

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/22/2015
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NAME OF PROVIDER OR SUPPLIER RIVER BLUFF NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 4401 NORTH MAIN STREET ROCKFORD, IL 61103
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violation:</p> <p>300.1210b) 300.1210d)2 300.1210d)3 300.1210d)5 300.3240a)</p> <p>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: 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</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/13/15

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to identify a pressure ulcer prior to a stage III, failed to consistently follow treatments as ordered, and failed to reduce/eliminate pressure to the affected area. These failures contributed to the development and progression of a stage III pressure ulcer. (R1) The facility failed to replace a dressing on a stage IV pressure ulcer and failed to perform dressing changes as ordered by the physician. (R2)</p> <p>This applies to 2 of 3 residents (R1, R2) reviewed for pressure ulcers in the sample of 4.</p> <p>The findings include:</p> <p>1. The Minimum Data Set for R1 dated July 22, 2015, states R1 is at risk for developing pressure ulcer but does not have any pressure ulcers.</p> <p>The Braden scale for predicting pressure sore risk for R1 dated July 22, 2015, states R1 has a risk score of 12 which is high risk. The Braden</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>scale for R1 dated October 21, 2015, states R1 has a score of 14 which is a moderate risk.</p> <p>The facility's policy and procedure for the Prevention and Treatment of Skin Breakdown dated December 12, 2012 states, "Braden scale for predicting pressure sore risk will be done with a change in status (i.e., pressure ulcer development), daily skin checks will be done by team leaders for residents who are moderate and high risk with documentation weekly. The dietitian will be notified upon discovery of a wound, when a wound declines unexpectedly, and if a wound is not showing progress in 2-4 weeks."</p> <p>The facility's Wound Weekly Observation Tool instructions state, "Stage I=intact skin with non blanchable redness of a localized area usually over a bony prominence. Stage III=Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV=Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling."</p> <p>The facility's Skin/Wound Note dated August 30, 2015 states, "Weekly skin check: Applied new dressing to right lower buttock to old wound site with scar tissue."</p> <p>On October 21, 2015 at 10:15 AM, E3 (Unit Coordinator) stated, "R1's ishial wound was first noted on September 6, 2015." The facility's progress note for New Skin Concern dated September 6, 2015, states, "During weekly skin</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>check resident had an optifoam on left ischium removed and pressure area found very tender to touch. Area was cleaned and measured 2 centimeters x 2 centimeters with 0.5 centimeter depth."</p> <p>The facility's Health Status progress note dated September 7, 2015, states R1's wound on her left lower buttock measures 3 centimeters x 2.8 centimeters. Current yellow slough is less than 25 percent of open wound space. Night nursing sent treatment order request to primary care provider.</p> <p>The facility's Skin/Wound progress note dated September 8, 2015, states, "Wound to left ischium measures 2 centimeters x 2 centimeters with a depth of 1 centimeter. There is approximately 50 percent slough to wound bed."</p> <p>The facility's Wound Weekly observation tool dated September 9, 2015, states, "There was not any special equipment/preventative measures in place and the resident is on turning a repositioning routine. Pressure ulcer to left ishium is a stage III acquired on September 6, 2015. Overall impression: first observation, no reference. Slough over entire wound, measurements: 2 centimeters x 2 centimeters with a depth of 0.5 centimeters. Current treatment plan: Optifoam."</p> <p>R1's Physician Order Sheet dated September 9, 2015, states, "Left ischium wound-cleanse with wound cleanser, pack tunnel space with alginate rope. Cover wound with border gauze dressing."</p> <p>The facility's Skin/Wound progress note dated September 13, 2015, states, "Measurements of left ischium noted, stage II 2 centimeters x 1.5</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>centimeters x 1.5 centimeters."</p> <p>The facility's Skin/Wound progress noted dated September 18, 2015, states, "Reviewed weekly wound report and faxed to Z1 (Medical Doctor-MD) for view and possible increase in treatment."