**Final Observations**

**STATEMENT OF LICENSURE VIOLATIONS**

- 300.610a)
- 300.1210b)
- 300.1210d)(5)
- 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 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. (A, B) (Section 2-107 of the Act)

**THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:**

Based on observation, interview, and record review, the facility failed to identify a pressure ulcer, prevent a pressure ulcer from worsening, obtain a physician ordered treatment for a pressure ulcer, and maintain hand hygiene during pressure ulcer care for two of four residents (R23, R16) reviewed for pressure ulcers in the sample of 13. This failure resulted in R23 being admitted to the hospital with a stage four pressure ulcer...
and sepsis and R16's open area worsening to an unstageable pressure ulcer.

Findings include:

The facility's Pressure Ulcer/Wound Management policy, dated 10/2004, documents, "Optimal Wound management will include: Assessment of the skin and wound; Use of standardized protocols; Regular reassessment to monitor effectiveness of interventions. Treatment objectives to promote optimal wound healing are: Relieve pressure; Protect healthy tissue." The policy also documents, "Staging of Pressure Ulcers: Stage II: Partial thickness loss of skin layers (epidermis or dermis). The ulcer is superficial and presents as an abrasion, blister, or shallow crater. Stage III: Full thickness loss involving damage to or necrosis of subcutaneous tissue. Stage IV: Full thickness skin loss (deeper than the dermis) with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure (such as tendons). Ulcers with eschar or extensive necrosis cannot be accurately staged."

1. The Pressure Ulcer/Wound Management policy, dated 10/2004, documents, "The nurse will: Do a complete skin assessment of each new resident upon admission to identify any wounds present including pressure ulcers, stasis ulcers, surgical wounds, etc.; Document the size and description of the wound in the nurse's notes; Initiate a Wound Documentation form, identifying the type of wound, the size, the location, and the status of the wound; Obtain orders for appropriate treatment according to the Facility's Wound Care Protocols or physician's instructions; Implement appropriate Pressure Ulcer Prevention Protocols per policy (pressure relief, dietary supplements,
Continued From page 3

etc.). The policy also documents, "The Rehab/Restorative Nurse will: Re-assess the wound weekly or more often as necessary to measure progress or decline in wound status; Contact physician when a Pressure Ulcer progresses from one stage to another or when there is any significant change in the condition of a wound; Ensure the appropriate Pressure Ulcer Prevention Protocols have been implemented including a dietary supplement to promote healing."

The facility's Quick Reference guideline for Pressure Ulcers/Skin Tears, no date available, documents, "Stage II: Intact Blister: Apply skin prep to area daily. Stage II Drainage none to minimal: Apply hydrogel; Cover with composite dressing; Change every day and as needed; or Apply hydrocolloid dressing; Change every three days and as needed."

R23's Admission Assessment, dated 3/20/17, documents that R23 has blisters to R23's buttocks.

R23's Pressure Ulcer Risk assessment, dated 3/20/17, documents that R23 is at low risk of developing pressure ulcers.

R23's Medical records have no documentation of the physician being notified of R23's blistered areas upon admission nor of any physician's orders obtained to treat the areas.

R23's Skin Integrity care plan, dated 3/22/17, documents that R23 has an area to R23's gluteal folds. However, the care plan has no documentation of any new interventions being implemented following the identification of R23's areas.
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On 4/11/17 at 10:20 a.m., E3 (Care plan coordinator) stated, "No new interventions were put into place for (R23's) area."

R23's Nurse's notes, dated 3/23/17, documents, "In gluteal folds there was a blisier which has now popped." R23's Nurse's notes has no documentation that the physician was notified regarding the change in R23's wound, nor was a new treatment order obtained.

R23's Nurse's notes, dated 3/31/17 at 10:50 a.m., documents, "(R23) has off white-yellow slough (tissue) between gluteal folds."

The facility's Weekly Skin Report, dated 3/27/17 to 4/2/17, has no documentation of R23's gluteal fold wound being assessed or measured.

The facility's Weekly Skin Report, dated 4/3-4/9/17, documents that R23 has an open lesion other than ulcers, rashes, or cuts to R23's gluteal fold.

R23's Nurse's notes, dated 4/3/17 at 9:20 p.m., documents, "Temperature 101 degrees Fahrenheit. Very excoriated buttocks with purulent drainage with foul odor. 911 called."

R23's Nurse's notes, dated 4/4/17 at 12:25 a.m., documents, "(R23) admitted to hospital with the diagnosis of sepsis and decubitus ulcer.

R23's Hospital Progress note, dated 4/4/17, documents, "(R23) with pressure injury to coccygeal crease measuring 12 cm x 10 cm x 6 cm. Deepest aspect to center of wound with gray necrotic tissue to rim of base, deeper area with fibrinous moist tissue upon palpation of wound"
S9999 Continued From page 5

base. Bone is palpable, pressure injury is Stage IV."

R23's Hospital History & Physical, dated 4/4/17, documents, "Sepsis due to infected Sacral decubitus ulcer."

