

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012678	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/21/2018
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NAME OF PROVIDER OR SUPPLIER PRESENCE VILLA FRANCISCAN	STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435
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S 000	Initial Comments Complaint Investigation 1876138/IL105885	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210d)2)3) 300.3220F) 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	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/01/18

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S9999	<p>Continued From page 1.</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</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> <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 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidence by:</p> <p>Based on interview and record review the facility</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>failed to complete initial and weekly wound assessments and failed to identify deterioration, dehiscence and infection of a post-surgical wound.</p> <p>This applies to 1 of 4 residents (R1) reviewed for surgical wounds in a sample of 4.</p> <p>This failure resulted in R1's surgical wound deteriorating and developing a post-operative infection requiring surgery and a wound vac placement.</p> <p>Findings include:</p> <p>R1's hospital Discharge Instructions dated June 18, 2018 document R1 being discharged to the facility for after care of a femoral-popliteal bypass surgery. Instructions include to notify Cardiovascular Surgeon (V6) of incision redness, swelling, drainage or foul smell and to paint right groin incision with Betadine twice per day and cover with a dressing.</p> <p>R1's Admission Skin Evaluation Report dated June 18, 2018 documents R1 admitted to the facility with 27 staples to a groin incision measuring 7 centimeters (cm) by 0.1 cm. A picture of the right groin surgical incision dated June 18, 2018 show staples intact and the incision closed.</p> <p>R1's June 2018 Physician Order Sheets (POS) document to monitor right groin for signs of infection, redness, warmth and notify the physician of any changes and to paint the right groin with Betadine twice per day and cover with a dressing.</p> <p>R1's Departmental Note dated June 29, 2018 as</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>a late entry for June 25, 2018 documents R1's incision was intact and staples in place...."Wound and Peri wound noted to not have a any staining from Betadine as order to be applied twice daily by floor nursing...informed the nurses that the wound is to be painted with Betadine twice daily per surgeon orders and to be monitored each shift..." This is the only Departmental Nursing note between June 19, 2018 and June 28, 2018 documenting a wound assessment. A Daylight Assessment Note dated June 23, 2018 documents the groin wound intact but no other wound characteristics and measurements were identified.</p> <p>There was no comprehensive wound assessments, weekly wound assessments or evidence in Departmental Notes June 18, 2018 through June 28, 2018 of a comprehensive wound assessment being completed initially or weekly in R1's clinical record.</p> <p>On September 20, 2018 at 2:32pm, V2 (Director of Nursing) stated the procedure for monitoring and assessing wounds at the facility consists of an initial assessment by the admitting nurse, then the next working day a comprehensive wound assessment is completed initially then every week; these assessments document wound characteristics, measurements, and changes. V2 stated the facility does not have evidence R1's wound assessments being completed per the facility procedure.</p> <p>On September 20, 2018 at 5:34pm, V6 (Cardiovascular Surgeon) stated, V6 completed a "huge" surgery for R1. V6 stated R1 was set up for not healing due to obesity and poor tissue quality and was at great risk for infection due to non-compliance. V6 stated R1 then reported</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>back to V6's office on June 28, 2018 and R1 was found to have an extensive wound infection, the wound had deteriorated and staples were sticking out all over. V6 stated, "That being said, when (R1) came in it was not a wound that fell apart in 12 hours, it deteriorated over a few days. (R1's) staples were falling out and the wound was foul smelling. It should have been identified sooner. I do not think the people on the ground were observing (R1) closely." V6 continued stating R1's infection should have been identified sooner and the wound care team should have been monitoring. V6 stated, if it was identified sooner the outcome likely would have been better and "the quicker it (infection and wound deterioration) was identified I may have been able to treat (R1) sooner and avoid surgery or at least a more limited surgery. (R1) required extensive surgery hours after admission due to infection because it was so bad."</p> <p>The hospital Discharge Report dated for R1's June 28, 2018 admission documents pre-operative diagnoses to include morbid obesity with a pre-operative yeast infection to the skin and right wound dehiscence. The procedure completed was a right groin incision and drainage, antibiotic irrigation and a wound vac placement. This report documents Discharge diagnoses to include post right femoral-popliteal bypass surgery with right groin wound dehiscence with infection.</p> <p>(A)</p>	S9999		