</p> <p>The facility's Wound Weekly observation tool dated September 18, 2015, states, "Pressure ulcer to left ischium is stage III-unchanged. Special equipment/preventative measures: No answer. Resident is on turning and repositioning routine. Wound measurements: 2.1 centimeters x 1.8 centimeters, with a depth of 2.1 centimeters. There is tunneling inside the outer wound area. Current treatment plan: cleanse with wound cleaner, pack tunnel space with alginate rope until wound is debrided then stop alginate." (alginate does not have debriding properties)</p> <p>The facility's Wound Weekly observation tool dated September 21, 2015, states, "Pressure ulcer to left ischium is stage III and worsening. Special equipment/preventative measures: special mattress, custom wheelchair seating system, resident is on turning and repositioning routine. Length is 2.2 centimeters width is 2.3 centimeters. Tunneling at 6-8 o'clock-2.6 centimeters, 11 o'clock-1.2 centimeters, 5 o'clock-1.4 centimeters. Current treatment: pack tunnel space with alginate rope."</p> <p>The facility's Physician Order Sheet dated September 21, 2015, states, "May have wound care clinic evaluation related to left ishium wound." Appointment set for October 1, 2015.</p> <p>The facility's Health Status progress note dated</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>September 22, 2015, states, "Had wound nurse evaluate area. Recommendation to soak packing strips in 1/4 strength wound cleanser with bleach and gently pack into wound then cover with gauze. Do treatment twice daily."</p> <p>The facility's Wound Weekly observation tool dated September 25, 2015, states, "Left ischium pressure ulcer is worsening. Measurements: 2.5 centimeters x 2.4 centimeters with tunneling at 6-8 o'clock 2.6 centimeters, 11 o'clock 1.4 centimeters, 5 o'clock 1.7 centimeters, and 11-5 o'clock unknown depth. Wound depth obscured with visible moist necrotic tissue."</p> <p>The facility's Skin/Wound progress noted dated September 28, 2015, states, "Wound progression is declining with increasing discoloration-advancing tunneling. Anticipating wound care clinic consult October 1, 2015."</p> <p>The Wound Care Clinic assessment and plan dated October 1, 2015 states, "Patient with likely stage IV pressure sore by left ischium likely from sitting. Apply santyl nickel thick to left ischium wound and cover with dry dressing. Low air loss mattress and turn or roll patient every two hours. Limit wheelchair time to less than 1/2 hour at a time."</p> <p>R1's Physician Order Sheet dated October 1, 2015, confirms the above orders by the wound care clinic.</p> <p>The facility's Wound Weekly observation tool dated October 3, 2015, states, "R1's left ischium pressure ulcer is a stage III pressure ulcer which is worsening."</p> <p>The New Incident progress note dated October 8,</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>2015, states, "Dressing changed to buttocks. Dressing was halfway off with foul smelling tan drainage."</p> <p>R1's Physician Order Sheet dated October 15, 2015 states, "Left ischium wound measures 3 centimeters x 3.5 centimeters with a 1 centimeter depth. Continue with debriement agent to left ischial wound and cover with an abdominal dressing."</p> <p>The Wound Center progress notes dated October 15, 2015 states, "Left ischium: 3 centimeters x 3.5 centimeters with a 1 centimeter depth pressure sore noted with necrotic tissue and malodor. Wound appears to go down to muscle layer."</p> <p>On October 20, 2015 at 9:40 AM E5 (Licensed Practical Nurse-LPN) removed a bordered gauze dressing and then removed gauze that was packed inside of R1's wounded on her left ishium. There was a small amount of yellow drainage on the dressings. The wound was about the size of a half dollar. The wound bed was pink/red with a dime sized area of slough(dead tissue). E5 cleansed the wound then applied an enzymatic debriding agent to the tan area. E5 took a dry 4 x 4 piece of gauze and layed it over the entire wound pushing some gauze into the wound. E5 then applied a bordered gauze dressing to secure the dressing. E5 stated, "I would call her wound a stage IV pressure ulcer. I wound say 1/3 of the wound bed has slough. I put a little bit of gauze inside of the wound." R1 also had 4 x 4 gauze secured with paper tape to R1's right knee which was not due to be changed.</p> <p>On October 21, 2015 at 2:00 PM, E4 (LPN) stated, "On October 21, 2015, I cleaned R1's</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>wound with wound cleanser, applied santyl to the slough, covered the wound with a 2 x 2 gauze, and then covered that with a 4 x 4 bordered gauze."</p> <p>On October 21, 2015 at 1:45 PM, Z1 (MD) stated, "R1 is wheel chair bound and she goes to the wound clinic. She spends all day in the wheel chair and has not had a pressure ulcer before. I believe her pressure ulcer is a stage IV based on the wound clinic notes. Yes it is my expectation that the facility probably should identify a pressure ulcer prior to a stage III."</p> <p>The New Skin Concern progress note, with a late entry dated October 15, 2015, states, "Noted a red spot on right inner thigh above the knee noted a stage 1 pressure ulcer measures 1 centimeter x 0.5 centimeter. Wound care called and notified if a foam dressing would be beneficial covering for this spot. They agreed and Z1 faxed an order to notify and change the foam dressing every three days and as needed."