

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009112</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST PAUL'S HOUSE &amp; HLTH CR CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3800 NORTH CALIFORNIA AVENUE CHICAGO, IL 60618</b>
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S 000	Initial Comments  Annual Licensure and Certification Survey	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1010h) 300.1210b) 300.1210c)3) 300.1210d)5) 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	S9999		

**Attachment A**  
**Statement of Licensure Violations**

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

TITLE

(X6) DATE

08/23/17

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S9999	<p>Continued From page 1</p> <p>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</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>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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> <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,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</p> <p>These regulations are not met as evidence by:</p> <p>Based on observation, interview, and record review the facility failed to: assess and manage pain, medicate a resident for pain before wound care treatment, and ensure that a resident did not experience pain during wound care treatment according to facility policy for pain management. This deficient practice affected 2 residents (R2, R6) reviewed for pain. 2) the facility failed to follow their pressure ulcer prevention policy and procedures by failing to prevent the development of a new pressure ulcer and the healing of a current pressure ulcer for 1 high risk resident (R2) of 4 residents reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R6's Profile Face Sheet documents a readmission date of 7/21/2017. The following medical diagnosis are listed, in part: Chronic pain, Hypertension, Chronic Kidney Disease, Anemia</p>	S9999		
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S9999	<p>Continued From page 3 and Hyperlipidemia.</p> <p>On 7/24/17, the facility submitted a pressure sore list that indicated R6 was admitted to the facility with a Stage 2 sacral pressure sore. R6's Skin Evaluation Form dated 7/21/17 documents a Stage 2 coccyx pressure sore which measured 1.0 centimeter in length, 1.1 centimeter width and 0.01 centimeter depth.</p> <p>R6's Physician Order Sheet (POS) documented the following wound care treatment: Cleanse with normal saline, pat dry and apply hydrogel on coccyx area and cover with foam dressing daily and as needed.</p> <p>R6's initial pain evaluation documents that R6 has chronic intermittent pain in R6's legs. This form also documents that possible indicators of R6's pain are as follows: Nonverbal sounds-crying, whining, gasping, moaning and groaning) and Vocal complaints of pain (that hurts, ouch, stop).</p> <p>R6's Medication Administration Record (MAR) dated 7/25/17 documents that R6 received Norco 5-325 mg (milligrams) one tablet at 12:15pm. E12 (RN-Registered Nurse) indicated that the pain pill was initially given in preparation for R6's wound treatment but physical therapy came to work with R6.</p> <p>R6's MAR denotes that from 7/22/17 through 7/25/17, R6 received Norco three times on 7/22/17 for back pain.</p> <p>On 7/25/17 at 2:45pm, E12 stated, "I gave (R6) one tablet of Norco at 12:30pm. I'm not so sure if it wore off." E12 proceeded to explain the wound care procedure to R6. E12 did not ask R6 if R6 was in any pain. E12 and E22 (CNA-Certified Nurse Assistant) turned R6 onto R6's right side. It was visible that R6 was experiencing discomfort</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>with the position change. E22 stated, "I'm sorry." E12 started to peel off the adhesive dressing that covered R6's coccyx wound. R6 stated, "Ouch. Oh my god, ouch." E12 apologized and continued to slowly remove the dressing while R6 continued to be verbal about the pain. E22 rubbed R6's left arm in an attempt to comfort R6. As E12 continued to peel back the dressing, E22 encouraged R6 to, "Hang in there." R6 started to moan and cry. E12 stated, "I'm sorry. I wish I could hurry." R6 stated, "It hurts so much." E12 apologized again. As E12 cleansed R6's pressure sore with normal saline, R6's body tensed up as she audibly groaned. When E12 applied the hydrogel to the wound, R6 covered R6's mouth with R6's left hand and started to cry. E12 asked E22 how R6 was. E22 stated, "She's hurting" to which E12 responded, "Almost done."</p> <p>R6's initial MDS (Minimum Data Set) dated 6/27/17 documents a Brief Interview of Mental Status (BIMS) score of 14 out of 15 which indicates that R6 is cognitively intact.