

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145611	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/29/2012
NAME OF PROVIDER OR SUPPLIER ST JAMES MANOR & VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1521 EAST RICHTON ROAD CRETE, IL 60417		
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F 309	Continued From page 6 performed. This included: -After handling used dressings, contaminated equipment, etc... -After contact with blood, body fluids, excretions, secretions, mucous membranes, or non intact skin. -After handling items potentially contaminated with blood, body fluids, excretions, or secretions. -After removing gloves. The policy also notes, "The use of gloves does not replace handwashing."	F 309			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.696a) 300.696c)2)4) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.3240a) 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code. Activities shall be monitored to ensure that these policies and procedures are followed. c) Each facility shall adhere to the following	F9999			

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F9999	<p>Continued From page 7</p> <p>guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services.</p> <p>2) Guideline for Hand Hygiene in Health-Care Settings</p> <p>4) Guideline for Prevention of Surgical Site Infection</p> <p>300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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</p>	F9999			

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F9999	Continued From page 8 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. 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. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, record review, and interview the facility failed to:	F9999			

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F9999	<p>Continued From page 9</p> <ol style="list-style-type: none"> 1. Ensure a thorough assessment was done on admission to the facility for R4's left hip surgical wound. 2. Ensure R4's left hip surgical wound site was assessed, monitored for signs and symptoms of infection, and documented on daily. 3. Prevent infection of R4's left hip surgical wound site. 4. Develop a plan of care to address care, treatment, and monitoring of signs and symptoms of infection to R4's left hip surgical wound site. 5. Ensure nursing staff washed their hands at appropriate times and did not contaminate items during wound care treatment. (R1 and R2) <p>Due to these failures R4's left hip surgical site became infected and R4 suffered severe and increased pain to the surgical site. R4 was admitted to a nearby hospital where he was diagnosed with an infected left hip surgical site and suspected sepsis syndrome.</p> <p>This is for 1 resident in the sample of 4 (R4) cited for assessment, monitoring, and documentation of a wound and 2 residents in the sample of 4 (R1 and R2) cited for infection control procedures during wound care.</p> <p>The findings include:</p> <p>Review of R4 's admission face sheet showed R4 was re-admitted to the facility on 1/20/12 with diagnoses including Left Hip Repair, Dementia, Cerebral Vascular Accident, Gastro Esophageal Reflux, and Anxiety.</p> <p>Hospital documentation dated 1/17/12 showed</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>R4 came to the hospital emergency room with diagnosis of recurrent left hip dislocation. R4 was admitted to the hospital at this time and a left hip replacement was performed.</p> <p>1. Facility documentation showed R4 was admitted to the facility on 1/20/12. Nursing documentation on admission showed there was no thorough assessment of R4's left hip surgical site. Nursing documentation on the Skin Impairment Assessment form dated 1/20/12 showed R4 had staple sutures to the site but the number of sutures was not documented and there was no documentation the sutures were intact. In addition, there was no documentation of the appearance of the wound margins. Documentation showed there was no signs and symptoms of infection. Review of physician's orders showed R4 was to have a dressing change daily to the site on the 7-3 shift.</p> <p>2. Nursing documentation dated 1/21/12 (7-3 shift) showed "Left hip surgical site, staples intact (number of staple sutures not documented), no drainage, surrounding skin intact. No complaints of pain." Nursing documentation dated 1/22/12 (7-3 shift) showed, "L hip surgical site, staples intact (no number documented), treatment per M.D. order. Surrounding skin intact, no redness, no edema, no complaints of pain."</p> <p>On 1/23/12 nursing documentation only showed, "No complaints of pain or discomfort. L hip dressing dry and intact." There was no further documentation of the appearance of the surgical site from 1/22/12 to 1/25/12.</p> <p>3. On 1/25/12 Z1 (wound doctor) assessed R4's</p>	F9999			

