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
	IL6004881	A. BUILDING: ______ B. WING ______	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK REHABILITATION & HCC	1700 WHITE STREET MOUNT VERNON, IL 62864

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S 000	Initial Comments Complaint Investigation 2450209/IL168537	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010) 300.1210 b) 300.1210 d)5) 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 300.1010 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 of care for the care or treatment of such accident, injury or change in condition at the time	S9999		

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of notification.

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 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 300.3240 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)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to obtain timely wound care orders and

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implement pressure wound treatment for 1 (R3) of 5 residents reviewed for wounds in the sample of 5. This failure resulted in R3 receiving no treatment to pressure wounds on his bilateral buttocks from 12/27/2023 to 1/02/2024 with wounds deteriorating as evidence by an increase in size, staging, and onset of odor.

Findings include:

Review of R3's "New Admission Information" sheet documents an admission date to the facility as 09/15/2023. The same document listed V9 (Physician) as R3's physician.

R3's "Cumulative Diagnosis Log" (undated) includes diagnoses listed as, but not limited to, of: Urinary Incontinence, moderate intellectual disabilities, drug-induced Parkinson's, chronic obstructive pulmonary disease, and edema.

R3's "Baseline Care Plan", dated 10/02/2023, documented an entry made on bottom of care plan, dated 1/02/2024, with following note-New Wounds-(contracted wound company) to see, air mattress placed, weekly skin checks, wound care. No previous entries or documentation of communication or wounds was noted. Review of an additional care plan provided by the facility, dated 12/27/2023, with goal and interventions noted on 1/02/2024, for pressure injury/skin breakdown. Although requested from V1, the comprehensive care plan in place prior to 12/27/23 could t be provided.

R3's Minimum Data Set (MDS), dated 12/14/2023, documents in section C, Cognitive Patterns, a Brief Interview for Mental Status (BIMS) of 99, indicating that R3 was unable to complete the interview. Additionally, this same

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MDS documents in section M, Skin Conditions, that R3 is at risk for developing pressure ulcers/injury but has none at this time.

R3's Weekly Skin Assessment was documented as being completed on 12/15/23, with no areas of concern documented.

R3's nurses note, dated 12/16/2023 at 6:40 PM, documented R3 was vomiting and less responsive than usual. Vomit was cleared from nose and mouth, with R3 not responding. V9 was notified at 6:44 PM and R3 was transferred to local Emergency Department via ambulance for evaluation and treatment.

R3's local hospital discharge summary, dated 12/27/2023, documented an admission to the local hospital as 12/16/2023 to 12/27/2023. Final diagnoses were as follows: 1. Urinary Tract Infection 2. Malnutrition noted.

R3's "Hospital Transfer Chart" in the hospital records document an entry dated 12/17/2023, in which R3 is noted to have pressure injuries to his right and left buttock. The origination date of the pressure injuries to R3's right and left buttock were not documented and could not be determined.

R3's "Nursing Admission Assessment", completed on 12/27/2023, with no time entered and no signature on the documentation, documents, "1 inch by 0.5 inch, stage 2 to right buttock and 1.5 inch by 1 inch, stage 2 to left buttock area." On 1/11/2024 at 12:03pm, V6 stated although her assessments were documented in inches she meant to document in centimeters for wound measurements. This would indicate the final measurements as being 1

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centimeter (cm) by 0.5 cm to the right buttock and 1.5 cm by 1 cm to the left buttock. V6 also confirms she was the nursing staff who completed the "Nursing Admission Assessment", dated 12/27/23.

R3's wound pictures from the hospital records, dated 1/07/2024 at 12:47 AM, documented a 5.5 cm by 4 cm wound to the right buttock area, and at 12:51 AM a 4 cm by 3.8 cm wound to the left buttock. These photos were taken by the hospital upon an unrelated re-admission R3 had to the hospital on 1/6/23.

