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WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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S 000	Initial Comments Complaint #1875201/IL104843	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)2)3)5) 300.1220b) (1 of 1) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 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:	S9999		

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S9999	Continued From page 2 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 WERE NOT MET AS EVIDENCED BY: Based on interview, record, and observation review the facility failed to prevent, assess, and implement interventions to prevent pressure ulcer development. This applies to 2 of 3 residents (R1, R2 &R3) reviewed for pressure injury in the sample of 3. The findings include: On August 8, 2018, R1 was on his back (Not turned and repositioned) from 10AM to 1:10 PM when V4 CNA (Certified Nursing Assistant) assisted R1 up to his chair and placed him near the nurses' station. On August 8, 2018 at 1:00 PM, V4 was assisting R1 up to his chair and did not check his	S9999		

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incontinent brief which was obviously soiled when writer stopped V4 and stated R1 needs to be changed because his brief is obviously soiled.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility January 2018 with multiple diagnoses including pneumonia, pulmonary edema, dementia with behavioral disturbance, cerebral vascular accident, atrial fibrillation, hemiplegia, congestive heart failure and muscle weakness.

R1's MDS (Minimum Data Set) dated May 7, 2018 shows R1 BIMs's has severe cognitive impairment, required extensive assistance with ADLs (Activities of Daily Living), and was frequently incontinent of bowel and bladder and history of pressure ulcers.

R1's Braden scale dated February 23, 2018 shows high risk for developing a pressure ulcer

Physician orders in the EMR (Electronic Medical Record) dated March 10, 2018 shows R1 had a facility acquired open area to his sacrum.

R1's Nurses note dated March 10, 2018, shows R1 was "in bed at change of shift, family at bedside, patient has soaked diaper, incontinent of large amount of urine most of the time. Patient with open areas on the sacrum were assessed and will refer again to the wound nurse and wound doctor; turned to sides, needs frequent changes to keep dry, with pressure relieving heel boots, air mattress in place."

R1's Skin integrity care plan was initiated on March 20, 2018. R1's air mattress was ordered on March 11, 2018.

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R1's Physician progress note dated March 12, 2018 shows patient with pressure ulcer to buttocks. Coordinated care with Nurse Practitioner, treatment nurse and staff nurse. R1 has underlying bladder incontinence discussed with POA (Power of Attorney) family concerns of poor wound healing.

R1's Physician order dated April 25, 2018 shows order for turn and reposition every two hours as needed, every shift for prevent skin alteration.

R1's Physician orders dated April 30, 2018 shows barrier cream to buttocks and peri area topically every shift and as needed.

R1's Physician orders dated June 7, 2018 a specialized wheelchair was ordered.

R1's Physician note dated August 7, 2018 shows R1 has a healed skin tear on his right elbow, left side of buttocks reddened, continue to turn often, continue pressure relieving boots.

R1's Nurses note dated August 7, 2018 shows on left buttocks a 2cm area of redness that is very fragile with skin just hanging and can easily breakdown and penile area slightly red.

On August 9, 2018 shows R1 has a skin opening to buttocks. Observed a skin reopening to the right buttock 1cm x 1cm x 0.2.

On August 8, 2018 at 12:30 PM, V6 RN (Wound Nurse- Registered Nurse) stated R1 had a facility acquired pressure wound to his sacrum and we closed it. V6 stated R1 does not move and needs to be turned and repositioned by staff and now has a new opening again. V6 stated staff is to be turning and repositioning every two hours, notify

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the nurse if any change in skin integrity and use barrier cream with each incontinence episode to decrease breakdown.

