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
	IL6007504	A. BUILDING: ____ B. WING ____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW REHAB & HCC	500 NORTH JACKSON STREET MORRISON, IL 61270

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S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
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

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

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1 care needs of the resident. 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: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. Section 300.3240 Abuse and Neglect	S9999		

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

These Requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure daily skin monitoring was done for a resident at high risk for pressure ulcers. The facility failed to thoroughly assess a pressure ulcer upon identification, and failed to monitor R1's pressure ulcers with weekly pressure ulcer assessments. The facility failed to include interventions to treat R1's pressure ulcers in the pressure ulcer care plan.

This failure contributed to R1 acquiring a stage four pressure ulcer to her coccyx on 11/3/14, and a stage four pressure ulcer to R1's left shin on 11/3/14.

This applies to 1 of 5 residents (R1) reviewed for pressure ulcers in the sample of 14.

The findings include:

R1's Minimum Data Set (MDS) of 12/11/14 shows R1 requires extensive assistance from staff with dressing, repositioning in bed, transfers, hygiene, and bathing.

R1's Physician Order Sheet dated 2/1/15 shows diagnoses to include: Arthritis, Degenerative Joint Disease, Depression, and Anxiety.

R1's Pressure Ulcer Risk Assessments dated

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9/25/14 and 12/11/14 show R1 is at high risk for pressure ulcers.

R1's facility admission assessment dated 4/25/13 shows R1 was admitted to the facility without pressure ulcers to her coccyx, and bilateral shins.

On 2/26/15 at 9:45 AM, E3 (Registered Nurse-RN), and E14 (Licensed Practical Nurse- LPN) rolled R1 onto her left side. E3 removed the dressing to R1's coccyx. R1 had an irregular circular open area to her coccyx with a deep, pink wound bed. E3 said "this is much better than what it was" and "there is a little tunneling going up the coccyx". E3 cleaned R1's wound with saline, and then packed the wound with a medicated, wet gauze.

E3 and E14 rolled R1 onto her back and R1 had a pink scar to her left shin. E3 said the pressure ulcer to her shin "healed".

R1's Nurse notes dated 10/21/14 shows "Noticed two bruises with open area in buttocks. ...Telephone order. Clean buttocks with normal saline. Apply Barrier cream to right buttocks with open area, cover with border dressing 3x daily".

The next wound entry did not occur until 10/23/14 and states "treatment completed to coccyx as ordered...

10/30/14 Nurse notes show "treatment to coccyx performed. Area a stage 4 with moderate amounts of yellow/brown drainage with 0.5cm depth. Area has dark brown/black necrotic tissue present in wound bed ".

The 11/5/14 at 10:30 AM, Nurse notes show "Treatment to coccyx changed...DON [Director of

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Nursing] consulted concerning severity of wound...Resident yelling in pain...wound bed displaying increased - medium amount of yellow slough".

The November, 2014 Treatment Administration Record (TAR) shows "11/2/14 Coccyx: cleanse with wound cleanser apply santyl ointment to slough areas, cover with bordered gauze.

The first documented assessment of R1's coccyx wound on the TAR did not get completed until 11/17/14, almost 4 weeks (27 days) after the wound was identified. The initial assessment in the nurse notes did not include a description of stage, size, shape, depth, color, drainage, or description of the wound bed. There were no other weekly wound assessments completed on the November, 2014 TAR.

The facility Weekly Wound Tracking sheet shows the onset of R1's coccyx wound was 10/21/14 and the first assessment was not documented until 11/3/14, (13 days after the wound was identified). The 11/3/14 assessment shows "Coccyx, Stage IV, 4cm, 3.4cmx .5cm, deteriorating status, and minimal drainage".

R1's nurse notes dated 10/24/14 at 2:30 AM shows "2.5 cm x 2.2cm bruise noted to anterior left shin and 1.5cm x 1.7cm blister noted to lateral left shin. 1.5cm x 1.7 cm red area to top of foot..." This assessment did not include the stage, size, shape, or description of the wound bed and surrounding tissue.

The November TAR shows a treatment ordered 11/2/14 "areas on left shin cleanse with wound cleanser apply and cover two times per day...D/C [discontinue] when necrotic tissue/slough is

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minimal..."

The facility did not provide any documented TAR assessments of the wound to R1's shin for October or November.

The facility Wound Tracking documents show the onset of R1's "left lateral shin wound" was 10/21/14 (nurse notes identify as 10/24/14). The first assessment was not completed until 11/3/14 (10 days after it was identified in the nurse notes) and showed "Stage IV Pressure Ulcer, 2.3cm x 1.4cm x 0.2cm, deteriorating status and minimal drainage".

R1's 11/13/14 physician orders shows "wound clinic consult".

R1's 12/1/14 Wound Care Clinic notes shows a full thickness, Pressure injury to the left lower leg-lateral, measuring 1.3cm x 0.8cm x 0.1cm. This report shows a small amount of purulent, yellow, brown, green drainage, and "large (67-100%) necrotic tissue and adherent slough.

R1's 12/1/14 Wound Care Clinic notes show a Stage III pressure injury to coccyx, measuring 3.5cm x 3cm x 2.3cm. This assessment shows the wound had a medium amount of red/brown drainage.

