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HELIA SOUTHBELT HEALTHCARE	101 SOUTH BELT WEST BELLEVILLE, IL 62220

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F9999	FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS:

300.610a)
300.1010h)
300.1210b)
330.3240a)

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, 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

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidneced by:

Based on interview, observation, and record review, the facility failed to consistently assess, monitor, and treat a surgical incision line for signs and symptoms of infection for 1of 5 residents (R2) reviewed for wound care/management. This failure resulted in R2 developing an infection, being directly admitted to the hospital from the physician's office, and undergoing surgery on for revision and debridement of her surgical wound.

Findings include:

1. According to the Admission Sheet, R2 is a 45

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F9999	Continued From page 14 year old female admitted to the facility on 3/9/12 following hospitalization for a recurrent umbilical hernia c (with) repair (herniorrhaphy with panniculectomy) on 3/6/12. The hospital Discharge Summary dated 3/9/12 describes R2's mid abdominal incision line as "25cm well approximated - steri strips intact" and the lower abdominal lateral incision line as "20cm well approximated - steri strips intact." Treatment Orders for the facility included "ABD (abdominal) pads covering incisional sites held in place w (with)/abdominal binder. Change dressing daily." The Hospital Discharge summary also indicates R2 needs assistance to ambulate with walker. The facility's Admission Nursing Assessment dated 3/9/12 identifies R2 as being oriented, cooperative with her surgical site presenting as an "upside down T" measuring 25cm midline, 27cm vertical. Interim care plan identifies the dressing change to be done daily. The nurses notes written on admission dated 3/9/12 do not include documentation of the incisional line. The first entry into the nurses notes that reflect R2's incision is on 3/10/12 and documents "(changed) drsg (dressing) today - left some tape on steri strips where s/s (signs and symptoms) bleeding thru steri strips" but no identification as to where the bleeding was noted or how much. The next entry/documentation of R2's surgical incision line is on 3/12/12 at 10am "Abdominal dressing has steri strips to T incision. Small amt (amount) of Dried bloody drainage at lower incision." No further documentation of the wound site is reflected in the nurses notes nor is there any information given toward R2's compliance with wearing the abdominal binder.	F9999		

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F9999	Continued From page 15 On 3/14/12 at 10:45am, the nurse notes documents "Abd drsg (dressing) done per wnd (wound) nrs (nurse) this am + intact." The wound/treatment nurse, E4 Licensed Practical Nurse (LPN), documented on the back of the treatment administration record (TAR) dated 3/14/12 and describes R2's incisional line as "not approximated well" with no drainage noted. This is a change from the "well approximated" incision line on admisison. On 3/29/12, E4 provided her "own notes" that she keeps in her office which describes R2's incisional line as being 27 cm (centimeter) side to side c 10 cm incisional forming an upside down T shape - has an area that's pulled apart at (cross section) - area approx (approximately) 2cm x .7cm c tissue pinkish/red - (no) odor - (no) slough of tissue - (no) open hole in tissue observed - wound bed c pinkish/red tissue - does have some sero sang (sanguneous) drainage to mid abd. site - cleansed c drsg applied as directed." E4 also stated that R2 was non-compliant with wearing her abdominal binder from the start but does not have that documented in her notes. There is no indication the physician and/or the surgeon were notified of any changes to R2's incision line or her non-compliance with the binder. On the evening of 3/14/12, the nurses notes at 9pm document that R2 was complaining to E11, LPN, of "very intense pain" at the lower abdominal incision line. Z2 (primary physician) was called and he told E11 to call the surgeon. At 9pm, E11 documented the physician on call for R2's surgeon was called and gave orders to send R2 to the emergency room. In addition, E1 documented that R2's incision line had "some drainage" but the line was not warm to touch. At	F9999		

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10:50pm on 3/14/11, the surgeon gave an order to send R2 to the emergency room which E11 did. She documented that R2 returned to the facility following the emergency room visit at 2:30am. No other information was provided in the nurses notes.