</p> <p>The facility's fax transmission sheet requesting an order for the foam dressing for R1's right knee was faxed to the physician on October 16, 2015, but the order was not obtained until October 21, 2015 when E4 placed a call out to R1's physician.</p> <p>R1's Skin/Wound progress note dated October 18, 2015, states, "Right inner knee bony prominence discoloration, optifoam applied per protection."</p> <p>R1's treatment record for the stage 1 to her right knee states the optifoam (foam dressing) was signed off on October 16, 19, and 21, 2015.</p> <p>R1's Skin/Wound progress note dated October</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>21, 2015, 12:13 AM states, "Right inner knee optifoam intact." Observations on October 20, 2015 and October 21, 2015 showed there was a gauze dressing secured with paper tape on R1's right knee.</p> <p>On October 21, 2015 at 10:15 AM, E3 (Unit Coordinator) was asked if she was aware that R1 had a gauze dressing to her right knee on October 20 and 21, 2015. E3 stated, "Really? R1 shouldn't have a gauze on her right knee, it should be optifoam (foam dressing)." E3 removed the 4 x 4 gauze to R1's right inner knee at 10:35 AM. E4 stated, "The gauze on R1's right knee may have been a temporary fix."</p> <p>On October 20, 2015 at 12:25 PM, R1 was sitting in the wheel chair eating lunch. At 1:00 PM R1 was sitting in her wheel chair in the dining room. At 1:10 PM R1 was sitting in her wheel chair in the dining room. At 1:22 PM R1 was in bed on her right side.</p> <p>On October 21, 2015 at 11:30 AM, R1 was observed in her wheel chair being pushed down the hallway toward her room by E6 (Certified Nursing Assistant-CNA). 12:07 PM R1 sitting in her wheel chair in the dining room and E6 was taking lunch orders. 12:30 PM R1 was sitting in her wheel chair at the dining table with her lunch tray in front of her. 12:45 PM R1 is in the wheel chair eating lunch. 1:00 PM R1 sitting at the table in the dining room watching television. 1:05 PM E6 stated, "We were getting R1's weight prior to lunch. I'll be putting R1 down any minute. She can only be up for 30 minutes. I know it has been longer but it is hard because of the feeders."</p> <p>R1's careplan dated September 6, 2015 states, "R1 has an area on her left ischium measuring 2</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>centimeters x 2 centimeters and is covered with yellow slough." The care plan was revised on October 1, 2015 to state the new measurements of the ischial wound was 4 centimeters x 3 centimeters with a depth of 2 centimeters and tunneling at 6 o'clock of 3 centimeters deep. The treatment of packing the wound with alginate and cover with gauze until free of slough was initiated on September 9, 2015. New intervention initiated October 1, 2015 was resident to be up in wheel chair for no longer than 30 minutes at a time. Change of treatment initiated October 15, 2015: Optifoam dressing for protection to bony prominence inner knee."</p> <p>The Nutrition/Dietary note dated August 4, 2015 from the facility's dietitian states, "Registered dietitian significant change assessment: Noted improvement in skin. Meal intake most meal 76-100 percent and at times less. No pressure areas at this time." There was no documentation that the dietitian was notified upon discovery of new pressure area.</p> <p>2. On October 20, 2015 at 12:40 PM, R2 was observed without a dressing to the pressure ulcer on his sacrum. There was a small amount of red/yellow drainage on the pad underneath R2. E5 stated, "They took off the dressing to do peri care. I don't know when they took it off. R2's pressure ulcer is a stage IV." E5 placed a chemical debriding agent plus a crushed antibiotic on the yellow tissue to R2's sacral pressure ulcer after cleansing the wound. E5 then place gauze moistened with saline in the wound bed and covered it with a 4 x 4 gauze secured with paper tape.</p> <p>R2's careplan dated September 9, 2014, states, "Monitor dressing to sacral area to ensure it is</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>intact and adhering."</p> <p>On October 20, 2015 at 1:15 PM, E3 stated, "I removed R2's dressing to his sacrum at about 11:30 AM/11:45 AM."</p> <p>R2's Physician Order Sheet for October 2015, states, "Sacral wound: Cleanse with normal saline, skin prep to wound edges, if slough is present sprinkle crushed flagyl (antibiotic) into wound, apply a think layer of santyl to yellow slough, apply thin layer of venelex to wound bed without slough and to skin around the wound."</p> <p>On October 20, 2015 at 2:45 PM, E5 stated, "I only put santyl (debriding agent) and the antibiotic in R2's wound bed. I did not put venelex (promote wound healing) on it, I'm sorry."</p> <p>On October 20, 2015 at 3:00 PM, E2 (Director of Nursing-DON) stated, "R2's dressing should be replaced as soon as possible when it is removed. We do not typically remove a dressing and leave it off. If the resident has had a bowel movement then the wound should be redressed by the nurse as soon as possible. The nurses are to follow treatment orders as prescribed by the physician."</p> <p>(B)</p>	S9999		
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