

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Final Observations</p> <p>Statement Of Licensure Violations:</p> <p>300.1010h) 300.1210d)2) 300.1210d)3) 300.3240a)</p> <p>Section 300.1010 Medical Care Policies</p> <p>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 notification.</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>2) All treatments and procedures shall be administered as ordered by the physician.</p>	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 1</p> <p>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.</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 Requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was monitored during transport out of the facility while a tube feeding was infusing. The facility also failed to ensure the nursing staff was notified when the resident returned to the facility. This failure resulted in R36 receiving a 900 ml enteral (tube) feeding bolus causing the resident to vomit for 14 hours.</p> <p>This applies to 1 of 1 residents (R36) reviewed for Gastric Tubes in the sample of 17.</p> <p>The findings include:</p> <p>R36's MDS of 2/11/14 shows diagnoses to include Gastroesophageal Reflux Disease (GERD), Renal Insufficiency, Aphasia, and Cerebral Vascular Disorder. The 2/11/14 MDS</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 2</p> <p>shows R36 has an abdominal feeding tube, and requires extensive assistance from staff with bed mobility, transfers, dressing, eating, and personal hygiene. This MDS also shows R36 has severe cognitive impairment, difficulty focusing attention, disorganized thinking, and unclear speech.</p> <p>On 4/22/14 at 11:00 AM, R36 was sitting in a wheelchair in the sitting room located on the 300 hall. R36 had a neck brace on, and an enteral feeding infusing to gravity. R36's enteral feeding and enteral feeding pump were attached to a pole on her wheelchair. The pump was turned off, and the enteral feeding tubing was outside of the pump chamber and free flowing to gravity. R36's enteral feeding bag was dated 4/22/14 and the label stated the bag was hung at 9:50 AM.</p> <p>On 4/22/14 at 12:05 PM, E7 (Certified Nurse Assistant- CNA) wheeled R36 out of the dining room. R36 had vomited a large amount of pale, milky, white, tube-feeding substance on her neck brace, down the front of her shirt, and saturating through her pants. R36 continued to cough as she was wheeled down the hallway. E7 said he was sitting next to R36 in the dining room, and she (R36) attempted to take a drink and started "profusely throwing up". R36's enteral feeding was then infusing through the pump at a rate of 50ml per hour. There was approximately 500mls remaining in the bag.</p> <p>On 4/22/14 at 12:05 PM, E8 (Registered Nurse - RN) said she hung R36's bag of enteral feeding at 9:50 AM. E8 said she put 1500ml in the bag and the pump was to infuse 50 ml's per hour. E8 looked at the hanging feeding bag and said "there is only 500 ml's left". E8 said R36 should have only had "about 100mls since the bag was hung, and instead she got 1000mls (900 mls more than</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 3</p> <p>ordered in a two hour time frame)". E8 said R36's feeding is supposed to be infused by a pump, not to gravity. E8 said she sent R36 out of the facility to the hospital for a CT scan with the pump on at 50 ml/hour. E8 said she heard R36 returned to the facility with the pump off, and the feeding flowing to gravity. E8 said she did not turn R36's pump back on and did not know who did. E8 said if the tubing is hooked up to the abdominal tube, the feeding will infuse to gravity. E8 also said she did not know when R36 returned to the facility, and was not notified when she returned.</p> <p>On 4/22/14 at 12:25 PM, E5 (Licensed Practical Nurse- LPN) said she turned R36's feeding pump back on between 11:00 and 11:30 AM. E5 said she noticed the feeding was flowing to gravity and the pump was turned off. E5 said she put the tubing back in the pump and set the pump to infuse at 50ml per hour. E5 said the tube feeding should not infuse to gravity and should be administered through a pump.</p> <p>A Facility faxed Nursing documentation dated 4/22/14 at 11:25 to R36's physician shows "at 9:50 AM I hung a new bag of feeding, at lunch she threw up. I noted only 500ml in bag. State surveyor observed bag to gravity at 10:50 AM. This resident left facility for appointment at [medical center]. She got approximately 1000mls of feeding in about an hour". Z1 [physician] faxed response on same form dated 4/22/14 at 2:15 PM states "need to be cautious with feeding. 1000ML certainly excessive. Continue to follow. Use PUMP"</p> <p>R36's nurse notes dated 4/22/14 at 12:12 show "at 11:55am I observed resident coughing and she had thrown up at the lunch room table. I</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 4</p> <p>noted only 500 ml in feeding bag, new bag was hung at 0950 am..."