Emergency Room documentation dated 3/15/11 at 12:10am documented "Noted large incision across lower abd with saturated abd dressings with serosanginous drainage. A & O X 3 (alert and oriented times three)." Additional notes describe the line as having "redness noted" with some bruising adjacent to the line but have no signs of infection and that R2 stated she had stopped taking her pain medications at the nursing home. R2 returned with an order for Nystatin for a peri area yeast dermatitis and to continue pain medications at the facility.

There is no further documentation in the nurses notes regarding R2's incisional line until 3/17/12 at 3pm when E12 LPN documents "drsg ch'd (changed) to abd (lower) sero sanguiness drgn (drainage)" The notes include no specifics as to how much drainage was present, color, odor, or location of the drainage. A check list nurses note dated 3/18/12 was completed that identifies R2 as being cooperative, continent, with a surgical treatment site with a statement "abd. wnd (wound) sersangous drng mod (moderate) amount" added. There is no indication either R2's physician or surgeon was notified and no documentation of the incision line itself. The next entry into the nurses notes is 2 days later on 3/20/12 at 315p when is documents Z2 (R2's primary physician) "here to see" R2." There is no documentation that indicates the nurses followed

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up on the line that was documented earlier in the week as being unapproximated and/or the presence of drainage.

Z2's progress notes/orders dated 3/20/12 restate R2's primary diagnoses of hernia repair and include an order for discharge the following day with home physical therapy and health care.

On 3/30/12 at 8:45am, Z2 stated he saw R2 on 3/20/12 as she sat outside the facility and she asked to go home. Z2 stated she told him she was seeing the plastic surgeon (Z1) the next day and he told her if everything went well, she could be discharged from the nursing home after that. Z2 stated he did not look at R2's surgical incision line on 3/20/12 as she was outside and she was seeing the surgeon the next day. Z2 stated he was not informed of any drainage or redness of the incision line at any time during her stay at the facility. When asked if that was something he or the plastic surgeon should have been informed on, stated "Absolutely."

The next entry into the nurses notes is written on 3/20/12 (no time) by E4 Treatment nurse and documents "reported by housekeeping supervisor that resident observed taking drsg apart et stuffing wash cloths to abd incision site -redirected et drsg replaced - floor nurse to monitor for changes." On 3/29/12 at 2:15pm, E4 stated she did not do the dressing change but told the floor nurse E9 (LPN) to do it. E4 stated she was unaware as to whether or not the facility had a wound management policy or not but by instructing her to "monitor" the site would expect the nurse to "reevaluate and look for drainage, any change to the site, odor, appearance, any

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increase in redness, any complaints of tenderness" or any change from before. There is no documentation either in the nurses notes or on the treatment sheet that the nurse followed these instructions.

On 3/30/12, E9 stated she was never informed that R2 was "stuffing" wash clothes in her abdominal fold until after R2's discharge to the hospital but did recall doing her dressing that evening around 7:45pm to 8pm. E9 stated the incisional line looked "great" that night with no redness, no discoloration or odor. She stated it had some serosanguinous drainage present.

The next entry into the nurses notes is written by E5 LPN on 3/21/12 (no time) and documents "ABD pads were present vertically c no drainage present to the outside of the pad Res then lifted abdominal apron + pulled a drainage soaked wash clothe from under the center ABD pad. Res then c/o (complained of) foul odor from incision Nurse advised that she should express her concerns to her surgeon that she was seeing today Nurse further advised against this nurse from performing drsg (change) as it would be in the res best interest to see the amount of drainage + the odor so that way the dr can best address her concerns. res agreeable to allow dr to (change) drsg."

On 3/28/12 at 3pm, E5 LPN stated when he approached R2 to ask about her dressing, she voiced concerned then lifting her abdominal fold up, reached under it and pulled out a drainage saturated washcloth from her fold. E5 stated R2 did not have a binder on as it was hanging in the closet but did have ABD dressings intact that