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F9999	<p>Continued From page 11</p> <p>wound. Z1's documentation showed R4's surgical wound had redness with a moderate amount of serosanguinous drainage. Z1 also noted R4 experienced pain with cleaning of the wound. R4 was sent to a nearby emergency room for evaluation of the left hip surgical wound. R4 returned to the facility on the same day (1/25/12) with orders to continue dressing change daily to the site.</p> <p>No further nursing documentation was found regarding daily assessment of R4's left hip surgical wound site for 1/26 or 1/27/12. The next nursing documentation found was dated 1/28/12 at 1:00 p.m. which noted the following:</p> <p>"Noted very large amount of brown drainage to L hip. Pt. complains of severe pain to L hip. Pt has more pain than usual. Pt is lethargic and weak. Pt's urine is brown color."</p> <p>R4 was transferred to the hospital on 1/28/12 at 2:00 p.m. and returned to the facility at 10:00 p.m. with orders for 2 antibiotics (Keflex and Levaquin). At 12:00 midnight R4 complained of difficulty urinating and was sent back out to another hospital on 1/29/12. Emergency room documentation showed R4 had a large amount of foul smelling serous drainage. R4 was admitted to the hospital with diagnoses including infected L hip surgical wound. Hospital progress notes dated 1/30 and 1/31/12 continued with documentation that R4's left hip incision had large/copious amounts of serosanguinous and/or purulent, foul smelling drainage. Progress note documentation showed R4 was also in severe pain rating his pain at a 10 of 10 on a pain scale of 1-10. R4 was given IV Morphine for pain and</p>	F9999			

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F9999	<p>Continued From page 12 IV antibiotic therapy.</p> <p>Review of a hospital Infectious Disease Consult dated 1/31/12 showed documentation from the Infectious Disease physician for R4 of "Postoperative infection with gross purulent drainage from the incision, and I suspect sepsis syndrome given the bandemia and intermittent tachycardia and tachypnea."</p> <p>Review of hospital lab culture of R4's left hip wound dated 1/30/12 showed results of "many staph aureus and proteus mirabilis" bacteria. Review of hospital blood cultures for R4 dated 1/30/12 showed positive results of "staph aureus" in R4's blood which verified Infectious Disease sepsis syndrome.</p> <p>4. Review of the facility's plan of care for R4 showed no care plan was developed for the care, treatment, or monitoring for signs and symptoms of infection of R4's left hip surgical wound site.</p> <p>5. On 2/28/12 at 11:45 a.m. E4 (LPN) was observed performing a dressing change to R1's left lower leg wound. When E4 removed R1's old dressing she did not remove her gloves or wash her hands before cleaning and dressing the site.</p> <p>During interview with R1 at this time R1 stated, "My dressing is supposed to be changed one time a day. It's not always changed once a day. Sometimes it is not done every day. It depends on who's on duty. I'm not going to remind them to change the dressing."</p> <p>Review of treatment sheet documentation for R1 and R2 showed dressing changes were not</p>	F9999			

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F9999	<p>Continued From page 13</p> <p>documented as being done every day as ordered.</p> <p>On 2/28/12 at 1:20 p.m. E5 (LPN) was observed performing wound care on R2's left heel. E5 removed the old dressing from R2's left heel by cutting the dressing off with her bandage scissors. After E5 removed the old dressing she laid the bandage scissors on R2's bed, thereby contaminating the bed. The old dressing had a large amount of bloody drainage on it. When removing R2's old dressing, a section of the bloody dressing was stuck to R2's heel and E5 had to saturate the dressing and peel it off with her gloved hand. E5 changed gloves but did not wash her hands after removing the old bloody dressing. E5 also had R2's treatment sheet in the room with her which she laid on R2's bed and later on R2's overbed table, thereby contaminating the treatment sheet and the overbed table.</p> <p>Interview with E2 (Director of Nurses) on 12/29/12 at 11:20 a.m. noted E2 to say the nurses are to do a thorough assessment of all wounds of residents on admission to the facility. E2 stated R4's left surgical wound site should have been assessed, monitored for signs and symptoms of infection, and documented on daily. E2 stated a plan of care should have been developed for the care and treatment of R4's surgical wound. E2 also stated that the nurses should have washed their hands at the appropriate times during wound care and should not contaminate items during wound care and treatment.</p> <p>Review of the facility's policy on Wound and Skin Care included to "Reevaluate dressing and skin</p>	F9999			

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F9999	<p>Continued From page 14 integrity every shift."</p> <p>Review of the facility policy on Handwashing notes "Handwashing shall be regarded by this organization as the single most important means of preventing the spread of infections.</p> <p>The policy Interpretation and Implementation included:</p> <p>All personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors.</p> <p>The policy noted several situations in which appropriate 10-15 second handwashing must be performed. This included:</p> <ul style="list-style-type: none"> -After handling used dressings, contaminated equipment, etc... -After contact with blood, body fluids, excretions, secretions, mucous membranes, or non intact skin. -After handling items potentially contaminated with blood, body fluids, excretions, or secretions. -After removing gloves. <p>The policy also notes, "The use of gloves does not replace handwashing."</p> <p style="text-align: center;">(B)</p>	F9999			