R3's "(Facility Name) Weekly Wound Tracking", dated January 2024 with a "late entry" date of 1/02/2024, documented right buttock wound as stage 3, 2 cm by 3 cm, 1 cm depth, moderate drainage and odor noted and left buttock wound as stage 3, 4.6 cm by 3 cm, 1 cm in depth, moderate drainage and odor noted. This same document has an entry for 1/05/2024 with same measurements and no change in drainage and odor from 1/02/2024 documentation.

R3's "Physician Orders", dated from 1/01/2024 to 1/31/2024, documented the following telephone orders from V9 (Physician) dated 1/2/23: 1. cleanse area on right buttock with normal saline, pat dry. Apply calcium alginate, cover with dry dressing daily and prn (as needed). 2. Cleanse area on left buttock with normal saline. Pat dry. Apply Calcium alginate cover with dry dressing daily and prn. 3. Apply betadine to left lateral foot daily. R3's "Physician Orders", dated for 12/1/23 - 12/31/23, noted no wound care orders to R3's buttocks were in place.

On 1/10/24 at 10:15 AM, V5 stated she does the wound tracking for the facility. V5 stated R3's

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cognition varies due to being hard to communicate with, as he is Spanish speaking in nature. V5 stated R3 can understand English, but does not speak it well. V5 stated staff are able to communicate using yes/no and pointing gestures to make needs known. V5 stated all residents receive weekly skin checks by nursing staff assigned to that hall. V5 explained prior to R3's most recent hospitalization, no skin breakdown was present, although occasional redness was treated and resolved with barrier cream. V5 stated on 1/2/24, she was made aware of wounds to R3's buttocks by V7 (Certified Nurse Assistant/CNA). V5 stated that V7 reported that the 2 brown bandages to R3's buttocks smelled so bad that he had to take them off during R3's shower. V5 stated she did not view the bandages as they had been thrown away. V5 stated in reviewing R3's re-admission data to the facility on 12/27/23, V6 (Licensed Practical Nurse/LPN) was determined to have completed the assessment. V6 documented wounds to both buttocks, although no treatment orders were carried out or physician notification of wounds was noted. V5 stated once she had been made aware, she immediately notified V8 (Advanced Practice Registered Nurse), who made the referral to (contracted wound company). V5 stated she viewed the wounds, which were pressure in nature to both buttocks, with tan, foul smelling drainage. V5 stated it is the policy of the facility that wounds are immediately reported to the physician for treatment orders to be obtained.

On 1/10/24 at 10:37 AM, V2 (Director of Nursing) stated R3 only speaks mumbled Spanish, so it's hard to determine his true cognition. V2 stated R3 does not have a history of wounds and was ambulatory in the past, until recently having an overall decline starting around the end of

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November, where he has routinely been in and out of the hospital and started utilizing a wheelchair. V2 described R3 as being incontinent and developmentally disabled. V2 stated during R3's most recent readmission to the facility from the local hospital, it was brought to nurse's attention on 1/2/24 of R3's presence of wounds to his buttocks by V7. V2 confirmed no wound care orders, no nursing notes, and no physician notification regarding the wounds was in place prior to 1/2/24. V2 acknowledged the untimely wound evaluation, treatment and care provided to R3 upon his return to the facility, and stated a discipline form has been initiated for the nurse (V6) who completed R3's re-admission assessment to the facility on 12/27/23, notating the presence of wounds, but taking no further action.

On 1/10/24 at 10:55 AM, V1(Administrator) stated she would expect residents that have wounds or impaired skin integrity to be evaluated with physician notification for orders and interventions implemented immediately. V1 acknowledges there was a delay in wound care treatment for R3, as R3's wound care had not begun until 1/2/24, when herself and V5 were notified of wounds present to R3. V1 stated a staff education and counseling form has been initiated.

On 1/10/24 at 11:20 AM, V7 (Certified Nursing Assistant/CNA) stated he was changing R3 on 1/2/24, and noticed he had foul smelling, visibly soiled, tan/brown bandages, one to each buttock. V7 stated he cannot recall for sure what the dressings were dated. V7 stated he immediately notified V5 that R3's dressings would need changed, in which V5 then expressed she wasn't aware R3 had any wounds. V7 stated he cannot say when the wounds had formed.

