

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2017
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NAME OF PROVIDER OR SUPPLIER COVENANT HLTH CR CTR-NORTHBK	STREET ADDRESS, CITY, STATE, ZIP CODE 2155 PFINGSTEN ROAD NORTHBROOK, IL 60062
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S 000	Initial Comments Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210d)5) 300.1220b)3) 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 300.1210 General Requirements for Nursing and Personal Care 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	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 06/13/17
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S9999	<p>Continued From page 1</p> <p>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</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 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</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to develop an individualized plan of care and identify/implement interventions to address immobility/poor nutrition to prevent the development of facility-acquired pressure ulcers for a resident.</p> <p>This failure resulted in R1 acquiring an unstageable pressure ulcer on her left heel, an unstageable pressure wound on her right heel and a Stage 2 sacral pressure wound at the</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>facility.</p> <p>This applies to 1 of 2 residents (R1) reviewed for new or worsened pressure ulcers in a sample of 16.</p> <p>The findings include:</p> <p>Physician order sheet (POS) dated May 1-23, 2017, showed that R1 was admitted on March 17, 2017. POS showed R1's diagnoses included fracture of the right femur and closed fracture with routine healing, orthopedic aftercare, difficulty in walking, type 2 diabetes without complications, and muscle weakness. The MDS (Minimum Data Set), dated March 24, March 31 and April 14, 2017, all showed that R1's cognition was intact and required the assistance of two staff members for bed mobility and transfers.</p> <p>Facility Admission Data Collection and Documentation form dated March 17, 2017, showed that R1 was alert and oriented to person/place and time. R1 did not have edema of both lower extremities. The form showed that R1 had a surgical scar to her sternum, scratch marks to her right upper arm, a surgical scar to her abdominal area, a peripheral line inserted to her right arm, ten staples to R1's right upper hip, sixteen staples to the right hip, and three staples to the right incision above the knee. No pressure ulcers were identified on the Admission Data Collection form. R1 had an indwelling urinary catheter on admission. R1's POS showed that the indwelling urinary catheter was discontinued per physician order on April 13, 2017. R1's Braden Scale score was assessed as 16.</p> <p>On May 22, 2017 at 9:45 AM during initial tour of the facility with E2 (Director of Nursing), E2 was</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>asked why R1 developed pressure ulcers after admission to the facility. E2 responded that R1's pressure ulcers were the result of poor nutritional intake and decreased movement.</p> <p>On May 22, 2017 at 12:40 PM in R1's room, R1 was sipping a nutritional supplement. R1 stated she had not been eating at the facility but noted some improvement in appetite recently. R1 stated, "Apparently I was in bed when I first got here - just laying here..." R1 also stated, "something killed my appetite!"</p> <p>On May 23, 2017 at 9:05 AM, R1 was sitting upright in bed with her head of bed at 45 degrees and slowly nibbling on breakfast. R1 had a pillow under her knees and protective boots on both feet. R1 did not have pillows under her calves or heels. R1's bilateral heels were resting on the bed. At 9:20 AM, E7 (Registered Nurse) examined the position of R1's heels and stated, "It should be off more. We should have used more pillows."</p> <p>On May 27, 2017 at 12:20 PM, E8 (Certified Nursing Assistant) stated that R1 did not want to get out of bed and her tolerance sitting in the wheel chair was not good when she was admitted. E8 stated that two staff were needed to turn and change R1 in bed. E8 also stated that R1 was in a lot of pain on admission and could not assist with repositioning in bed. E8 stated that he would offer to turn R1, however, R1 would complain that she could not see the television. E8 said that the staff would encourage R1 to sit in the wheelchair, however, R1 preferred to be in bed. E8 described the proper way to off-load the heels by placing a pillow under a resident's calves so there is no pressure placed on a resident's heels. E8 further stated that the heels should not</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>be in contact with the bed.</p> <p>Nursing notes dated March 17- 22, 2017, showed that R1 required extensive assistance of two staff for transfers and toileting. Nursing notes showed that R1's pain was being managed by morphine and tramadol. The nursing notes dated March 18, 2017, showed that R1 "rested quietly in bed throughout the day, pain is increased by position changes." The notes lacked documentation regarding R1 being turned or repositioned, the use of heel protectors or R1's heels being floated while in bed. The nursing notes did not show any concerns with R1 refusing care, declining turning or repositioning or declining to have her feet off-loaded.</p> <p>ADL (Activities of Daily Living) Verification Worksheet dated March 18-March 22, 2017, showed that R1's meal intake on March 19 and March 22, 2017 was less than 25 % for all three meals and the rest of the days it was less than 25 to 50 %.