

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER ROCHELLE REHAB & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH 3RD STREET ROCHELLE, IL 61068
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a)</p> <p>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.</p> <p>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</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>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>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)</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>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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, 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 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs 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.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>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)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure residents at high risk for skin breakdown were assessed, pressure reducing interventions were implemented, and new wounds were reported. The facility failed to monitor and evaluate the effectiveness of wound treatments. This applies to 3 of 4 residents (R2, R3, R4) reviewed for pressure in a sample of 10. The findings include:</p> <p>1. The Physician Order Sheet (POS) dated 4/19/14 lists R4 ' s diagnoses to include Urosepsis, Pressure Ulcers, Pneumonia, and Diabetes. On 5/12/14 at 9:25 PM, R4 was in bed having pressure ulcer treatment and dressings applied to the coccyx, and right and left ischial tuberosity areas. The wounds were packed with Silver Alginate and covered with foam dressings. R4 complained of discomfort in the wound areas, " Not bad now, but hurts when they poke around"</p> <p>The Minimum Data Set (MDS) dated 11/25/13 shows R4 was admitted on 11/19/13 to the facility with 3 Stage II pressure ulcers. The MDS dated 2/17/14 shows R4 had 1 Stage II and 3 Stage IV pressure ulcers. The resident care plan for R4 dated 12/10/13 shows R4 has pressure ulcer present on the buttocks and ischial prominence. (The plan does not identify the staging or specific treatment plan for the pressure ulcers). The care</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>plan interventions include having the nurse measure and monitor the wound status progression or deterioration every week. The wound tracking flow sheets show a wound assessment on 11/20/13. The next wound assessment is dated 1/16/14, (8 weeks later). The coccyx wound changed from 1.0 x 1.0 cm Stage II on 11/20/13, to 1.7 x 2.4 cm Stage IV on 1/16/14 and was evaluated as improved. The right ischial wound changed from 3.0 x 3.0x 3.5 cm Stage III on 11/20/13 to 2.5 x 3.2 x 2.4 cm Stage IV on 1/16/14 and was evaluated as improved. The left ischial wound changed from 4.5 x 1.0x 1.0 cm Stage III on 11/20/13 to 5.0 x 7.7 x unable to determine depth, Stage IV and is evaluated as improved. On 4/18/14, a resident referral to the wound clinic was made for R4. The measurements on 4/16/14 showed the coccyx wound size had increased to 3.0 x 2.6 x 0.1 cm. The right ischial wound increased to 3.0 x 3.6 x 1.1 cm and the left increased to 4.6 x 5.4 x 0.8 cm. All wounds were evaluated as improved. A wound culture of the right ischial wound was completed on 3/26/14. The lab report shows heavy growth in the wound for Escherichia coli (extended spectrum beta-lactamase,ESBL) and Staphylococcus aureus (methicillin-resistant staphylococcus aureus, MRSA). On 5/15/14 at 10:05 AM, E3 (Assistant Director of Nurses - LPN) presented wound assessment documentation for R4 and stated no additional information was available. E3 stated weekly wound assessments are to be completed as the care plan shows. The facility policy regarding Decubitus Care dated 5/2007 states "5) Documentation of the pressure area must occur upon identification and at least once each week on the treatment record. 6)</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>Reevaluate the treatment for response at least every 2 -4 weeks. Most pressure areas will respond to treatment in this amount of time. If no improvement is seen in this time frame, contact the physician for a new treatment order."</p> <p>2. R2's POS dated 4/19/14 shows diagnoses to include Down Syndrome and Rt Patella Subluxation.</p> <p>The MDS of 4/25/14 shows R2 is unable to ambulate, and totally dependent on staff for transfers, personal hygiene, toilet use, and dressing. The 4/25/14 MDS shows R2 has a limited ability to make requests known, and only responds adequately to simple direct communication.</p> <p>R2's 2/25/14 Skin Assessment for Predicting Pressure Ulcer Risk shows a score of 14 with 16 or less placing R2 at high risk for pressure ulcers. R2's 11/19/13, Weekly Wound Tracking shows a previously healed left heel pressure ulcer, also placing R2 at high risk for pressure ulcers.</p> <p>On 5/12/14 at 6:40 PM, E7 (CNA) wheeled R2 from the dining room to her room. R2's left foot rest was extended straight out with her leg and knee straight and left heel resting on the foot rest. R2's right foot pedal was down with her knee bent. E7 and E8 (CNA's) transferred R2 to the bed, and provided incontinence care. E7 removed R2's athletic shoes and socks. An approximate dime size dry black area was noted above R2's heel. E7 said "where is the sore" when asked about it, and said she did not know it was there, or when it started.</p> <p>On 5/12/14 at 7:08 PM, E5 (Licensed Practical</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>Nurse - LPN) said he was not aware that R2 had a sore on her left Achilles. E5 palpated the area and said "I don't know what it is but it is not blanching and it feels hard all the way through". E5 said "it's scabbed over" and "it's deep".