</p> <p>R36's nurse notes dated 4/22/14 at 23:39 show "Tube feeding infusing as ordered. Resident up in w/c (wheelchair) and in dining room for supper when resident had 2 emesis. Tube fdg shut off and resident put back to bed. No further emesis noted and at 8:15 PM, tube feeding restarted at regular rate..."</p> <p>The nursing notes contain no documentation of the physician being notified of multriple emesis, or that the tube feeding was shut off.</p> <p>R36's nurses notes for 4/23/14 at 0038am (12:38 AM) show, "tube feeding held at this time. pt had a small emesis prior to 12M rounds...abd(abdomen) is soft and slightly distended...will continue to monitor closely and restart tube feeding when pt better able to tolerate..."</p> <p>There is no documentation that the physican was notified of any emesis or that the tube feeding was shut off.</p> <p>R36's nurse noted dated 4/23/14 at 2:11 AM shows "Pt in bed with coffee ground emesis, large amt noted. Odor of stool noted. Dr notified...discuss with family and if they wish her to be treated then send to ER..."</p> <p>R36's Emergency Room documentation dated 4/23/14 at 5:45 AM shows "pt had 1000 mL of feeding free flow into g tube because tubing was disconnected from pump. pt vomiting unknown amount of times...Impression and Plan - Diagnosis - Hematemesis, Acute Upper GI Bleed".</p> <p>On 4/23/14 at 9:50 AM, E2 (Director of Nursing -</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 5</p> <p>DON) said R36 left the facility on 4/22/14 in the morning for an appointment at the local hospital. E2 said the enteral feeding was infusing on a pump, and the only person who accompanied R36 was E18 (transport/maintenance). E2 said when E18 brought R36 back to the facility he took her to the sitting room on the 300 wing, but did not notify a nurse R36 was back in the facility. E2 said R36 has gone to a Doctor's appointment out of town (over an hour away), accompanied by a CNA, via the facility transportation van, with her enteral feeding infusing on a pump. E2 said E18 and the CNA's are not qualified to monitor a resident, or a tube feeding. E2 said E18 and the CNA's have not had any training to care for an enteral feeding or a feeding pump. E2 said only a nurse is qualified to care for the enteral feeding, feeding pump, and monitor the resident. E2 said R36 should not have left the facility with her enteral feeding infusing.</p> <p>On 4/23/14 at 9:50 AM, E2 said when the transporter returns a resident to the facility, he is supposed to report to the nurse that the resident is back. E2 said E18 did not do this on 4/22/14, "he just wheeled her (R36) back and left".</p> <p>The facility policy dated 11/03 titled "Enteral Tube Feeding Administration Guideline" shows "A resident who is fed by a nasogastric, gastrostomy, or jejunostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration..."</p> <p>"27. Resident will be monitored for: changes in site-drainage or foul odor, signs and symptoms of aspiration, abnormal lung sounds, shortness of breath, fever, distended abdomen, diarrhea, pain, appearance and volume of gastric aspirates, heartburn, vomiting, abdominal pain or cramping,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 6</p> <p>constipation, rapid hear rate, agitation, coughing, choking..."</p> <p>The 11/13 facility policy "Enteral Feedings-Safety Precautions" states "2. Slow, continuous, pump-regulated feedings are generally better tolerated than gravity or syringe feedings." "Preventing Aspiration 2." Check gastric residual volume...every 6-8 hours after target feeding volume and rate have been established." 5. "Recognize the risk factors for aspiration, including: d. Vomiting" "Report unusual findings and/or signs of complication to the Physician"</p> <p>The facility "Nursing Services Policy and Procedure - Tube Feeding Potential Problems/Complications" states "Symptoms - Heartburn or vomiting, coughing, choking Immediate Action - Stop the tube feeding Notify health care practitioner Prevention- Do not administer feeding if stomach feels full, is distended, or if person is vomiting"</p> <p>(A)</p> <p>300.610a) 300.1010h) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 7</p> <p>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</p> <p>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 notification.</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</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 8</p> <p>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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure pressure relieving devices, ordered barrier cream was used, and failed to monitor a resident's skin condition and obtain orders for a new pressure area to prevent skin breakdown. The facility failed to reduce friction for a resident during transfers. These failures resulted in a resident (R41) acquiring a Stage IV pressure ulcer.</p> <p>This applies to 3 of 5 residents (R41, R36, R35) reviewed for pressure ulcers in the sample of 17.