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S 000	Initial Comments Complaint Investigations: 2329861/IL167122 23210096/IL167426 A Partial Extended Survey was conducted	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d) 2) 3)5) 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,	S9999		

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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

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 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)

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.

c) Each direct care-giving staff shall review

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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.

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.

These Regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement wound interventions, failed to notify resident representative of a new wound, failed to follow physician orders, failed to develop a plan of care to address all wounds, failed to assess a posterior knee wound dressing resulting in an

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S9999	Continued From page 3 avoidable traumatic wound to right contracted posterior knee for one resident (R1) reviewed for wounds in the sample of four. Findings include: Facility Policy/Pressure Ulcers/Skin Integrity/Wound Management (undated) documents: Definitions: Pressure Ulcer: 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 primarily causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. Avoidable means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: Define and Implement interventions that are consistent with the resident needs, resident goals, and recognized standards of practice; Monitor and evaluate the impact of the intervention's; and/or revise the interventions as appropriate. Wound Assessment: All interventions should be evaluated for efficacy and modified/changed as needed. Documentation: Assessment information should identify specific factors that might increase the risk of pressure ulcer development or healing of a pressure ulcer such as: decreased mobility, cognitive impairment, significant weight loss in a resident who has mobility/positioning concerns, impaired nutrition or history of impaired nutrition, non-compliance or history of non-compliance, altered sensory perception, incontinence, significant abnormal lab values, history of pressure ulcers and any decline in clinical status or co-morbid diagnoses affecting mobility/positioning or tissue tolerance.	S9999		

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Care Planning: For the resident who is at risk for developing a pressure ulcer or who has a pressure ulcer, an individualized care plan will be developed per the Resident Assessment Manual/care plan timelines. The care plan should address prevention of any skin breakdown, including shearing or friction, repositioning or "off-loading", pressure relief equipment and the care and treatment to be provided to the resident for a pressure ulcer or non-pressure wound behaviors and preferences. All care plan interventions should be revised if there is recurring pressure ulcers, a lack of progress toward healing, or if the resident acquires a new ulcer.
Routine/Ongoing Documentation: Daily and/or routine ongoing documentation should be conducted by the licensed nurse related to the resident's skin condition and the resident's response to the care and treatment of the skin. Measurements of all pressure ulcers and non-pressure wounds will be done at least weekly and with any noticeable changes.

Facility Policy/Wound Care Policy, Comprehensive Wound Program (undated) documents:
If a residents Braden score equals out to high risk, they will continue to have appropriate interventions in place deemed necessary by wound care nurse/DON (Director of Nursing). Any high-risk resident or a resident with a wound will receive the appropriate pressure relieving devices deemed appropriate by wound care nurse/DON. The designated wound nurse will weekly measure all wounds, completing weekly wound care report. The care committee will review and discuss. The facility wound care program takes into account the patient as a whole including nutrition, Braden scale, dietary

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supplements needed to heal the wound, weight loss and weekly wound changes.

Facility Policy/Wound Care Documentation and Management dated 8/25/19 documents:
It is the policy of this facility to provide wound care as needed and to record care given. Wound assessment documentation will be completed at least weekly and as changes in the wound are apparent. Weekly wound documentation will include a description of the area, including color, size, depth, location, extent of any drainage; condition of the wound area, as well as surrounding area; assess for pain. Weekly documentation of skin care will include measures used to prevent development of pressure ulcers (special mattress, protective dressings or lotions, pressure-relief devices, etc.) Also included will be any signs and symptoms of infection, cultures obtained.
Documentation of all skin injuries will include a description of condition, size, and treatment required, how the accident happened, reports completed, and notification of family and physician. Treatment of all wounds will be administered per physician/Wound NP (Nurse Practitioner) order.

Current Physician Order Summary Report indicates R1 was admitted to the facility on 4/13/23 with diagnoses that include End Stage Renal Disease/Dialysis Dependent, Seizure Disorder, Hemiplegia/Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Unspecified Protein Calorie Malnutrition, Dementia, Gastrostomy.