</p> <p>R2's Nurse Notes entry dated 5/13/14 shows "Left foot small 2.5 x 1 black scab noted...scab is black and does not blanch around area..."</p> <p>R2's 5/12/14 "Weekly Wound Tracking" shows "Friction Scab, 1.5x1cm, status-new"</p> <p>On 5/13/14, R2 was sitting in her wheelchair in the dining room and lounge area from 7:40 AM until 1:05 PM. R2's left leg was extended straight out with her heel resting on the foot rest. R2 had an athletic shoe on her left and right foot. On 5/13/14 at 1:05 PM, E15 (CNA) said she was caring for R2 for the 7-3 shift. E15 said she had not repositioned R2 since she put her in the wheelchair in the morning.</p> <p>On 5/14/14 at 2:15 PM, E6 (LPN) said R2 can only move her leg "a little bit" and would need help repositioning while she is in bed and in the wheelchair. E6 said R2 needs to keep her left leg straight but should have a pillow under her leg while she is in the wheelchair to help prevent pressure to her heel.</p> <p>On 5/14/14 at 2:10 PM, E26 (CNA) said "we should put a pillow under her [R2's] leg while she is in the wheelchair" to reduce pressure.</p> <p>R2's Physician Order Sheet (POS) dated 12/13/13 shows an order for "heel protector" (left heel). There is no intervention on R2's Pressure Ulcer care plan for a heel protector, and R2's "ADL Record" does not show an intervention for</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>the heel protector.</p> <p>On 5/15/14 at 9:30 AM, E3 (ADON- LPN) said there is no physician order to discontinue the heel protector. E3 said the heel protector was ordered because R2 had a previous pressure sore to her left heel that resolved. E3 said there should be an intervention on the care plan and on the ADL Record for the heel protector, and if the skin concern resolves, the physician should be notified for an order to discontinue the protector. E3 said the ADL record is kept in the residents' room and includes interventions for the CNA's to use to care for the residents.</p> <p>E3 said R2 should be repositioned "frequently" while in the wheelchair, but there is "no specific time frame". E3 said "I believe the scab is caused from friction and it could be friction from her shoe". E3 was unable to identify any interventions in place to reduce friction to R2 heels expect "frequent repositioning". R2's pressure ulcer care plan does not include any interventions to reduce pressure/friction to her heel and prevent the previous pressure ulcer from reoccurring.</p> <p>The 5/07 facility policy "Decubitus Care/Pressure Areas" states "When the pressure area is healed, a preventative regimen must be instituted".</p> <p>3. R3 ' s May 2014 POS shows that R3 ' s diagnosis as Failure to Thrive, Coronary Artery Disease, Low Back Pain, Osteoarthritis, Dementia, and Anemia. The MDS (Minimum Data Set) on 4/10/14 shows R3 has a Braden score of 13 which indicates a moderate risk to develop pressure sores.</p> <p>On 5/12/14 at 7:05 pm E7 CNA (Certified Nursing Assistant) and E8 CNA were performing perineal</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>care on R3, and an open area was discovered on the right side of R3 coccyx area. E7 CNA states this was the first time she saw that open area. On 5/12/14 at 7:30pm E5 LPN (Licensed Practical Nurse) assessed R3 and measured the wound at 2mm (Millimeters). E5 documented " 2mm wound which is currently being treated ". The 5/01/14 Nursing progress notes showed R3 was ordered a compound cream which consist of 1/3 Desitin, 1/3 Mycolog, and 1/3 Silvadene for a sore on R3 ' s left gluteal crease. There is no mention of the open area on R3 ' s right coccyx in the nursing progress notes or the physicians notes.</p> <p>On 5/13/14 R3 states " I have pain on my bottom. I try to shift from side to side. "</p> <p>On 5/13/14 at 9:00 am, record review shows no new orders or that a Physician was notified by E3 or E5 about R3 ' s new open area.</p> <p>On 5/13/14 E3 ADON (Assistant Director on Nursing) measured the open area 1.6 x 1.0 cm (centimeters). E3 states " It looks like a skin shear ". E3 states she expects the CNA to report any open area to the staff nurse on duty and the staff nurse is expected to document the wound, call the physician and notify the family. On 5/15/14 there is no documentation that the physician was notified.</p> <p>The facility policy on " DECUBITUS CARE/PRESSURE AREAS " revised 05/07 under Procedures 1) Upon notification of skin breakdown, a Newly Acquired Skin Condition report will be completed and forwarded to the director of nurses. 2) The pressure area will be assessed and documented on the TAR (Treatment Administration Record). 3) Complete all areas on the TAR. i) Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician). ii) Document the stages of pressure ulcers as follows: (C)</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>Stage II Broken skin, an abrasion, blister or shallow crater. 4) Notify Physician for treatment orders. The physician orders should include: i) Type of treatment. ii) Frequency treatment is to be performed. iii) How to cleanse, if needed. iv) Site of application. v) The order must have specific frequencies. vi) Initiate physician order on treatment sheet. 5) Documentation of the pressure area must occur upon identification and at least once each week on the TAR. The assessment must include: i) Characteristics (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.) ii) Treatment and response to treatment.</p> <p style="text-align: center;">(B)</p>	S9999		