</p> <p>On 7/25/17 at 3:10pm, R6 stated, "Usually, it hurts that much (when they do the dressing). Right now pain is 7-8. During the procedure, it was 9. Hurt most when she pulled dressing off. But also hurt a lot when they were cleaning the wound. That's why I hate having it changed. For that reason."</p> <p>On 7/25/17 at 3:35pm, E12 stated, "I usually do the wound care for (R6). She went to the hospital with Stage 1 in sacrum. Came back with Stage 2. Gave Norco at 12:30pm. Should have stopped the treatment and addressed her pain. Provide comfort measures or offer more pain medications."</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>E12's Interdisciplinary Note dated 7/25/17 denotes that R6 complained of pain during wound care treatment despite administration of pain medication.</p> <p>R6's Care Plan regarding pressure ulcers documents, in part: Approach: Give PRN (as needed) pain medication prior to dressing change.</p> <p>A Care Plan addressing Comfort/Pain reads, in part: Approach: Administer PRN and scheduled pain medication as ordered. Evaluation: Will monitor and inform MD (Medical Doctor)/NP (Nurse Practitioner) if resident does not express relief with current pain. Approach: Anticipate needs. Administer PRN pain medication before doing wound care.</p> <p>A policy dated 3/25/14 and titled, "Pain Management" documents, in part: We will achieve these goals through: Recognizing and evaluating the resident for pain to determine causes and characteristics of the pain as well as factors influencing the pain. Recognizing and providing measures to minimize or prevent pain for situations where pain could be anticipated. Monitoring the effects of interventions and modifying the approaches as needed.</p> <p>R2 is an 83 year old resident admitted to the facility on 1/13/17 per facility face sheet dated 7/24/17 and diagnoses listed in part with dysphagia, spinal stenosis, stage 4 pressure ulcer sacral region, hypothyroidism, and cerebrovascular disease.</p> <p>Physician order sheet dated 7/1/17 show "Sacral wound- apply antifungal cream daily during dressing change; turn and reposition every 2 hours and PRN (as needed); Off-load sacral</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>wound"</p> <p>Care Plan for R2 dated 6/5/17 states in part, "Goal: Resident will not develop further pressure sore. Approaches: Assess skin daily during care--if open or bruised areas noted, report to Nurse, MD and responsible party. Evaluation: Resident at times screams during dressing change when being asked if she's oke but is redirectable. Per wound nurse, resident noted with screaming during dressing changes at times but not daily. Staff to monitor for pain during treatments and provide PRN meds if needed prior to procedure."</p> <p>MDS (Minimum Data Set) dated 5/26/17 shows R2 unable to complete the brief interview for mental status indicating cognitive impairment. R2's bed mobility shows that she requires extensive assistance during self performance and actual one person physical assistance. All other activities of daily living show that R2 being total dependence on staff for toileting, eating and transferring.</p> <p>Section on skin conditions (Section M) of the same MDS shows resident at risk of developing pressure ulcers and shows one stage 4 pressure ulcer that is unhealed and present upon admission of 1/13/17.</p> <p>Skin and ulcer treatments for R2, show resident on a pressure reducing device for chair, bed; a turning and repositioning program, nutrition and hydration intervention, pressure ulcer care, application of nonsurgical dressings, and application of ointments/medications.</p> <p>Facility skin assessments provided by E8 (Wound care nurse) show initial assessment of wound upon 1/13/17 admission with the pressure ulcer measuring 1.5cm length X 1.2 cm width X 0.3</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>cm.</p> <p>Proceeding skin assessment dated 1/23/17 show the wound worsening and increasing in size and depth to 3.0cm length X 2.5 cm width X 0.6 depth.</p> <p>Skin assessment dated 3/27/17 show the pressure ulcer worsening again in width from an original 1.2 centimeters to 1.5 centimeters.</p> <p>Skin assessment dated 4/17/17 show the depth of the pressure ulcer worsening from an original 0.3 centimeters to 0.7 centimeters.</p> <p>During initial tour with E6 (LPN-licensed practical nurse) on 7/24/17 at 10:09AM, R2 was laying in bed asleep on R2's back.</p> <p>At 11:30 AM, R2 was still in bed asleep in the same position laying on R2's back.</p> <p>At 12:45PM, R2 did not change positions, remained asleep, and still flat on R2's back.</p> <p>From 1:30 through 3:00 PM, no staff entered R2's room and was observed still in the same position on R2's back. R2 was awake and had R2's eyes open.</p> <p>Surveyor went to nursing station and asked E6 if (R2) would be gotten up today, E6 responded, "She is only gotten up from bed on Tuesdays, Thursdays, and Saturdays."