On 4/9/17 at 11:40 a.m., Z2 (R23's family member) stated, "(R23) first had blisters, and they did nothing. Then the blisters popped and were open, and they still didn't do anything. Now he's in the hospital with sepsis and a Stage four pressure ulcers."

On 4/10/17 at 3:25 p.m., E4 (Registered Nurse) stated that on 3/23/17 she didn't notify the physician when (R23's) blister opened. E4 also stated that she did not feel like the area was a pressure ulcer, and that on 3/31/17 the wound was on R23's entire gluteal fold and it was weeping, odorous, and covered in slough (yellow tissue).

On 4/11/17 at 1:00 p.m., E7 (Wound Nurse) stated, "When the blisters were found they should have followed the facility protocol by notifying the physician and getting a treatment order. Normally we do skin prep until the blister pops. Then you notify the physician and change the treatment per protocol which would be hydrogel and a dry dressing."

On 4/11/17 at 1:10 p.m., E2 (Director of Nursing) stated that R23's physician was not notified when blisters were noted on R23's buttocks at admission, and that any resident with wounds should be assessed with measurements, staging, progress, etc. on a weekly basis.

On 4/11/17 at 1:45 p.m., Z3 (R23's Physician)
IL6012165

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF PEORIA  1500 WEST NORTHMOOR ROAD  PEORIA, IL  61614

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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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<td>Continued From page 6 stated, &quot;I wasn't notified about (R23) having blisters on his buttocks then them popping and opening, I would have expected them to notify me when the wound was found and got a treatment order. Then when it popped they should have notified me and gotten another treatment order. Interventions should have been put into place to prevent it from worsening.&quot;</td>
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On 4/11/17 at 2:55 p.m., E1 (Administrator) confirmed that the facility did not identify R23's area as a pressure ulcer.

2. The facility's Infection Control Dressing Changes, dated 11/1998, documents, "To ensure the prevention of the spread of infection, the facility will utilize aseptic technique when changing a resident's dressings. Procedure: Gloves will be worn to remove old dressing; New gloves will be worn to put on new dressings; A change of gloves is required between multiple treatments on the same resident."

R16's Admission Assessment, dated 3/3/17, documents that R16 does not have any open areas/ulcers.

R16's Pressure ulcer risk assessment, dated 3/3/17, documents that R16 was at moderate risk for developing a pressure ulcer.

R16's Wound documentation, dated 3/31/17 and 4/9/17, documents that R16 has an area to R16's left gluteal fold (left ischium) measuring 3 cm (centimeters) x 3 cm on 3/31/17, and 2 cm x 1 cm on 4/9/17.

The facility's Weekly Skin Report, dated 4/3-4/9/17, documents that R16 has an open
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<td>lesion other than ulcers, rashes, or cuts to R16's left gluteal fold.</td>
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<td>R16's Skin Integrity care plan, dated 3/28/17, documents that R16 has an open area to R16's left gluteal fold. However, R16's skin integrity care plan has no documentation of any new interventions being implemented following the development of R16's open area on 3/31/17.</td>
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<td>R16's Wound Care Specialist Initial Evaluation, dated 4/10/17, documents that R16 has an unstageable pressure ulcer due to necrosis of the left ischium that measures 1.5 cm x 2.3 cm. The evaluation also documents that the area is clearly a pressure injury.</td>
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|       | On 4/10/17 at 9:50 a.m., Z1 (Wound Doctor) stated, "(R16's) left ischium wound measures 1.5 cm x 2.3 cm and it is an unstageable pressure ulcer covered with necrotic tissue. This ulcer was caused by prolonged sitting in (R16's) wheelchair. The facility is going to have to limit her time spent in the wheelchair."
|       | On 4/10/17 at 10:10 a.m., R16 had an irregular shaped wound to R16's left ischium with active bloody drainage. E4 (Registered Nurse) cleansed R16's wound with wound cleanser. Then, with the same gloves on, E4 used E4's right index finger to directly apply hydrogel to R16's wound bed and covered the wound with a border gauze dressing. |
|       | On 4/10/17 at 10:15 a.m., E4 stated that she did not change her gloves during R16's wound care, and that she should have changed her gloves after cleansing R16's wound. |
|       | On 4/11/17 at 9:45 a.m., Z1 stated, "The sooner new interventions are put into place the better..." |
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chance you have for it to work. When the area was discovered the facility needed to discuss a pressure reduction plan, and come up with new interventions to prevent the pressure ulcer from worsening."

On 4/11/17 at 10:20 a.m., E3 (Care plan coordinator) stated, "No new interventions were put into place after her area was discovered on 3/3/17.

On 4/11/17 at 1:00 p.m., E7 (Wound Nurse) stated, "(R16's) wound is an unstageable pressure ulcer on her left ischium. It's a pressure ulcer especially with being on a bony prominence."

On 4/11/17 at 2:55 p.m., E1 (Administrator) confirmed that the facility did not identify R16's area as a pressure ulcer until R16 was seen by Z1 on 4/10/17.