Order Summary indicates R1 has orders as follows:
--Liquid nutritional feeding every 24 hours as

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needed may give 2 cans of (liquid nutrition) if dialysis meal is not available before leaving for dialysis and/or returning from Dialysis; flush with 170cc water before and after bolus, date ordered 11/13/23.
--Enteral Feed three times per day bolus 1 can (liquid nutrition) with water flush 170cc before and after bolus, date ordered 11/30/23.
--Instill 500ml (milliliters) water into R1 stomach through feeding tube three times per day, give R1 at least one 8-ounce container of thickened water orally every 8 hours, date ordered 11/8/23.
--Cleanse R1 middle finger to left hand with normal saline, pat dry, apply triple antibiotic ointment and cover with bandage every 8 hours everyday shift and as needed.
--Doxycycline Hyclate (antibiotic) 100mg (milligrams) two times a day for wound to left middle finger, date ordered 11/27/23.
--Left distal thigh treatment: Cleanse with normal saline, apply antibiotic ointment to wound bed, cover with (petrolatum infused gauze) 4 x 4 dressing, abdominal dressing, wrap daily and as needed related to Necrotizing Fasciitis, date ordered 11/27/23.

Braden Scale for Predicting Pressure Ulcer Risk dated 8/2/23 indicates R1 is at High Risk for pressure ulcer development.

Practitioner Wound Care Note dated 12/11/23 indicates R1 has multiple wounds including a left hip to knee wound with history of Necrotizing Fasciitis and debridement, left hip surgical wound, left posterior knee traumatic wound, and wound to left middle finger knuckle.
Note indicates left posterior knee wound "Traumatic, onset 11/20/23" suspect related to dressing and patient contractures. Wound description includes 10% yellow slough, moderate

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exudate, wound bed pink. Note indicates left middle finger knuckle traumatic wound length 0.9cm (centimeters), width 0.8cm, depth 0.1-0.2cm with slight decline in depth; wound bed pink, moderate exudate; 70% slough with observed shiny striation/suspect possible tendon. Wound Plan Note indicates: Discussed with PT (Physical Therapy) - need for strengthening and endurance exercises. Discussed with Dietician - treatment plan including need for protein supplements with meals. Discussed with OT (Occupational Therapy) need for evaluation for ADL's (Activities of Daily Living). Discussed with patient frequent repositioning for pressure relief/nutritional support/hygiene and incontinent cares. Discussed with RN (Registered Nurse)/ADON (Assistant Director of Nursing) treatment plan, frequent wound care treatment orders and risk for significant wound decline.

Patient and staff re-instructed to wear pants/sweats at all times to promote wound healing.
Instructed staff to attempt to place small pillow to posterior calf/post thigh for his contracture.

On 12/12/23 at 1:30pm R1 was in bed with a mitt restraint on right hand and left hand partially tucked underneath left side of R1's body. R1's left hand was in a closed position with all knuckles of left hand pressing against the mattress surface. R1's left hand was removed from under his body by V4, Wound Nurse and a small bandage was removed from around left middle finger knuckle. At that time V4 stated that "I personally believe the wound to (R1's) knuckle is from pressure/friction from the way R1's arm/hand get positioned under his body against the sheets." V4 stated R1's left side of his body is the stroke-affected side. V4 stated she discussed

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with V5, Wound NP (Nurse Practitioner) about putting a restraint mitt on R1's left hand as well to try to keep the pressure off his knuckles. V4 then removed the bandage from R1's left knuckle which exposed an irregular ulcer of R1's entire knuckle and stated "(R1) is receiving antibiotics for wound infection." V4 cleansed the left knuckle wound, re-bandaged and placed R1's arm/hand back onto the bed with no off-loading of affected areas.

R1's left leg was noted to be in a contracted position without any pillows or appliances in place to lessen the severity of the contracted leg. V4 removed the wrapped gauze from R1's left upper thigh that extended down past R1's knee which exposed a large scar that extended from mid-left anterior thigh past R1's left kneecap. The area closest to R1's knee was open requiring cleansing and treatment. V4 then assessed behind R1's left knee which also had an open area. At that time V4 stated the wound behind R1's knee was caused from having the gauze wrap dressings too tight - so a combination of constricted pressure and R1's contracted knee joint. The wound behind R1's knee was reddened with a white cord -like striation extending across the open wound. V4 stated "The wound didn't look like that the other day. I've never seen it this bad. I think that's an exposed tendon. The other day it was just red with some drainage." V4 stated that when the wound under the knee started out it was from trauma. "I believe it was from bandage being too tight. There should have been some padding to prevent a wound from forming. Now as of yesterday we are adding an ABD (abdominal pad) under the gauze wrap." V4 also stated "Today is the most extended I've seen (R1's) leg. It's usually more contracted and difficult to assess." No pillow or other positioning

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device was placed under R1's knee after wound care was completed.