</p> <p>Asked if R2 has an order for bed rest, E6 responded, "No, this is a family preference."</p> <p>Asked if the family was ever educated on the risks for remaining in bed, E6 responded, "I'm not</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>sure sir."</p> <p>Review of records show no patient or family teaching referring to days R2 would be gotten up from bed.</p> <p>Request for records showing any care plan conference indicating family preference for R2 to remain in bed revealed no evidence to show such request.</p> <p>Interview with Z6 (R2's power of attorney) 7/27/17 at 10:45AM states in part:</p> <p>Asked if their preference was for (R2) to be gotten up from bed every other day, Z6 stated, "No. We never would say that. In fact when I do visit along with my other sister, we tell them to get her out of the room so she can experience another environment. This is upsetting to hear."</p> <p>Asked if they were educated at all on the risks of remaining in bed, Z6 stated, "Well I already know that, but like I said I would not want my sister (R2) to be in bed all day, every day, so there would be no reason for them to tell me the risk, but no I was not informed of that either."</p> <p>Asked if Z6 was informed of a newly developed pressure ulcer on R2's back, Z6 stated, "No, I was not told."</p> <p>Telephone interview on 7/27/17 at 10:45AM with Z6 (R2's sister and power of attorney) states in part, "I was contacted yesterday about getting pain medication but the young man I spoke to didn't mention she was in pain during wound care."</p> <p>Asked if Z6 was informed about a new pressure</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>sore, Z6 responded, "No they didn't tell me that."</p> <p>Z6 continued, "I know she has one above her butt but is this new one?"</p> <p>Surveyor clarified with Z6 who responded again, "Well, no they did not tell me that at all."</p> <p>The pain assessment interview section in the same MDS (section J0200) is left blank or scored zero for no pain exhibited by R2 however a care plan presented shows R2 screams during wound care.</p> <p>The CAA (Care Area Assessment) summary of the MDS dated 5/26/17 states in part, "Pain: Resident noted with no complaints of pain at this time, with facial grimace at times but denies pain, with diagnoses of status post laminectomy due to spinal stenosis and with stage 4 to sacral at this time will proceed to care plan.</p> <p>On 7/25/17 at 8:40AM during R2's wound care observation performed by E6 (LPN-licensed practical nurse) with the assistance of E9 (c.n.a.-certified nurses aide), the following was noted:</p> <p>E6 (licensed practical nurse) went into R2's room to wash E6's hands in the bathroom and proceeded to walk out of the room and gather E6's supplies to perform the wound care treatment. E6 opened up the treatment cart with E6's washed and ungloved hands, grabbed several supplies out of the cart, closed the cart, flipped through the treatment book, then re-entered R2's room without rewashing E6's hands.</p> <p>E9 (c.n.a.-certified nurses aide) came into the room donning gloves and did not wash E9's</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>hands prior to handling R2. E9 placed both unwashed and gloved hands on R2's hips to turn R2 and removed R2's incontinence brief revealing a very moist and macerated skin around R2's reddened sacral pressure ulcer. Neither E6 nor E9 asked R2 whether R2 was ok or not.</p> <p>E6 proceeded to cleanse the pressure ulcer with saline solution whereupon, R2 screamed, "Ow,ow,ow,ow, ow" five times while E6 continued on with the procedure and did not stop. E6 then placed medication cream around the pressure ulcer whereupon R2 recoiled back and grimaced with discomfort. Again, E6 continued on with the treatment without stopping nor asking R2 whether E6 should continue or not.</p> <p>After the procedure, E6 placed an incontinence brief back on R2 and proceeded to place R2 on R2's back but did not inform R2 they were done nor asked how R2 was feeling. The surveyor asked both E6 and E9 to stop what they were doing to point something observed on R2's spine area.</p> <p>E6 remarked, "Oh I see that, it's new sir, I didn't see that before."</p> <p>E9 stated, "It looks fresh. I never saw that before either."</p> <p>Asked to describe the new sore, E6 stated, "It looks new, reddened, maybe a skin tear, I'm not sure because we cannot stage it sir, but I will inform the wound care nurse."</p> <p>Asked whether it is located on a bony prominence, E6 stated, "Yes it's right on her spine</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>area."</p> <p>Asked whether a sore acquired on a bony prominence would be considered a pressure ulcer, E6 stated, "Yes, I think so."