On 2/25/15 at 3:00 PM, E12 (RN) said when a new pressure ulcer is identified the nurse completes an initial assessment to include a description of the wound, size, stage, depth, odor, drainage and wound bed. E12 said this information is documented on the forms in the wound packet and also in the nurse notes. E12 said a complete assessment should be documented in the nurse notes when the wound

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is identified.

On 2/26/15 at 9:45 AM, E3 and E14 said R1 was high risk for skin breakdown before her pressure ulcers developed. E3 and E14 said a daily skin assessment should be completed by the nurse on all residents who are high risk for skin breakdown. E3 and E14 said these assessments are documented on the TAR daily and if any change is noted or a new area is discovered an assessment is completed on the back of the TAR and in the nurse notes. E3 and E14 said if a wound is identified, a full assessment is completed weekly to include stage, size, color, odor, and wound bed, and is documented on the back of the TAR, on the weekly Pressure Ulcer Monitoring sheet, and in the nurse notes.

R1's September, 2014 TAR shows an order written on 4/25/13 for "weekly skin check by Licensed Staff", not daily skin checks.

R1's high risk for pressure ulcer care plan has an intervention dated 4/8/14 "High Risk-Daily skin check with documentation and as needed with any new open area". R1's High Risk for Pressure Ulcer care plan did not include the pressure ulcer to R1's coccyx, or R1's shin. This care plan does not have any interventions or treatments ordered for R1's left shin pressure ulcer. R1's Pressure Ulcer Care Plan did not have an intervention to reposition from side to side only, and up for meals only, as ordered by the wound care clinic on 12/9/14.

On 2/26/15 at 9:25 AM, E2 (Director of Nursing-DON) said the Pressure Ulcer Risk Assessment determines whether skin monitoring is completed by the nurses daily or weekly. E2 said if a resident is high risk for breakdown the

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S9999	Continued From page 7 resident will get a skin assessment completed daily by the nurse. E2 said this assessment is documented on the TAR, and each resident has either a weekly or daily skin assessment. E2 said R1 was a high risk and should have had daily skin assessments completed by the nurse and documented on the TAR. E2 said she would "absolutely" expect a wound to be identified as a stage I if daily skin assessments are being done. E2 said daily skin assessments are done on high risk residents so problem areas can be identified right away. E2 said when a wound is identified a complete assessment should be documented to include "wound bed, drainage, stage, and size". E2 said this assessment should be documented in the nurse notes, and on the back of the TAR on identification, and then weekly. E2 said she could not find an assessment of R1's wounds in October, and only one assessment of R1's coccyx on the Novemeber TAR. E2 said she did not have any assessments on the TAR in October or November for the wound to R1's shin. E2 said a complete desription of the wounds, including stage, and wound bed should have been documented in the nurse notes and the assessment completed on the back of the TAR when the pressure ulcer was identified to R1's coccyx, and shin. E2 said any pressure ulcer treatment, order from the wound care clinic, and pressure relieving interventions should be part of the pressure ulcer care plan. On 2/26/15 at 12:10 PM, Z1 (Medical Physician) said he would consider R1 high risk for pressure breakdown prior to development of the pressure sores in October, 2014. Z1 said he would expect a complete assessment of a pressure ulcer to be completed on identification and no later than three days after identification if a wound care team was completing the assessment. Z1 said	S9999		

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complete weekly skin assessments should be done after identification until the wound heals. Z1 said if daily skin assessments were completed a resident would "not likely" go from nothing to a stage III or stage IV, and it would be "unusual" to go from no wound to a "stage III" in one day.

The 1/02 facility policy "Skin Condition Monitoring" states
1. Upon notification of a skin lesion, wound, stasis ulcer, or other skin abnormality, the Charge Nurse will assess and document the findings.
4. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed.
Documentation of the area must include the following:
a. Characteristic
1. Size
2. Shape
3. Depth
4. Color
5. Presence of granulation tissue or necrotic tissue
b. Treatment and response to treatment.
c. Prevention techniques.
The 4/06 facility policy "Pressure Sore Prevention Guidelines" states: "To provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the [pressure ulcer risk assessment tool].
The following guidelines will be implemented for any resident assessed at a Moderate of High skin risk.
Daily skin checks
Care Plan Entry - Skin risk and appropriate interventions are to be placed on the Care Plan.
If despite interventions, a Pressure ulcer

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develops, the care plan must reflect updated interventions for healing of ulcers and additional interventions for further preventions of pressure ulcers.

Any resident scoring a High or Moderate risk for skin breakdown will be noted on the Treatment sheet and signed off by the nurse. In addition, a brief weekly narrative will be completed describing the resident's skin condition on the back of the treatment sheet."

The 5/07 facility policy "Decubitus Care/Pressure Areas" states
1) Upon notification of skin breakdown a Newly Acquired Skin Condition report will be completed...
2) The pressure area will be assessed and documented on the Treatment Administration Record (TAR).
3) Complete all areas of the TAR
i) Document size, stage, site, depth, drainage, color, odor, and treatment...
5) Documentation of the pressure area must occur upon identification and at least once each week on the TAR. The assessment must include:
i) Characteristic (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc)."

(B)