V13, R1's POA (Power of Attorney) was also present during R1's wound care. V13 stated that she has talked to staff about keeping a "carrot" or rolled washcloth in R1's left hand to help with the contraction and would also help keep his knuckles from pressing into or rubbing on the sheets. V13 then asked V4 when R1 had developed the wound under his knee because she was not notified. V13 stated "This is the first I'm finding out about this wound."

On 12/13/23 at 10am R1 was sitting in a recliner chair in the hallway. R1's left hand was positioned partially under the left side of his body with all fingers/knuckles of left hand in contact with the chair cushion.

On 12/14/23 at 9:10am V5, Wound Nurse Practitioner (NP) stated half of the time he encounters R1 at the facility his dressings are off. V5 stated he had to initiate the elastic stocking over R1's left leg to keep the dressings in place for the anterior wounds on R1's left leg. V5 stated the combination of the gauze wrap on R1's leg and leg contractures caused the wound behind R1's left knee. V5 stated "If the tendon is exposed behind (R1's) knee it would require a surgeon to assess because that type of wound would be beyond my ability to heal. (R1) is probably not a surgical candidate due to his present physical state and dialysis." V5 stated "I can put in all the best orders but if they're not followed, they won't work." V5 stated that the nutrition and protein supplements are "Essential" for healing R1's wounds "These are key factors in wound healing." V5 stated R1 can't feed himself so he is reliant on staff to follow orders and be sure he is getting the

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nutrition and hydration he needs.

Wound NP wound assessment notes dated 12/11/23 indicates left posterior knee wound measures 1.6cm (centimeter) x 1.4cm x 0.1cm.

NP wound assessment notes dated 12/18/23 indicates left posterior knee wound measures 3.1cm x 1.2cm x 0.2cm.
Note indicates wound with moderate serosanguinous drainage, 30% yellow with striation - suspect tendon and 70%pink. Note indicates "Referral to surgeon related to possible tendon."

Progress Note dated 12/18/23 at 3:24pm indicates "New order for surgeon in regard to possible tendon (exposure) of left posterior knee.

R1's current care plan - date initiated 5/17/23/revised 10/17/23 - indicates R1 has a pressure ulcer or potential for pressure ulcer development related to disease process, history of ulcers. Care plan indicates R1 has necrotizing Fasciitis to left hip, thigh, knee.

Care plan does not identify left finger knuckle wound or left (popliteal) posterior knee wound.
Interventions include: R1 "Requires" supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing, date initiated 5/17/23. Inform caregivers/family of any new area of skin breakdown, date initiated 5/17/23. Weekly treatment documentation to include measurements of each area of skin breakdown - width, length, depth, type of tissue and exudate, date initiated 5/17/23.
Dietician to review nutritional needs for wound healing, date initiated 11/23/23.

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No interventions to off-load, reposition or any preventative interventions are included in R1's current care plan to prevent further damage or deterioration of wounds.

Dietary Recommendation dated 11/13/23 indicates R1 had a non-significant undesirable weight change of (negative) 2.5% 1 month, 3 months and 6 months. An order added: On Dialysis days (M/W/F) if dialysis meal is not available before or upon returning from dialysis, give 2 cans (therapeutic liquid nutrition) in place of meal with water flush 170cc (cubic centimeters) before and after bolus.

Dietary Recommendation dated 11/30/23 indicates increase R1's nutrient needs related to Hemodialysis. Added liquid nutrition (therapeutic liquid nutrition) bolus three times per day with water flush 170cc (cubic centimeters) before and after bolus.