</p> <p>Asked about whether E6 washed E6's hands coming back in the room, E6 stated, "Yes I should have washed my hands before I came back in to the room."</p> <p>E9 was also asked why E9 didn't wash E9's hands at all when entering the room, E9 stated, "I'm sorry sir, I forgot, but I used my gloves though."</p> <p>E6 was asked whether R2 was given any pain medications before performing the treatment, E6 stated, "No, sir. She used to have pain medications when she was on hospice but she doesn't get them anymore."</p> <p>Asked when R2 was discharged from hospice, E6 stated, "I think in May."</p> <p>Asked whether R2 gets any pain medications before wound care treatments, E6 responded, "No, sir."</p> <p>Asked why E6 didn't stop the procedure when R2 exhibited pain several times during the procedure, E6 stated, "Well, she's usually like that, but she's not in pain."</p> <p>Interview with E2 (DON-director of nursing) on 7/25/17 at 10:00 AM states in part, "Pain should be assessed every shift and as needed. Staff should provide pharmacological and nonpharmacological ways to alleviate pain. They should ask if they (residents) have pain on a pain</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>rating scale, validate the pain and it's severity that has to be intervened so you can provide the necessary measures."</p> <p>Asked if staff informed E2 about (R2) experiencing pain during R2's wound treatment, E2 remarked, "Yes they told me about it. We called the physician and he ordered pain medication for her now."</p> <p>Asked about the facility pain management flow sheets presented, E2 commented "it's from 7am to 7pm and form 7pm to 7am the next morning."</p> <p>Facility pain management flow sheets show for 3 months, R2 exhibited no signs or symptoms of pain for 24hours for 3 months.</p> <p>Asked how (R2) with a stage 4 pressure ulcer on her sacral area can show no signs of pain for 3 months or longer, E2 commented, "I don't know."</p> <p>Signed interview on 7/25/17 at 10:00 am with E2 (DON-director of nursing) states in part, "My expectation is that we don't expect to acquire pressure ulcers so we work to ensure we implement our skin prevention protocols for all avoidable pressure ulcers. We do skin assessments upon admission, weekly and as needed. We use pressure relieving devices as needed, pressure ulcer mattresses, elevating of heels or cushion devices. Staff reports skin and referrals as needed to the wound nurse and doctor, referrals to the dietician."</p> <p>E2 continued, "We do regular incontinence care, check and change when wet, getting them up in the morning before and after lunch, in the afternoon and evaluate them. If they are</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>heavy-wetter's we change them every 2 hours. Staff should not be double padding the bed."</p> <p>Asked why E2 brought up double padding of beds, E2 responded, "They (the staff) told me you saw that on some residents. That is not acceptable. We have inserviced the staff again about that."</p> <p>Telephone interview on 7/26/17 at 2:30PM with Z2 (Physician) stated in part: "Yes I am the physican attending to (R2). I was at the facility yesterday and what was mentioned to me was she was having pain during therapy so I ordered Tylenol." Z2 continued on, "I've had her for two months as there was another physician before I took over for her when she was on hospice at the time. So I've just had her recently as my patient."</p> <p>Asked if he was informed of R2's pain during wound care, Z2 stated, "I don't recall getting a call about that. I thought it was pertaining to her physical therapy but I may have gotten mixed up."</p> <p>Asked if Z2 was informed about a newly developed pressure ulcer on Z2's visit or via phone call Z2 stated, "No."</p> <p>Asked if a newly acquired pressure ulcer would qualify as a change of condition, Z2 stated, "Yes, it does."</p> <p>Asked if Z2 was informed of that (new pressure ulcer) Z2 stated, "I'm usually informed but I don't recall being told of that. I come to the facility almost daily for a variety of reasons, they usually speak to me about it in person and I was not</p>	S9999		

