

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007512	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2014
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NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW LUTHER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 505 COLLEGE AVENUE OTTAWA, IL 61350
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</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>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</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</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>services to promote healing, prevent infection, and prevent new pressure sores from developing.</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.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to prevent one of five sampled residents (R1) from developing two facility acquired stage II pressure areas to the right outer foot/ankle area in a sample of 17. The facility also failed to have qualified staff to evaluate and implement the proper treatment to prevent the pressure ulcers. This failure resulted in R1 acquiring two stage II pressure areas which were regressing in condition, including inflammation/antibiotic use and severe pain during treatment of the right ankle wound.</p> <p>Findings include:</p> <p>The face sheet dated 6/22/2011 states R1 admitted to facility with following diagnoses which includes Dementia, Chronic Kidney Disease, Anemia, and Difficulty Walking.</p> <p>The Braden Scale for Predicting Pressure Ulcer Risk dated 11/5/2013 documents R1 is a high risk for skin break down.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>The Minimum Data Set (MDS) dated 11/5/2013, states R1 requires extensive assistance of two staff for bed mobility, transfer, dressing, toileting and bathing.</p> <p>R1's nursing progress note dated 10/9/2013 at 6:30 PM states "1.5 centimeter (cm) by 1.5cm by 0.1 cm open area to right outer ankle bone. 1.5 cm by 1 cm open area to the border of the right foot noted. Apparent pressure ulcers. Cleanse with normal saline apply PolyMem with silver, mefix. Will change treatment every three days and as needed. call to physician and power of attorney."</p> <p>On 1/29/2014 at 10:15 AM, E10 (Licensed Practical Nurse) put on a pair of gloves and removed the dressing from R1's right lateral foot and ankle pressure area. E10 then washed her hands putting on a new pair of gloves. E10 then measured the areas and placed the measuring tool which had touched the dirty wound back into the tub with the clean dressings, cleaning solution, scissors and tape. E10 then cleaned the wound with normal saline. E10 washed her hands, changed gloves and used scissors to cut the PolyMem Silver placing this over both the right lateral foot wound and the right outer ankle wound. E10 then taped the PolyMem Silver in place removing her gloves and again washing E10's hands. E10 then placed the container with the rest of the clean dressing supplies and the contaminated measuring tool back in the treatment cart in the treatment room.</p> <p>On 1/29/2014 at 10:15 AM, E10 measured the right lateral ankle wound as 1.7 centimeters (cm) by 1.4cm with a depth of less than 0.1 cm the wound bed was yellow in color with the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>surrounding tissue red and inflamed. R1 began screaming "It hurts to much, It hurts" when E10 cleaned the area. E10 continued to clean and treat the area. E10 measured the right lateral foot wound as 0.4 cm by 0. 5 cm with no depth.</p> <p>On 1/29/2014 at 10:20 AM, E10 stated R1 receives Tylenol for pain. E10 stated "I did not pass R1's medications this morning but I'm sure the other nurse gave (R1) her the Tylenol for pain." E10 stated the pain medication should be given to a patient at least 30 minutes before a treatment is completed. E10 stated R1 never yells or acts like R1 is in pain when her treatment is done. E10 also stated the ankle area appears to be red and inflamed today. E10 stated the area also appears bigger in size than when E10 measured the area on 1/26/2014.</p> <p>R1s physician orders dated 1/1/2014 shows order for Tylenol Extra Strength, 1 caplet every 4 hours for pain but no current order for routine pain medication.</p> <p>Review of the Medication Administration Record dated 1/2014 shows that the last time R1 received Tylenol Extra Strength 1 caplet was on 1/19/2014 at 12 PM. The physicians orders also show no current treatment orders for pressure ulcer treatment of the right lateral foot and ankle wounds.</p> <p>The Wound Evaluation Flow sheet dated 1/17/2014 shows R1 is to have the following preventative measures in place: pressure reduction mattress, elevate legs, and eggcrate foam boot.</p> <p>R1 was observed on 1/28/2014 at 10:00 AM and 1/29/2014 at 10:30 AM, 12:30 PM and 1:30 PM</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>sitting in her wheelchair with both legs in a downward position with stocking feet resting on the foot rest and no eggcrate foam boot on the right or left foot. R1's wheelchair had stationary foot rest in place. The wheel chair foot and leg rest were not able to be elevated.</p> <p>On 1/30/2014 at 10:15 AM, E8 (Certified Nurses Aide) stated R1 usually has a brown foam boot on her right foot. E8 stated the boot was to help relieve pressure on R1's foot. E8 then went to R1's room finding the eggcrate foam boot on the floor of R1's closet under a bag of pillows. E8 placed the boot back in the closet leaving R1's room. E8 did not take the boot to the day area where R1 was sitting and place the boot on R1's foot.</p> <p>On 1/30/2014 at 9:30 AM, E2 (Director of Nursing) stated "I review the pressure ulcer logs on a weekly basis. I do not routinely look at pressure ulcers, the floor nurses measure the wound, get the treatment orders and put the interventions in place. The same nurse does not always measure the wound each week. The floor nurses receive inservices on wound care. I am not wound care certified, but one of the floor nurses on the third floor is. The facility does not utilize the third floor nurse as a wound care nurse. The facility provides all of the wound care supplies as stock supplies therefore each resident does not receive a labeled supply of treatment supplies from pharmacy. Each resident should have a current physicians order for any wound treatment ordered. The floor nurse is to fax these orders to the pharmacy so that the order is placed on the printed physicians order sheet." E2 also stated the facility does not have a system in place to track, trend or analyze the progress of pressure ulcers nor is this a part of</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>the quality assurance process.</p> <p>On 1/30/2014 at 11:00 AM, Z1 (R1's primary physician) stated "(R1) can't move herself so the pressure ulcer occurred one of two ways, (R1) either bumped (R1) self or (R1) lays on the right side too much. Clinically when I assessed (R1) today (R1) may have Peripheral Vascular Disease. I couldn't feel good pedal pulses in the feet. I am going to order a Doppler study of (R1's) legs and an X-ray to make sure there is no Osteomyelitis of the right lower extremity. As far as (R1's) pain goes, (R1) is very unpredictable and hard to assess for pain."</p> <p>The Physicians progress note dated 1/30/2014 states "Left ankle ulcer: poorly healing, check arterial Doppler of lower extremities to evaluate circulation, check x-ray of the right ankle to rule out Osteomyelitis, start Bactrim DS, continue wound dressing and give as needed pain medication."</p> <p>The Physicians order dated 1/30/2014 states the following: Arterial Doppler of lower extremities, X-ray of the right ankle to rule out Osteomyelitis, Bactrim DS one tablet twice a day, Norco 5/325 every eight hours as needed for pain and elevate right leg when in bed.</p> <p>The Facility Infection Control Policy stated hand washing is to occur before a treatment, after removing or touching soiled material and after a treatment is completed.</p> <p style="text-align: center;">(B)</p>	S9999		