Medication Administration Record (MAR) dated 11/23 to 11/30/23 indicates the following:
Progress Notes dated 11/3, 11/6, 11/8, 11/10, 11/13, 11/22, 11/27 and 11/29, 2023 indicates liquid nutrition was not given prior to dialysis due to R1 "Ate 100% of breakfast meal. No (liquid nutrition) needed." CNA (Certified Nurse Assistant) documentation "Amount Eaten (per meal) indicates R1 did not eat 100% on these dates. Amount eaten was "zero" on 11/3, 11/8, 11/13, 11/22; 51-75% on 11/27 and 26-50% on 11/29.

MAR dated 12/1/23 to 12/31/23 indicates the following:
Progress Notes dated 12/6, 12/8, 12/11 and 12/13 indicate liquid nutrition was not given due to R1 "Ate 100% of breakfast. No (liquid

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Supplement) needed."
CNA documentation "Amount Eaten" indicates R1 ate "zero" on 12/6, 51-75% on 12/8, 12/13 and 25-50% on 12/11, 2023.

None of the current physician orders or dietary recommendations are based on a percent of meal eaten by R1.

TAR (Treatment Administration Record) dated 12/1/23 to 12/31/23 indicates "Record feeding intake at the end of every shift" for R1. No intake is documented for day shift on 12/1, 12/3 through 12/10, 100ml is documented on 12/11, 12/12, 12/13, 12/15, 12/16 and 12/18; 500ml is documented on 12/2 and 875ml is documented on 12/18/23. TAR indicates no intake is documented for evening shift on 12/2, 12/3, 12/8, 12/9, 12/10. No intake documentation for night shift except 12/5 and 12/14, 2023.

TAR dated 12/1/23 to 12/31/23 indicates "Record water intake at end of each shift for gastric tube." No water intake is documented for 12/1, 12/3, 12/4 and 12/6 through 12/10.

On 12/13/23 at 2:40pm V7, LPN (Licensed Practical Nurse) stated "We haven't had cans of (liquid nutrition) for a long time. We use these" and showed a large bottle (1000ml/milliliters) of liquid nutrition. V7 stated she gives R1 320ml three time/day. At that time, V8, LPN stated "Well, isn't that interesting? I give 240ml." V7 then stated "If you ask other nurses, they will probably also give a different amount." V7 also stated "(R1) ate 100% of his meal this morning. He didn't need extra." Both V7 and V8 did not know how much was in one can of liquid supplement or how much the physician's order indicated to give. Both V7 and V8 acknowledged the amount

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
	IL6008866	A. BUILDING: ______ B. WING ______	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NSG & REHAB CTR	767 30TH STREET ROCK ISLAND, IL 61201

(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
S9999		S9999		

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(volume) of liquid nutrition to be given should have been clarified with the dietician.

Nutrition/Dietary Note dated 12/18/23 at 1:44pm indicates "RD (Registered Dietician) note for malnutrition diagnosis, dialysis and tube feeding. Note indicates R1 oral intake per intake log is between zero and 75% which most likely does not meet enteral nutrition as evidenced by general appearance and dialysis information.

On 12/19/23 at 9:41am V14, RD (Registered Dietician) stated that one can of (liquid supplement) is 237ml or 8 ounces. V14 stated she was not aware the facility did not have cans of liquid supplements or that nurses were giving various amounts. V14 stated her expectation is R1 should be getting meals and supplements as ordered. V14 stated R1 is no longer getting the liquid supplements based on percent of meal eaten "That order changed on 11/30/23."
V14 stated she spoke to the dialysis dietician on 11/30/23 and was told R1 was coming into dialysis dehydrated so recommendation was made to give additional water by bolus and orally. V14 stated that R1's Albumin level did drop and is now 3.2g/dl (grams per deciliter). V14 stated "We are offering an excessive amount of calories to maintain his general nutritional status. The focus with residents with dialysis and wounds is protein - an essential part of healing."

On 12/15/23 at 11:30am V4, Wound Nurse stated prior to 12/13/23 there was no wound documentation in R1's chart. V4 stated R1 does not have an air mattress but he should have because he is "prone to pressure."

On 12/19/23 at 11:40am V4 stated she previously was the ADON) Assistant Director of Nursing) at

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ST ANTHONY'S NSG & REHAB CTR	767 30TH STREET ROCK ISLAND, IL 61201

(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
S9999	Continued From page 14 the facility and in the summer she became the wound nurse. V4 stated she does not have any specific wound training and only started (this month) doing wound care plans. (A)	S9999		