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F9999	Continued From page 19 were not soiled as she reached under them. E5 stated R2 hardly ever wore her binder. E5 described the wash cloth as having brownish drainage that had a "funky foul infection smell" to it. He said he told her to leave it alone so the doctor could smell it. E5 stated he had not taken care of R2 before that day and that he was shocked when she pulled the cloth out. He stated the "whole room had that odor." E5 stated he did not look at R2's incision line nor did he touch her after that. E4's personal notes dated 3/21/12 provided after asking E4 if she had any other documentation, document that R2 refused to have E5 change her dressing and that the nurses reported to her that R2 "stuck her hand up under the abd pads et pulled out wash cloths from abd area incision area - goes to dr's appt (appointment) today." E4 stated she did not approach R2 regarding the wound drainage in an attempt to assess it. Nurses notes dated 3/21/12 (no time) documents that R2's mother was in the facility and reported that resident was sent from Z1's office to the hospita on 3/21/12 for another surgery adding that the incision line had a foul odor to it and needed to be "cleaned out." The surgery was performed 3/22/12. According to the hospital Surgical Note dated 3/22/12, R2's abdominal incision line measured 23.5cm mid abdomen with the horizontal incision line measuring 65cm across. It was described as reddened around the edges, incision has opened up minimal amount to this area and draining a purulent drainage, foul smelling with some steri strips still intact.	F9999		

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Interview with Z4 Registered Nurse (RN) on 3/29/12 at 10:45am stated she did the dressing change on 3/22/12 at the hospital prior to surgery provided pictures taken of R2's surgical site dated 3/21/12 and pointing to an area on the upper right of the picture stated R2 had a large black necrotic area present on the right and a boggy soupy area with foul smelling copious amounts of drainage on the lower left. Z4 stated that "if drainage and odor are present, its a clear indication of something going on and someone should be notified." Z4 also stated that as they were cleansing the incisional line, R2 stated "they never did that at the nursing home." but did put a new dressing on. R2 told Z4 she was putting wash cloths over the incision line to catch the drainage. Z4 stated R2 is alert/oriented and reliable and interview with her is possible.

At 11:15am on 3/29/12, R2 was in bed in the hospital. She had a wound vaccum on and stated she was comfortable at the time. R2 was asked about the wound drainage at the nursing home and stated she put wash cloths under her abdomen because that's what the nurses were doing to catch the drainage. R2 said that the nurses at the nursing home did not change the dressings daily and did not clean the wound like they do in the hospital. R2 stated the incisional line started to smell with drainage and that she had a lot of pain with it.

On 3/29/12 at 2:20pm, Z5, Z1's office nurse said Z1 stated that R2 is of sound mind and could tell you anything you wanted to know." Z5 stated that drainage is something Z1 would have wanted to know about. R2's Hospital Discharge Summary

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F9999	Continued From page 21 from her surgery on 3/22/12, documents discharge condition as "DX (diagnoses) Infection of Abdominal surgical site." On 3/30/12 at 8:45am, Z2 stated he was not informed R2 developed a "bad infection that was overlooked by the facility." On 3/30/12 at 1pm, E1 Administrator provided a "late entry" note dated 3/14/12 that she identified as being written that morning by E11 LPN that documents "res c/o drainage c order from (lower) abd drsg. Abd pad removed, incision intact c steri strips abd pad had some serosanguineous drainage c no odor noted. Res made aware of integrity of incision. Skin not warm to touch around incision site (no) inflammation noted at the time. Drsg (changed(+ abd binder reapplied." An additional note documents "Dr (Z1) notified of drainage + assessment to abd incision + res c/o pain. Z1 stated that from the details of the assessment, an infection does not seem likely, however, d/t (due to) uncontrollable pain, its okay to send res to ER (emergency room) for tx (treatment) + eval (evaluation.). This documentation conflicts with the emergency room notes that identifies some seperation of the line and redness. A policy/procedure on Wound Management was requested from E1 and E2, Director of Nurses on 3/29/12 and a policy entitled PRESSURE ULCER MEASUREMENT AND ASSESSMENT was provided. E1 stated the facility does not have a specific policy on wound management but they use the pressure ulcer one. The policy under assessment documents that each ulcer will be measured in centimeters; include location,	F9999		

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F9999	Continued From page 22 measurement, size, depth, drainage, and approximate amount, undermining or tunneling, odor, color and type e.g. slough or eschar, description of wound edges and surrounding tissue. Document pain is present, nature and frequency." An additional statement includes "ulcers that appear purulent require physician notification." (B)	F9999		