</p> <p>The findings include:</p> <p>1. R41 was admitted to the facility on 9/10/13 according to the 9/10/13 Minimum Data Set.. The admission nursing assessment completed on</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 9</p> <p>9/10/13, performed by the facility nurse shows R41 to have no history of pressure ulcers and no current pressure ulcers. The Head to Toe body diagram of 9/10/13 shows R41's buttock area to be chaffing and scaling. The 9/10/13 Braden Scale for predicting pressure sores risk score was 12, indicating R41 was at a high risk for pressure ulcers. The 9/17/13 admission MDS (Minimum Data Set) documents R41 required extensive assistance with a 2 person physical assist for bed mobility and transferring from a bed to a chair.</p> <p>On 9/10/13, the wound nurse documented R41 was admitted with red, dry flaky skin to buttock and over the counter creams were being applied. The 9/10/13 care plan for R41 shows a risk for skin breakdown due to immobility and incontinence (of bowel). The care plan interventions listed for R41 include review for skin breakdown, reposition every 2 hours, keep skin clean and dry, monitor placement of urinary drainage tubing, provide protective devices, skin check daily, and to use dimethicone wipes.</p> <p>On 4/24/14 at 9:15 AM, E9 CNA (Certified Nursing Assistant) stated R41 is never up out of bed for more than 1 hour at a time because of her pressure sore on her bottom. E9 stated she is turned every 2 hours on her sides, never onto her back. E9 said R41 is only up for meals. E9 stated there is no where to document when R41 is turned and on which side. E9 said a verbal report is given to the next shift and a walk through the hallway is done to check on each resident in bed. On 4/24/14 at 12:40 PM, E2 DON (Director of Nurses) stated there is no documentation for residents requiring turning. E2 stated the turns are done on the even hours. E2 stated " It is just a nursing thing, it is what you do. You turn people</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 10</p> <p>every 2 hours. I work the floor and see the aides do their rounds every even hour."</p> <p>On 9/17/13, the wound care nurse documented R41 had no improvement and treatment is to continue. On 9/24/13 the wound nurse documented the buttock area remains excoriated, no changes are made at this time. On 9/27/13, the wound nurse documented Calazyme order in place and areas of necrotic tissue (black, brown or tan tissue that adheres firmly to the wound bed) were noted. On 10/1/13 (4 days later) the wound nurse noted the wound is covered with necrotic tissue and measures 8 cm x 2.5 cm.</p> <p>On 4/23/14 at 11:20 AM, E4 Wound Nurse was observed measuring the wound. The wound measures 3.7 cm x 2.2 cm and 2.8 cm in depth and is a Stage IV pressure ulcer. The wound appears red, no drainage or odor noted. The wound is tunneling out at 3 different areas.</p> <p>On 4/24/14 at 11:15 AM, E4 said she would have approached R41's wound in a different manner right from admission. E4 stated she would have notified the physician and obtained an order for a stronger medication for the buttocks. E4 stated the stronger medication would have been a better moisture barrier and maybe would have been better. E4 stated she would have made sure the staff were turning R41 every 2 hours as it was scheduled. E4 stated that if a wound has shown no improvement after 2 weeks of the same treatment, then the physician is to be notified and a new order is obtained.</p> <p>On 10/25/13 and 12/21/13, R41's primary physician documented visits and made no documentation regarding the wound. The physician progress notes make no reference to</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 11</p> <p>the status of the pressure ulcer and documented nursing staff have no concerns.</p> <p>2. R36's MDS of 2/11/14 shows diagnoses to include Gastroesophageal Reflux Disease (GERD), Renal Insufficiency, Aphasia, and Cerebral Vascular Disorder. The 2/11/14 MDS shows R36 has an abdominal feeding tube, and requires extensive assistance from staff with bed mobility, transfers, dressing, eating, and personal hygiene. This MDS also shows R36 has severe cognitive impairment, difficulty focusing attention, disorganized thinking, and unclear speech.</p> <p>R36's "Braden Scale - For Predicting Pressure Sore Risk" dated 2/11/14 shows R36 had a score of 15 (Total Score of 12 or less represents high risk). This assessment shows that R36's skin is "Rarely Moist-Skin is usually dry".</p> <p>R36's "Pressure Sore/Wound Admission and Weekly Flow Sheet" shows R36 had a Stage II pressure ulcer develop on 1/12/14 to her left upper buttock and another Stage II Pressure Ulcer develop on 1/23/14 to her "L (left) Buttock".</p> <p>On 4/22/14 at 12:05 PM, E6(CNA) and E7 (CNA) transferred R36 to the toilet with a stand lift. E6 and E7 provided incontinence care to R36 after transferring her to the bed. R36 had a red dime-sized area to her left buttock. E6 said R36 "has an open area on her buttock that we put cream on".