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On 1/10/2024 at 12:15 PM, V5 stated R3 was not seen by (contracted wound company) on 1/2/2024 because the facility had not received orders for R3 to be referred until after (contracted wound company) had left the building for the week, and R3 was transported to the (name of local hospital) on 1/06/2024.

On 1/10/24 at 12:26 PM, V6 (Licensed Practical Nurse/LPN) stated she was the nurse who had sent R3 to the hospital for his 12/16/23 hospitalization. V6 described R3 as being lethargic and having emesis. V6 stated she had contacted the physician who ordered R3 to be sent to the local Emergency Department for evaluation. V6 stated R3 had no wounds on his buttocks prior to being transferred to the hospital, and she can say this confidently as he is frequently incontinent during the night, in which she helps assist in his care and views his buttocks routinely. V6 stated she is a newer nurse and confirmed she was the nurse who did R3's re-admission to the facility on 12/27/23, in which stage 2 pressure wounds were noted to his bilateral buttocks. V6 stated she measured the wounds upon his return, also including depth. V6 stated the wounds did not have any foul odor and the tissue was red in color. V6 stated she documented her wound findings on the nursing home assessment form which is completed upon a resident's admission. V6 stated she then passed on in report the next morning the presence of R3's wounds to V2 (Director of Nursing) or V5 (LPN), stating she cannot remember which one was working. V6 stated she had not contacted the physician for wound care orders because she didn't think it was an urgent matter to disrupt the physician. V6 stated she assumed day shift would contact the physician

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the next day when she told them in report that R3 had wounds to his buttocks.

On 1/10/24 at 1:08 PM, V5 (Licensed Practical Nurse/LPN) stated she was the staff member V6 gave report to upon R3's return from the hospital to the facility on 12/27/23. V5 stated no report of R3's wounds was made to her.

On 1/10/24 at 3:02 PM, V9 (Physician) stated it would be his expectation to be notified of skin integrity concerns or wounds immediately and have treatment promptly initiated. V9 stated if he was not notified, he would also find it acceptable if the facility notified the wound care physician directly to obtain wound care orders from them. V9 stated he cannot recall if he was notified, but would expect those correspondences to be documented. V9 agreed it is accurate to say that without treatment, a wound has the potential to significantly deteriorate from 12/27/23 - 1/2/24. R3's history of weight loss was also discussed with V9, in which V9 stated nutrition can affect wound healing or formation, but acknowledged, despite nutritional status, determining if a wound is unavoidable is difficult when there is no treatment in place to promote healing.

On 1/11/24 at 7:55 AM, V8 (Advanced Practice Registered Nurse) stated she would expect for herself or V9 to be notified of wounds immediately to have interventions and treatment implemented. V8 stated she was notified of wounds present to R3 on 1/2/24, and orders were given at that time for treatment.

Review of "Supervisor Report of Counsel" for V6, dated 1/10/2024, documented a date of occurrence as 12/27/2023, with a description of the occurrence as follows-skin assessment was

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not signed. No new skin report filled out, no nurse's notes were written, and no treatment orders reviewed for wounds to bottom. No documentation on 24-hour report. Counseling summary for V6 noted for education on skin protocol, how to approach new wounds, when to fill out quality assurance forms, and where to document new wounds. This document was noted to be signed and dated by V6, V1 and V2 on 1/10/24.

The facility policy titled, "Skin Condition Monitoring" with a most recent revision date of "1/18" documented, "It is the policy of this facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities.....1. Upon notification of a skin lesion, wound, or other skin abnormality, the Nurse will assess and document the findings in the nurses notes and complete the QA (Quality Assurance) form for Newly Acquired Skin Condition. 2. The Nurse will then implement the following procedure: a. Notify the physician and obtain treatment order. b. The treatment order will include: 1. Type of treatment. 2. Location of area to be treated. 3. Frequency of how often treatment is to be performed. 4. How area is to be cleansed. 5. Stop date, if needed.....4. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed..."

(B)