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S9999	<p>Continued From page 14 notified of that however."</p> <p>Z2 was told that the facility wrote a telephone order for a pain medication for R2 and asked again if Z2 remembers being informed about the change of condition of a new pressure sore, Z2 stated, "No I was not informed of that. Actually you're just telling me that now. As for telephone orders, I'm not usually called, they just wait till I sign it when I come in."</p> <p>Asked what Z2's expectation is related to pressure ulcer prevention, Z2 commented, "I usually speak on a normal basis with the wound care nurse at the facility and she usually updates me of any changes of condition or any new deep tissue injuries."</p> <p>Asked again, if Z2 was informed of the new tissue injury, Z2 again responded, "Correct, she did not tell me."</p> <p>Z2 continued, "Well they communicate with me and I speak to the wound care nurse and we decide if the wound care physician needs to be involved and she(wound care nurse) discusses what her recommendations are for wound management.</p> <p>Asked to comment further on Z2's expectations on pressure ulcer prevention, Z2 continued, "We monitor nutritional status, monitor any changes in weights, new injuries are reported, areas should be off-loaded, we sometimes order off-loading mattresses, I expect frequent repositioning and frequent checks on the resident."</p> <p>Asked how staff should treat pain experienced by patients based on Z2's expectations, Z2 stated, "It should be brought to my attention immediately. Pain should be reported immediately and they</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>should be able to characterize pain a little bit and that would allow me to provide an order or not."</p> <p>Z2 was told that during the wound treatment, R2 was recoiling and screaming. Z2 stated, "I was not informed of that specifically but that should be enough for staff to stop what they're doing as yes that would certainly indicate pain."</p> <p>Z2 added, "Like I said I'm in the facility often and I will see (R2) when I come in and also confer with the woundcare nurse."</p> <p>Review of Treatment Administration Records dated 7/1/17 show orders for dressing changes but no orders to premedicate or assess for pain before, during or after the treatments.</p> <p>Facility policy and procedure dated 3/25/14 titled "Pain Management" states in part,</p> <p>"The intent of this policy is to facilitate resident independence, promote resident comfort and preserve resident dignity through an effective pain management program. We will achieve these goals through:</p> <p>Recognizing and evaluating the resident for pain to determine causes and characteristics of the pain, as well as factors influencing the pain. Developing and implementing interventions for pain management for a resident experiencing pain, consistent with the resident's goals, risks, and current standards of practice. Recognizing and providing measures to minimize or prevent pain for situations where pain could be anticipated. Monitoring the effects of interventions and modifying the approaches as needed."</p> <p>This same policy goes on and states, "A standard</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>format for assessing, monitoring, and documenting pain in both cognitively intact and cognitively impaired residents will be utilized. For the purposes of this policy, pain is defined as "unpleasant sensory and emotional experience that can be acute, recurrent or persistent. Following are descriptions of several different types of pain: Acute pain is generally pain of abrupt onset and limited duration. Breakthrough pain refers to an episodic increase in pain in someone whose pain is generally being managed by his/her curent medication regimen. Incident pain refers to pain that is typically predictable and is related to a precipitating event such as movement (e.g. walking, dressing) or certain actions (e.g. wound care)."</p> <p>Procedure: Upon admission, all residents and families will receive the facility handout, "About Pain Management", encouraging residents to report pain early so pain management can be more effective. Physician Communication and Involvement: Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. Through communication with the physician will ensure an appropriate pain management plan."</p> <p>Facility policy on pressure ulcer prevention dated 4/6/17, titled, "Skin Conditions-Prevention, Assessment, and Treatment", states in part: "Any resident who is admitted without a pressure ulcer/pressure injury will not develop a pressure ulcer/pressure injury unless clinically unavoidable and a resident who has a pressure ulcer injury will receive care, services to promote healing, and prevention of additional pressure ulcers/pressure</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>injury. In implementing this guideline, the following shall apply: 1. Prevention of pressure ulcers/pressure injury will be through assessment, care plans, evaluation and monitoring of the resident in accordance with best practice standards.</p> <p>Definitions: A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. "Avoidable" means that the resident developed a pressure ulcer and that facility did not do one or more of the following: evaluate the resident's clinical condition and pressure, or pressure in combination with shear and/or friction."</p> <p>(B)</p>	S9999		
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