Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002489 | A. BUILDING: ____ B. WING ____ | 10/31/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CAPITOL HEALTHCARE AND REHAB CENTER** | **555 WEST CARPENTER SPRINGFIELD, IL 62702** |

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| S9999 | Final Observations | S9999 | | |

Statement of Licensure Violations:
300.610a)
300.1210a)
300.1210b)
300.1210d)5
300.1220b)3
300.3240a)

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.

Section 300.1210 General Requirements for Nursing and Personal Care
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

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| S9999 | Continued From page 1<br><br>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)<br>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. Restorative measures shall include, at a minimum, the following procedures:<br>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:<br>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<br><br>Section 300.1220 Supervision of Nursing Services<br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>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, | S9999 | | |

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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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are not met as evidenced by:

Based on observation, record review and interview, the facility failed to timely identify/monitor and treat pressure ulcers and failed to follow preventative measures 4 of 9 residents (R1, R4, R11, R14) reviewed for pressure ulcer prevention in a sample of 25. This failure resulted in R11's developing multiple facility acquired pressure ulcers including two unstageable pressure ulcers to his ankle and toe. Findings include:

1. R11's Admission Sheet documents was admitted on 9/19/14. R11's Minimum Data Set (MDS) dated 9/29/14 documents that R11 is an extensive assistance with one person for bed mobility, transfers, toileting, personal hygiene and bathing.

The Weekly Pressure Ulcer Record dated 9/19/14 documents that R11 had a Stage 2 pressure ulcer measuring 2.0 centimeters (cm) by 2.0 cm to his right buttock.

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R11's Braden Scale for Predicting Pressure Sore Risk documents that on 9/19/14 R11 had a score of 16 with mild risk being score of 15-18 even though R11 had a pressure ulcer on admission.

R11's Weekly Pressure Ulcer Record dated 9/25/14 written by E18, Wound Nurse, documents R11's pressure ulcer as healing scar tissue, resolved.

R11's weekly Pressure Ulcer Record dated 10/10/14 documents R11 had a newly in- house developed Stage 2 pressure ulcer, measuring 6. cm x 5.4 cm to Right trochanter. There is no explanation as to why the facility did not identify this area sooner since he was dependent on staff for all activities of daily living according to the care plan.

R11's Braden Scale, dated 10/10/14, documents R11 has a score of 11 (high risk 10-12). R11 was at high risk for skin breakdown.

R11's Care Plan dated 10/13/14 documents that R11 is at risk for impaired skin integrity related to fragile skin. R11's care plan documents that staff are to float R11's heels, report changes in skin status to physician and complete the Braden Scale. The Care plan documents that staff are to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing and daily skin care.

R11's Care Plan dated 10/13/14 documents that R11 has a stage 2 facility acquired pressure ulcer to Right and Left trochanter and R ishium. The Care Plan documents that R11 is to use wheelchair cushion to reduce pressure. Reposition/redistribute weight every 2 hours while

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awake in bed and hourly while in wheelchair.

The Facility's Weekly Pressure Ulcer Record, dated 10/17/14, documented R11 developed a new, unstageable pressure ulcer on his left toe measuring 1.0 cm by 1.0 cm with 100% brown eshcar, and an unstageable pressure ulcer to his Left dorsal foot measuring 0.5 cm x 0.5 cm with 100% brown eschar. Again, the facility had no explanation as to why these areas were not identified more timely given his dependency on staff for all cares.

On 10/27/14 at 11:00 AM, R11 was lying on his back in low bed with mat beside bed. E40, Licensed Practical Nurse (LPN) was doing skin check and R11 did become combative so E40 did not proceed. Dressing to L greater trochanter was in place during skin check. E40 did undo dressing and L greater trochanter had area that was unstageable due to dark eschar covering area.

On 10/27/14 at 11:00 AM , E40 LPN stated that R11 can be combative and does pick at his dressings so they keep pants on him while in bed. R11's Care Plan fails to document these behaviors. The facility failed to develop interventions for R11's behaviors.

On 10/31/14 at 9:55 AM, E18 stated that stage 2 pressure ulcer to the left trochanter was found during a random whole house skin check on 10/10/14. E18 stated that she would have expected staff to have found this during care prior to this time. E18 stated that E18 was incontinent of urine during the random whole house skin check on 10/10/14.

The facility's Policy Pressure Ulcers/Skin Breakdown- Clinical Protocol documents under

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| S9999 | Continued From page 5<br>Interventions and Preventative Measures to immediately report any signs of a developing pressure ulcer to the supervisor. The Policy documents that if chair fast to change position at least every hour.<br><br>2. R4's MDS dated 9/16/14, documents that R4 requires an extensive assist with two plus persons physical assist for bed mobility. R4's MDS documents that R4 requires total dependence with two persons physical assist and is frequently incontinent.<br><br>R4's Physician Order Sheet (POS) dated 9/11/14 documents that R4 is to have duoderm to left ischeal tuberosity , change every three days and prn (as needed).<br><br>On 10/26/14 at 1:55 PM, R4 was observed to have opened areas on L (Left) buttocks. No dressing was in place when incontinent brief was removed. R4 was incontinent of urine.<br><br>0n 10/29/14 at 2:00PM, E39, Treatment Nurse stated that R4's open areas on L buttocks was from moisture associated skin dermatitis. E39 stated that R4 is to have a duoderm to left buttocks and changed every three days.<br><br>3. R1's Braden Scale Risk for Pressure Ulcer Assessment of 10/10/14 documents R1 is at high risk for developing pressures.<br><br>R1's MDS of 9/8/14 documents R1 is totally dependent on 1 or more staff for transfer and bed mobility.<br><br>R1's Care Plan of 9/18/14 does not address R1's high risk for development of pressure sores. | S9999 | | |

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R1 was observed on 10/27/14 from 8:50 AM to 10:33 AM to be up in his wheel chair without being repositioned. At 10:33 AM, E15, Certified Nurse's Assistant (CNA) was in R1's room and stated she and E31, CNA, had just transferred R1 to bed. R1's incontinent brief was saturated with feces and urine and the back of his thighs were deep creased and red. E15 stated R1 had been up in his wheel chair since 7:45 AM.

4. R14's MDS of 8/14/14 documents R14 is totally dependent on 2 or more staff for transfer and bed mobility.

R14's Care Plan of 8/19/14 documents R14 is at risk for impaired skin integrity related to incontinence of bowel and bladder. Care Plan approach, in part; reposition resident as per facility protocol, provide incontinence care after incontinence episodes and apply barrier cream PRN (as needed).

R14 was observed on 10/27/14 every 5 to 10 minutes, to be up in a geriatric reclining chair from 8:50 AM to 11:40 AM with no positioning or checking for incontinence. At 2:55 PM, R14 was observed in bed and E15 was in the room and stated she had just put R14 to bed. R14 had a large bowel movement and she had an opaque hydrocholloid dressing on her coccyx that was soiled with feces. E39 stated the dressing was for a preventative and R14 did not have a pressure sore at this time

( B)