</p> <p>On 4/24/14 at 10:30 AM, E4 (RN-Wound Care Nurse) said she was not aware that R36 had a pressure ulcer to her bottom. E4 said when the nurses find a pressure ulcer or area of concern they report it to her, she assesses it, and chooses</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 12</p> <p>appropriate interventions.</p> <p>On 4/24/14 at 11:00 AM, E6 said R36 had a spot on her bottom that is "kind of red and open". E6 said she reported it to the nurse the day before. R36 record has no nursing documentation that R36 had a pressure sore to her left buttock documented on 4/22/14 or 4/23/14.</p> <p>R36's hospital nursing documentation dated 4/23/14 shows R36 was admitted to the hospital with a pressure sore to her coccyx. The facility had no documentation of the pressure sore prior to R36's discharge to the hospital.</p> <p>3. R35's Physician Order Sheet (POS) dated 4/1/14 shows diagnoses to include Muscle Weakness, Congestive Heart Failure, and Spinal Stenosis.</p> <p>The MDS of 3/25/14 shows R35 is cognitively intact and requires extensive assistance from staff with transfers, changing position in bed, dressing, toilet use, and personal hygiene. The 3/25/14 MDS shows R35 does not have an "unhealed pressure ulcer stage 1 or higher".</p> <p>On 4/23/14 at 2:00 PM, R35 said she had a small area under her abdominal fold that the nurses were treating. R35 lifted the abdominal fold to show an approximately one inch red slit along her abdominal fold. The surrounding tissue was red and moist.</p> <p>R35's admission skin assessment dated 2/21/14 does not show any areas of concern for her abdominal or groin area.</p> <p>R35's Skin Assessment dated 2/21/14 shows R35 was not at high risk for developing a pressure</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 13</p> <p>sore with a score of 17 (score of 12 or less represents high risk).</p> <p>R35's Nurse's Notes Wound assessment documentation dated 3/12/14 shows "Abd (abdomen) and peri-area and left upper thighs are less red. no open areas noted..."</p> <p>On 4/24/14 at 1:25 PM, E5 (Licensed Practical Nurse-LPN) said R35 has a small open area along her abdominal crease that the nurses are applying cream to. E5 said she does the treatment once a shift but does not complete the wound assessment. E5 said the wound care nurse does the weekly assessments on the pressure ulcers, not the treatment nurse. E5 said she would consider this a Stage II pressure ulcer because the skin is open.</p> <p>On 4/24/14 at 1:35 PM, E4 (wound nurse) said R35 does not have any pressure ulcers or open areas. E4 said R35 has a healed area to her coccyx that she does weekly assessments on, but she does not have any current pressures sores or open areas.</p> <p>R35's Pressure Sore Weekly Flow Sheet shows R35 developed a Stage II Pressure Sore to her Coccyx on 3/12/14. The same assessment shows R35's pressure sore reopened on 4/3/14. R35's 4/10/14 weekly assessment shows "wound bed is closed but will continue treatment as skin is fragile and gets stretched when she uses slide board to transfer".</p> <p>On 4/24/14 at 10:30 AM, E4 (wound nurse) said R35 got the pressure sore because her skin stretched and caused a slit to her coccyx. E4 said the area healed and then reopened not long after. E4 said R35 still uses the slide board to</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009179	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STERLING PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 23RD STREET STERLING, IL 61081
--	---

(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	<p>Continued From page 14</p> <p>transfer from her bed to her chair and from her chair to the bed.</p> <p>R35's skin breakdown/pressure ulcer care plans do not include any interventions to prevent the slit from reoccurring during the slide board transfers. R35's care plan does not include any interventions for other methods of transfer.</p> <p>The 8/11 facility policy "Pressure Ulcer Prevention/Skin Care" states "If the resident has any pressure ulcers, vascular ulcers, or diabetic ulcers, the documentation will be completed on the Pressure Ulcer and Wound Admission and Weekly Flow Sheet." "Individualize Plan of Care for resident when pressure ulcer is present." "PUSH tool will be completed for all pressure ulcers on a weekly basis."</p> <p>The 8/11 facility policy "Pressure Ulcer Potential Screening" states "5. If score is 15-18, resident is considered mild risk." "6. If score is 13-14, the resident is considered moderate risk." "7. If score is 10-12, the resident is considered high risk".</p> <p>"Documentation - Description of all existing pressure ulcers will be done on a weekly basis and will include the following documentation per individual site: Stages according to the NPUAP, Size in centimeters, Depth in centimeters, Color of Wound, Drainage, Location of necrotic tissue, Condition of wound margins, Any undermining or tunneling."</p>	S9999		

