsis, Septic Shock and Urinary Tract Infection. The Emergency Room Report contained Pictures of R1's wounds. The Left heel wound was necrotic and infected. The wound covered the entire left heel.</p> <p>On May 24, 2016 at 8:36AM, E15 (Nurse) said she was the nurse who sent R1 out on May 18, 2017 and the care she provided was documented in the note. E15 worked with R1 as the assigned nurse from May 16, 2017 through May18, 2017. E15 had no response for treatment of the heel wound.</p> <p>On May 24, 2016 at 9:12AM, R1 was in the hospital sitting in an adult recliner, with bilateral heel dressings on. R1 was confused and did not communicate.</p> <p>On May 24, 2016 at 9:17AM, Z1 (Hospital Nurse) said R1 came into the hospital with a necrotic left heel wound that was severely infected, someone at the nursing home should have known about the condition of the left heel wound.</p> <p>On May 24, 2017 at 10:20AM, E3 (Wound Care Nurse) said if the wound was not improving the physician should have been contacted to get orders. After viewing pictures of R1's left heel wound from the hospital, E3 could not explain what happened to the healing wound. E3 said the last wound description was on May 16, 2017 and</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>the floor nurse should have treated the wound afterwards. The Treatment Administration Record dated May 2017 documents the last time the wound was treated was on May 16, 2017, there was no assessment or treatment noted on May 17, or May 18, 2017.</p> <p>On May 25, 2017 at 11:03AM, Z3 (Medical Doctor) hospital and nursing home physician said R1's wound deteriorated quickly because it was infected, R1 was admitted to the hospital with severe sepsis and septic shock. When R1 was admitted to the hospital mutiple bacteria were infecting the left heel wound. R1 is currently treated with antibiotics in the hospital . Z3 said he was not made aware of the status of the wound, had he been made aware he would have prescribed treatment.</p> <p>The Facility's Policy titled Pressure Injury Prevention and Management undated states, " Treatment decisions will be based on characteristics of the wound, including the stage, size, amount of exeduate and presence of pain, infection, or non-viable tissue. The attending physician will be notified of the presence, progression towards healing or lack of healing of any pressure injuries upon identification of the injuries and at least weekly thereafter."</p> <p>2). Face Sheet doucuements R2 was admitted on April 13, 2017 with the following pertinent diagnosis, unstageable pressure ulcer to the sacral region.</p> <p>Weekly Wound Report dated May 15, 2017 documents a left ischium stage 3 wound.</p> <p>On May 23, 2017 at 10:54AM, R2 was laying in bed, there was a pervasive foul odor throughtut</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>the room. R2 said he was admitted with a sacral wound and he did not know how it looks because it is on his bottom.</p> <p>On May 23, 2017 at 11:06AM, E4 (Infection Control Nurse) said she was going to do the treatment for R2's sacral wound because the wound care nurse was scheduled off work today. R1 was laying in bed, again with a very foul smell. E4 removed a heavily saturated dressing from R1's large sacral wound. The dressing and wound contained fecal and wound drain material. The padding under R2's bottom was soiled with large amounts of serousanguineous drainage. The smell was overtly poignant. E4 said she was not the regular nurse. E4 changed the dressing and made no comment about the smell or saturation of the dressing/padding. E8(CNA) and E9 (CNA) entered the room to assist with transferring R2 from the bed to the wheelchair.</p> <p>On May 23, 2017 at 12:24PM, E9 (CNA) said she could not smell R2's wound because she was congested. E9 said R2's wound weeps constantly throughout the night and he has to lay in it until we change him in the morning.</p> <p>On May 23, 2017 at 2:32PM, R2 said his sense of smell is off and he does not know the status of his wound. R2 said they will leave him in bed all day sometimes.</p> <p>On May 23, 2017 at 3:13PM, E4 (Infection Control Nurse) said she did not smell anything other than a bowel movement with R2. E2 (DON) was present and said we will notify the doctor of the odor.</p> <p style="text-align: center;">(A)</p>	S9999		

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