FORM APPROVED

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
	IL6014955	A. BUILDING: ______ B. WING ______	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLAZA LISLE SNF	1800 ROBIN LANE LISLE, IL 60532

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S 000	Initial Comments Annual licensure and certification survey The Brookdale Plaza at Lisle is in compliance with the Sheltered Care Facilities code (77 Illinois Administrative Code 330) for this survey.	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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 needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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

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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 300.3220 Medical Care

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)

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 Regulations were not met as evidence by:

Based on observation, interview and record review failed to follow a physician's orders regarding skin care prevention order to prevent development of stage III pressure sore, failed to monitor and report skin changes and failed to update a care plan for redness on sacral area. These failures resulted in R16 developing a stage III pressure sore.

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This applies to 1 of 4 residents (R16) reviewed for pressure ulcers in the sample of 15.

The findings include:

R16 was admitted to the facility on 07/22/18 and has diagnoses including right femur fracture, diabetes mellitus, dementia based on the face sheet.

MDS (Minimum Data Set) assessment dated 08/18/18 showed that R16 is cognitively intact and needs extensive assistance with one person physical assist in bed mobility, personal hygiene, transfer, dressing and toilet use.

On 8/28/18 at 11:15 AM, R16 was up in wheelchair and V12 (CNA-Certified Nursing Assistant) wheeled R16 to the bathroom. V12 put gloves on and assisted R16 to sit on the toilet. V12 removed R16's incontinent pad and it was saturated with urine. V12 assisted R16 to standing position and was asked to check R16's bottom. Resident was noted with an open sore on the sacral/coccyx area with no wound dressing. V12 said that around 9:30 AM V12 assisted R16 to the bathroom and V12 had noticed that R16's wound on the sacral area had no dressing. V12 was asked if V12 informed the nurse that the dressing came off. V12 said no, and V12 thinks that the nurse knows R16 has an open wound. On 8/28/2018 at 11:45 AM V13 (Nurse) and V6 (ADON-Assistant Director of Nursing) said they were not informed about R16's sacral/coccyx wound and were not aware a wound was present.

On 8/28/18 at 1:05 PM, wound care was observed with V7 (NP-Nurse Practitioner) and

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S9999	Continued From page 4 V14 (Nurse) while R16 was standing in the bathroom. V7 measured the open wound on R16's coccyx/sacral pressure sore. The open wound measured 5.6 cm length x 1.4 width x 0.2 depth with small serosanguinous drainage, and V7 said the wound was a Stage III pressure ulcer, with 75 % slough and peri area red and wide spread rash. V7 said that V7 saw R16's buttocks during July 2018 sometime, with V15 (nurse) and R16 had redness on R16's bottom and V7 ordered Duoderm (hydrocolloid) dressing for skin prevention. On 08/28/18 at 1:15 PM V14 was asked who provides wound treatment for R16. V14 said that if it a pressure sore V6 (ADON-Assistant Director of Nursing) will do the measurements weekly and treatments are done by nurses. V14 said that shower schedules showed that R16 had a shower yesterday (Monday 08/27/18) day shift and Thursday evening shift for skin check. On 8/28/18 at 1:45 PM V13 (nurse) said that V13 did not see the wound because it is scheduled for afternoon shift to do the treatment and charting. V13 said all V13 did was take the order on 7/25/18, and on 8/13/18 V13 changed the order to afternoon shift because it is afternoon charting and treatment. Physician order dated 8/13/18 showed that R16 had an order for Duoderm thin to sacrum every 3-5 days and PRN (as needed) for skin care prevention. On 8/28/18 at 1:50 PM, V6 confirmed that on 7/25/18 the treatment order Duoderm to sacrum was ordered for skin care prevention for R16's redness on the sacral area.	S9999		

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On 8/30/18 at 9:30 AM, V7 stated that V7 saw R16 with V15 (Nurse) present, and that there was nothing on R16's bottom, it was just redness. Duoderm was ordered for skin protection. V7 said that on 8/28/18 was V7's first time to see the pressure sore on R16's sacral/coccyx area. V7 stated the wound could have been caught earlier than the Stage III. The aide should have reported any skin changes and been treated earlier or changed the treatment order. The wound could have been avoided if closer observation and reporting to the nurse was done.

On 8/30/18 at 10:15 AM, V17 (Physician) stated that V17 was notified on 8/28/18 that R16 has a Stage III pressure ulcer with slough 75% on R16 sacral/coccyx area. V17 said V17 does not know when the wound happened. V17 said that R16 is not moving, has diagnosis of diabetes mellitus and high risk for development of wound. Daily skin checks, monitoring and reporting is important to prevent the development of a pressure sore and to prevent a pressure ulcer from becoming a Stage III wound. V17 was asked if R16's wound could have been prevented from becoming a Stage III pressure ulcer if the wound was monitored more closely, and daily skin checks were done since this resident is high risk and had redness on R16's bottom, and V17 agreed.

The facility did not have any skin assessment information or any charting/documentation on R16's sacral redness or condition of the wound documented on the chart prior to 08/28/18.

POS (Physician Order Sheet) dated 8/13/18 has an order to cover the area with Duoderm, change every 3 days and PRN (as needed).

On 8/29/18, at 2:55 PM, V2 (DON-Director of

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Nursing) stated that skin checks are done weekly and if the CNA notices anything, the CNAs have to report skin changes to the nurse. Skin checks are done on shower days. The CNA and nurse check the skin together and the nurse documents on the skin integrity form.

MDS (Minimum Data Set) dated 8/18/18 showed that R16 is cognitively intact, requires extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. R16 is also coded as frequently incontinent with bowel and occasionally incontinent of urine.

R16's current care plan did not show plan of care for redness on R16's sacral area.

The facility's procedure with revision date of October 2010 on wound care showed under documentation:
The following information should be recorded in the resident's electronic medical record:
- The type of wound care given,
- The date and time the wound care was given,
- The name and title of the associate performing the wound care,
- Any change in resident's condition,
- All data (i.e. wound bed color, size, drainage etc.) collected when inspecting the wound.
- The signature and title of the associate recording the data.

(B)