</p> <p>The Nursing notes dated March 22, 2017, showed, "This RN (Registered Nurse) called to resident's room by staff reporting wetness on sheet by BLE (Bilateral Lower Extremities). Writer assessed to find resident with two intact blisters on bilateral heels measuring, one small bluish discoloration on right great toe, and an excoriation on right upper leg distal to incision. R1's blister on the right heel measured 66 cm (centimeters) by 7 cm, intact (writer did not observe opening) with clear fluid. The blister on left heel measured 4 cm by 4 cm, intact (writer did not observe opening) with clear fluid. Bluish discoloration on right great toe, non-blanchable, skin was intact, measuring 1 cm by 1 cm. Excoriation on right upper leg measuring 2 cm by</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>1 cm with scant sanguineous drainage. No signs/symptoms of infection present on wounds. Resident was unable to describe when or how the wounds occurred. R1 said, "I don't know how it got there." R1 did not complain of pain at sites. Writer informed Z1 (Advanced Practice Nurse) with new orders carried out. Bunny boots placed on BLE. Skin prep applied to blisters, heels floated while in bed, elevated while in chair. Low air loss mattress ordered. Care plan updated."</p> <p>The APN (Advanced Practice Nurse) notes dated March 22, 2017, showed, "Evaluation of blisters to BL (Bilateral) lateral heels noted this am. No injury, no fall, no prior history of similar symptoms in past. No any other associating symptoms. No fever, chills, numbness or tingling or extremities. Patient also denies pain. Patient was unable to describe when or how wounds occurred. Patient appeared more awake and alert.... Plan: ...Blisters, Pressure ulcers. Start skin prep BID (twice daily) to bilateral heels (blisters). Wear bunny boots and float heel while in bed and continuously 24 hours. Refer to wound doctor to eval and treat. Monitor skin integrity every shift. Reposition patient per facility protocol.... Nutrition support...."</p> <p>Wound Care Specialist Evaluation dated March 24, 2017, showed that R1 had an unstageable DTI (Deep Tissue Injury) of the left heel and the etiology was pressure. The duration of the wound was less than one day and the wound measured 5.5 cm by 5 cm. Wound evaluation shows R1 had an unstageable DTI of the right heel, the etiology was pressure, and the wound measured 5.5 cm by 5 cm. Recommendations for both heel wounds include off-loading of the wound and reposition per facility protocol. The wound evaluation describes R1's appetite as "good" and</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>does not indicate any sacral wounds on examination. The wound evaluation shows "Factors complicating wound healing: Diabetes mellitus without mention of complications - type II or unspecified type - not stated as uncontrolled, anemia - unspecified."</p> <p>The POS dated March 22, 2017, showed the physician orders for floating heels when in bed, monitor skin integrity to bilateral heels, reposition per facility protocol, and off-load wound.</p> <p>R1's care plan initiated and effective March 22, 2017, showed that R1 was identified as, "At risk for impaired skin integrity evidenced by actual skin breakdown; bilateral intact blisters on heel, sacral redness, and excoriation on right hip. The approaches all initiated on March 22, 2017, included offloading heels while in bed and chair, bunny boots bilaterally at all times, remove for integrity checks twice daily, reposition per facility protocol and encourage food and fluid intake."</p> <p>ADL Verification Worksheet, dated March 23-28, 2017, shows R1's meal intake for March 23 and March 24, 2017 was less than 25% for all three meals and rest of the time R1's intake was 25 % to 50 % with occasional 75 % consumed.</p> <p>Nursing note, dated May 29, 2017, shows a low air loss mattress was delivered to R1. Physiatrist note, dated March 29, 2017, shows R1's Doppler to her right lower extremity, was negative.</p> <p>Wound Care Specialist Evaluation, dated March 31, 2017, describes R1's appetite as "good" and shows R1's left heel wound had no changes however R1's right heel wound deteriorated. R1's right heel wound measurements were 6 cm by 6 cm.</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>ADL Verification Worksheet, dated March 31, 2017 to May 3, 2017, show R1's meal intake was usually <25-50% of most meals with an occasional meal consumed 75% or 100%.</p> <p>Wound Care Specialist Evaluation, dated April 7, 2017, shows R1's left heel had no change. R1's right heel now included the description as unstageable (due to necrosis) and included the description of thick adherent black necrotic tissue (eschar) covering 50% of the wound. R1's right heel wound size decreased to 5 cm by 6 cm. Wound evaluation included a new Stage 2 pressure wound on R1's sacrum which was less than 11 day in duration. The sacral wound measured 2 cm by 0.8 cm by 0.1 cm with light serous exudate noted. The wound description included "moisture associated with skin damage." Recommendations included off-load wound, reposition per facility protocol, multivitamin, zinc and Vitamin C supplementation, a low air loss mattress, complete blood count, comprehensive metabolic profile, and prealbumin lab draws. R1's wound was surgically debrided to remove necrotic tissue and establish the margins of viable tissue.</p> <p>POS, dated April 6, 2017, shows R1 received a physician order for an oral nutritional supplement to be given twice a day.</p> <p>Advanced Practice Nurse notes, dated April 13, 2017, shows "Patient complains of feeling 'very tired' in past two days. She states she has not been able to participate in therapy and 'cannot stay awake.' She is also complaining of having poor appetite...."