Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005888	A. BUILDING: _____ B. WING _____	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTOON REHAB & HCC	2121 SOUTH NINTH MATTOON, IL 61938

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S 000	Initial Comments Complaint 2269171/IL153416	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3)4)B)5) 300.1220b)2)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	Continued From page 2 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	S9999		

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S9999	Continued From page 3 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. 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) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to identify, assess, report and treat a facility-acquired sacral pressure ulcer for R1. The facility failed to provide daily cares related to preserving intact skin, including cleansing, incontinence care, repositioning, and individualized pressure relieving devices to promote healing for a resident. Significant change notifications were not made to obtain treatment and implement targeted interventions to prevent the development and worsening of a stage four pressure ulcer for a resident. This failure affects one (R1) of three residents reviewed for pressure ulcers. These failures resulted in R1 developing a Stage four facility acquired pressure ulcer contributing to R1's death. Findings include:	S9999		

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S9999	Continued From page 4 The facility Weekly Skin Check Policy revised date 1/2017 documents that it is the policy of the facility to complete skin checks by the licensed nurses for all residents weekly. The nurse will assess the individual resident's skin from head to toe, to determine if there are any new or additional skin issues present. The nurse will document any scars noted over bony prominence's. Any new wounds or skin conditions will be assessed by the nurse finding the wound or skin issue. The Wound Care Nurse will follow-up to ensure all interventions are in place. The nurse will pass information on in report and add information to the communication for continued monitoring and follow-up and the physician and resident representative will be notified of any newly identified issues. Treatment orders will be obtained and new treatments started as ordered. R1's progress notes document R1 admitting to the facility on 10/13/22. On the admission date, a skin assessment was completed with R1 being at moderate risk for skin breakdown with no breakdown documented on the sacrum. On 10/22/22, R1's skilled daily assessment documents, "a layer of skin on the coccyx/buttock that was compromised." No description, measurements, interventions, or notifications were documented. R1's activities of daily living documentation documents two baths given over the 31 days of admission, one on 10/14/22 and the other on 10/28/22. Toilet use documented on the same record documents R1 as incontinent and on 12 of the 31 days of admission, was toileted two or fewer times in a 24-hour period.	S9999		

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R1's Minimum Data Set dated 10/31/22 documents that R1 is totally dependent for toileting and bathing. Additionally, R1 requires extensive assistance with bed mobility.

On 11/6/22, R1's weekly skin report was filled out and described as a new area of skin impairment on the coccyx with no other description, measurement, or treatment was documented for the wound.

R1's physician order sheet dated 11/7/22 documents that the facility physician gave an order to clean the coccyx wound with cleanser, apply calcium alginate to the wound and cover with a border gauze. Additionally, the facility was ordered to obtain a referral to the wound physician. R1's medical records documents that this referral was not obtained. On 11/29/22 at 10:15AM, V1 Administrator stated, "They didn't even get a wound consultation because she (R1) was apparently sleeping."

On 11/8/22, V3 wound nurse completed R1's only skin and wound evaluation documenting a complete description and measurements of the sacral wound during admission to the facility. Documentation describes the wound as an open lesion of unknown age located on the coccyx, in house acquired, with a size of 8.2 centimeters by 5.5 centimeters by 2 centimeters with 80% of the wound covered by slough and no evidence of infection.

On 11/13/22, R1's progress notes document a fever with foul smelling drainage coming from the sacral wound. The facility physician ordered Augmentin 500/125 milligram antibiotic every twelve hours for the wound infection. Later that

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day, R1 fell out of a wheelchair and complained of pain. R1 was then sent to the emergency room. In the emergency department, surgery was consulted due to the size and infection in the wound, identified in the emergency room as the sacral area rather than coccyx, R1 was subsequently hospitalized to address the sacral wound.

R1's surgical notes dated 11/15/22, documents R1's sacral wound as 21 centimeters by 10 centimeters down to and including the periosteum (periosteum is a membranous tissue that covers the outer surfaces of bones) of the sacrum. R1's surgical notes dated 11/15/22 further document that the surgeon observed the wound in the operating room and due to the severity and extensiveness of this wound combined with the urinary and stool incontinence, this wound was not survivable and recommended hospice for the patient.

R1's death certificate dated 11/21/22 documents the date of R1's death as 11/20/22 cause of death stage four sacral decubitus ulcer.

On 11/21/22 at 3:22PM, V8 Certified Nursing Assistant stated, "I had told the nurse's every time I took care of (R1) that (R1's) bottom (sacral wound) was getting worse. At least a week or so after I told other nurses, I finally told an agency nurse and she told me that she was just going to put something on it with or without an order. I think that the nurses were having trouble getting an order for it, but I don't know why, but I always told them."

On 11/22/22 at 9:04AM, V3 Wound Nurse stated, "(R1's sacral wound) was probably preventable from getting so bad. I just learned about the

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wound from a third shift nurse on 11/6/22. That's when I got the order. I count on the nurses to let me know what the wounds look like."

On 11/22/22 at 9:22AM, V2 Director of Nursing stated, "(R1) was at risk for skin breakdown on admission. I would have expected them to reposition (R1) frequently and to keep her dry and to let someone know what it looked like." R1's care plan from 10/13/22 (admission) through 11/13/22 (discharge) does not include interventions such as repositioning nor maintaining a dry environment for R1's skin.

On 11/22/22 at 3:10PM V16 Wound Nurse Practitioner stated, "I spoke with the family about (R1's) condition and how this sacral wound came to be while she was in the hospital. They stated that she was often urine soaked in the facility and that (R1) would ask them to help her change her clothes. The dressing that the facility was using on the wound was not what we would expect to see on a wound like this. It certainly didn't help with healing. I saw the wound and it was tunneling in both directions from the center. This wound size was absolutely preventable."

On 11/29/22 at 10:00AM, V1 Administrator stated, "After looking at this failure, I identified that our systems failed. Nurses couldn't have been looking at this wound. We are taking this opportunity to revamp our wound program, holding staff accountable, educating, and changing facility leadership to ensure that this can never happen again. V11 Medical Director came in on November 23, 2022, and we discussed the quality plan. He stated that he did not believe that he had been given an accurate representation of (R1's) wound in size or description and that had it been communicated with him, his decision

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S9999	Continued From page 8 making would have been different. He would have either laid eyes on the wound himself, or sent (R1) to the emergency department." (A)	S9999		