On August 8, 2018 at 2:30 PM, V3 RN (Nurse Consultant) stated R1's Skin integrity Care plan is dated for March 20, 2018 after the sacrum wound was found on March 10, 2018. V3 stated the CNA's (Certified Nursing Assistants) should be checking residents' skin every shift and with showers. V4 stated it is the CNA's responsibility to notify the nurse with any changes. V3 clarified what offloading PRN (as needed) meaning; this means to offload the heels while in bed. V3 stated any resident who is high risk or have skin integrity issues should have on admission an air mattress and pressure relieving interventions V3 stated R1's air mattress was ordered on March 11, 2018 after the sacrum wound was found. V3 confirmed R1's weekly skin assessments were ordered on April 30, 2018 along with moisture barrier cream. V3 was unable to provide weekly skin documentation. V3 stated R1 had a physician order dated May 1, 2018 for Zinc oxide to be applied to buttocks for skin protection. V3 stated there is a lack of documentation to support that R1's facility acquired wound was unavoidable.

On August 9, 2018 at 10:12 AM, V13 (Nurse Practitioner for R1) stated if pressure ulcer prevention for R1 was not in place prior to getting wounds and if pressure relieving interventions were not be followed; yes this could be avoidable but facility might be doing interventions but not documenting.

2. On August 8, 2018 at 9:55 AM, Writer asked V4 to do a body check on R2. R2 had redness noted under her breast area, and no dressing

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was noted to R1's sacrum wound. V4 stated she saw R1's wound dressing at 7:30 AM when she provided incontinence care. V4 stated at 9:30 AM, R1 did not have a wound dressing on her coccyx. V4 stated the policy is for the CNA's (Certified Nursing Assistants) to notify the nurse if there is a resident skin issue and if a wound dressing fell off or is needed. V4 stated she "did not tell R1's nurse or notify the wound care nurse about the missing wound dressing she just forgot".

On August 8, 2018 from 9:30 AM to 12:10PM resident was laying on her back not turned or repositioned until writer notified V6 (Wound care nurse) of missing dressing.

On August 8, 2018 at 11:42 AM, V10 RN (Registered Nurse) stated she was unaware of R1's wound dressing was off. V10 stated the CNA did not notify her. V10 stated the wound care nurse usually changes her wound dressing daily and turned around to finish passing medications.

On August 8, 2018 at 12:10 PM, writer contacted V6 RN (Wound Care Registered Nurse) to ask if she was notified of R2's missing sacrum dressing. V6 stated she was unaware and would be on her way to address her wound. V6 stated the CNA's should have told the nurse on duty and the nurse should have put a temporary dressing on it until I could do wound treatment. Writer pointed to R1's front and back of her knee to new skin breakdown. V6 stated she did not see this until I brought it to her attention.V6 stated the wound doctor was here and she would address new breakdown with him. V6 provided incontinent care to R2, no infection control issues noted but V6 did not use barrier cream after

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incontinence care provided. V6 could not explain why her wound care documentation showed facility acquired on January 6, 2018 when R2 ' s nurses and skin alteration sheets show facility acquired unstageable pressure sore was found on December 27, 2017.

On August 8, 2018 at 12:42 PM, V4 stated R2's nurse did not tell me to get her up for the day and now it's too late to get her up now, I will be going home soon.

The EMR shows R2 was admitted to the facility in June 2009 with multiple diagnoses including cerebellar ataxia, pressure ulcer, hypothyroidism, dysphagia, tachycardia, contractures, degenerative disease and encephalopathy.

R2's MDS dated June 26 2018 shows R2 had severe cognitive impairment, requires extensive assistance with dressing and total assistance for hygiene, eating, transferring and bathing. In addition, incontinent of bowel and has a catheter for urine.

R2's Braden Scale dated August 22, 2017 shows resident is at high risk for skin breakdown.

R2's Treatment Skin Alteration record dated December 27, 2017, shows resident was noted with unstageable pressure ulcer measuring 4.2 x 2.7 x 1.3; seen by Wound Physician and orders for Santyl and foam dressing to be applied. R2 to be turned and repositioned every two hours and to be kept dry. Hand washing education given to staff.

R2's Nurses notes dated 12/28/18 shows Santyl ointment to be applied to sacrum.