</p> <p>Nutrition 30 Day / Skin Assessment, dated April 13, 2017, shows R1's most current weight as 181</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>pounds and "PO intake is fair and she is encourage to eat, take fluids and drink [supplement]. Will continue to monitor PRN." No further nutritional interventions were recommended for R1's poor PO intake.</p> <p>POS, dated April 13, 2017, shows R1's indwelling urinary catheter was removed.</p> <p>Advanced Practice Nurse notes, dated April 19, 2017, show "DP (Dorsalis Pedis) pulses intact, sensation intact, circulation intact."</p> <p>Wound Care Specialist Evaluation, dated April 26, 2017, shows R1's left heel wound was described as a Stage 3 pressure wound measuring 4 cm by 1.8 cm, 100% thick adherent black necrotic tissue (eschar). R1's right heel continued to be unstageable, measured 4 cm by 5.5 cm, and included 70% eschar. R1's stage 2 sacral pressure wound measured 1.8 cm by 0.6 cm by 0.1 cm with light serous exudate.</p> <p>Wound Care Specialist Evaluation, dated May 19, 2017, shows R1's Stage 3 pressure wound of the left heel measured 3.5 cm by 1,8 cm and was 100% eschar. R1's left heel wound was debrided. R1's right heel unstageable wound measured 4 cm by 5.5 cm and was 60% eschar. The right heel wound was surgically debrided. R1's stage 2 sacral pressure wound measured 1.5 cm by 0.5 cm by 0.1 cm with light serous exudate.</p> <p>Wound Care Specialist Evaluation, dated May 19, 2017, show little changes in heel or sacral wound measurements. Both heels were again surgically debrided.</p> <p>Wound Care Specialist Evaluation, dated May 24,</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>2017, shows "Stage 3 Pressure wound of the left heel was 100% eschar measuring 3.5 cm by 1.58 cm and R1's unstageable of the right heel was 60% eschar and measured 3.8 cm by 5.5 cm. The stage 2 pressure wound to the sacrum measured 1.5 cm by 0.5 cm by 0.1 cm.</p> <p>On May 24, 2017 at 11:10 AM R1's skin was checked with E7 (Registered Nurse). R1 had pressure sores on the left heel, right heel, and sacrum as described above. R1 also had two small areas of skin breakdown on the right and left buttocks. The area on the left buttock measured 0.8 cm by 0.8 cm by 0.1 cm. The area on the right buttocks measured 0.5 cm by 0.5 cm by 0.1cm.</p> <p>Advanced Nurse Practitioner note, dated May 11, 2017, shows R1's appetite is described as "poor." Progress note shows, "Plan: Weight loss, nutrition eval, nutrition support, check weights weekly." Physical examination shows, "General: frail..."</p> <p>On May 25, 2017 at 10:20 AM, Z1 (Advanced Nurse Practioner) stated she had followed R1 since she was admitted to the facility. Z1 stated R1 may have developed the heel breakdown due to high doses of morphine and R1 not being able to move in bed. Z1 stated R1 was very lethargic due to the morphine and was not able to move independently in bed. Z1 stated R1's heel ulcers declined so Z1 ordered a wound physician to follow R1's wounds. Z1 also stated R1 was depressed and R1's appetite was fair. Z1 stated that R1 had altered mental status due to depression which contributed to poor food intake which could contribute to the deterioration of the pressure ulcers.</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>On March 25, 2017 at 11:45 AM, Z4 (Dietician) stated if she had been aware R1 was eating only 25-50% of most meals in the five days prior to the development of R1's pressure ulcers, she would have been concerned. Z4 stated R1 only "started losing a lot of weight recently." Z4 confirmed there were no new nutritional interventions recommended for R1 after R1's weight loss of ten pounds from April to May, 2017 was identified and R1 continued to have three documented facility-acquired, pressure ulcers.</p> <p>The Facility's policy titled, "Prevention of Pressure Ulcers", dated July 1, 2009, showed, "Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues.... If pressure ulcers are not treated when discovered, they quickly get larger.... Pressure ulcers are often made worse by continual pressure, ...decline in nutrition and hydration status.... Ensure that the resident drinks plenty of fluids and eats a well-balanced diet." The document shows, "1. Risk Factor: Bedfastness/ Chairfastness Preventive Actions: For a person in bed - change position at least every two hours; use a special mattress that contains foam, air, gel, or water, as indicated.... 2. Risk Factor: Immobility Preventive Actions: ...When in bed, every attempt should be made to 'float heels' (keeping heels off the bed) by placing a pillow from knee to ankle or use of other devices.... 4. Risk Factor: Poor Nutrition Preventive Actions: Monitor nutrition and hydration status. Encourage proper dietary and fluid intake. If a normal diet is not possible, talk to physician about supplements."</p> <p>The Facility policy titled. "Turning A Resident On</p>	S9999		
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S9999	Continued From page 11 His/Her Side Away From You", dated July 1, 2009, showed, "The purposes of this procedure are to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment." Policy shows, "The following information should be reported to the staff/charge nurse and should be documented in the resident's clinical record: 1. The date and time the procedure was performed.... 6. Any problems or complaints made by the resident related to the procedure. 7. If the resident refused the treatment and the reason(s) why. 8. The signature and title of the person recording the data." (B)	S9999		
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