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R2's Nurses note dated January 6, 2018 shows resident with unstageable pressure ulcer noted to sacrum. Wound measures 4.6 x 3x1.4, 95% eschar black in color moderate serous drainage noted. Dressing change done; wound physician notified. Certified nursing assistant educated to keep resident turned every two hours and keep resident dry. Left message to update POA (Power of Attorney).

R2's Nurses note dated January 6, 2018, shows Wound physician called back and order received for resident to go to the hospital and be evaluated for wound. Shift nurse will call POA for permission to send to hospital for evaluation. Hospital was on bypass and directed to send resident out on January 7, 2018 to hospital.

R2's nurses notes show resident was admitted to hospital on January 7, 2018 through January 17, 2018 for wound management.

R2's Skin Integrity Care plan was dated January 7, 2018 shows pressure relieving interventions were implemented after facility acquired wound was found on December 27, 2018.

R2's Physician orders dated January 16, 2018 show air mattress, turn and reposition every two hours and as needed, moisture barrier cream, and Zinc oxide ointment 20 % apply to peri area every 8 hours as needed for skin protection were ordered.

R2's Physician order dated January 17, 2018 shows pressure relieving boots were ordered.

On August 9, 2018 at 10:12 AM, V12 (Wound Care Physician) stated R2 keeps moving her legs in bed all the time; she will not stay still. She

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should be cleaned, turned and repositioned and air mattress should be in place. If a resident is high risk for pressure ulcers then pressure relieving interventions should be in place immediately. I am not sure if her pressure ulcer was avoidable.

3. On August 8, 2018, 2018 at 11:00 AM, R3 was up in her wheelchair positioned by the window in the dining room. R3 did not have pressure relieving devices in place to R3 is to have right foot pressure relieving boot and hip splint while up in chair as Care planned. V5 stated R3 was up in her wheelchair from 7AM till 12:30 PM. V5 stated she did not provide incontinent care during this time and did not turn and reposition her in her wheelchair. V5 stated she put R3 to bed approximately 12:30PM only because she was tired.

On August 8. 2018 at 1:00 PM V5 pulled back R3's sheet and found a medicine cup containing a white substance in her bed. V5 provided peri care but did not apply barrier cream after providing incontinence care and did not apply pressure relieving boots on her feet while in bed.

On August 8, 2018 at 1:10 PM, V5 stated R3 was up in her wheelchair since 7AM today and if R3 is more awake we keep her up all day.

The EMR dated December 27, 2017 shows R3 was admitted to the facility on with multiple diagnoses including dementia, hypertension, chronic embolus, major depression, anemia and anxiety.

R3's MDS dated May 17, 2018 shows R3 has moderate cognitive impairment, requires extensive assistance with ADLs, and is frequently

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incontinent of bowel and bladder.

R3's Braden scale dated June 4, 2018 shows resident is a high risk for pressure ulcer.

R3's Pressure Wounds weekly summary dated August 1, 2018 shows on June 28, 2018 a facility acquired coccyx pressure wound and July 5, 2018 a facility acquired right buttock pressure wound.

R3's Skin Alteration Care plan with interventions such as turning and repositioning, barrier cream after incontinence care and pressure relieving boots to heels were not implemented on August 8, 2018.

Facility Pressure Injury Prevention Policy undated shows, "It is the policy of the facility to implement measures to protect the resident's skin integrity and prevent skin breakdown whenever possible ... The facility will implement interventions when residents are unable to turn and reposition independently will be assisted to turn and reposition every two hours or as appropriate ...Positioning devices will be used to keep bony prominences from direct contact with each other; pillows, foam wedges, or other devices may be used for this purpose ...Time spent up in chair may need to be limited ...Cleansing measures will be completed after each episode of incontinence and barrier ointments/creams will be applied as ordered by the physician.

Facility Wound Management Policy undated shows.. It is the policy of the facility to treat wounds according to clinical guidelines and this will be accomplished through the use of appropriate positioning practices, positioning devices, and support surfaces as described in

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S9999	Continued From page 11 Pressure Injury Prevention. (B)	S9999		