STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: _____ B. WING _____	C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

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S 000	Initial Comments Complaint 1946489/IL115423	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)2)3) 300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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S9999	Continued From page 2 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.3220 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. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 3	S9999		

These Regulations were not met as evidenced by:

A. Based on interview and record review, the facility failed to ensure that wounds were assessed, monitored and treated according to physician's orders for 1 of 3 residents (R3) reviewed for wound care in a sample of 5. This failure resulted in deterioration of leg wounds for R3 requiring hospitalization.

Finding include:

1. Hospital Discharge Records dated 8/24/19 document R3's diagnosis included complicated Urinary Tract Infection (UTI), Severe peripheral vascular disease (build-up of fatty material inside the vessels), and bilateral lower extremity wounds. The Hospital Course documents a wound care team was consulted for non-healing vascular ulcers and R3 was initially seen by V11 (Vascular Surgeon) who recommended amputation versus revascularization. The Record documented when a second consult was done by V12, (Vascular Surgeon) he recommended at "least initially good wound care and pressure offloading." The note continued to document that R3 was then discharged to an extended care facility on 8/24/19. Hospital Discharge orders reflected no leg wounds treatments but did have Eucerin Topical lotion to be applied two times daily as needed for dry skin.

The Facility's Admitting Progress Note, dated 8/24/19, at 4:01 PM, entered by V6, Licensed Practical Nurse (LPN) documents "(R3) has Vascular wounds to Bilateral Lower Legs that are wrapped at the time-CDI (clean, dry, intact), R

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S9999	Continued From page 4	S9999		

(right) Heel wounds with Mepilex covering-CDI, minimal edema to legs." This initial note does not include any specifics about R3's wounds on admission including size and condition of wounds. There was no documentation that the facility contacted V12 for treatment orders for R3's vascular wounds to his bilateral lower legs.

A Clinical Documentation - Admission Nursing Assessment, dated 8/24/19 at 1:02 PM, created by V6 in the electronic medical record (EMR) is totally blank including the areas for "any type of skin condition" and for the "Integumentary system" or skin in general. There was no documentation a thorough skin assessment was completed upon R3's admission.

R3's Initial Care Plan, dated 8/24/19, identifies R3's problem as Vascular wounds to legs. R3's Care Plan interventions dated 8/24/19 include "Repair cream as ordered - see TAR (Treatment Administration Record), Observe during care for any signs of breakdown, and preventative care as indicated." The Care Plan had no information regarding the treatments for R3's vascular wounds.

R3's Progress Note, dated 8/26/2019 at 1:45 AM, written by V7 documents "(Off-loading) boots in place bilaterally. Bilat (bilateral) lower legs dressings intact. Did secure them with stockinette earlier. Incontinent." Again, this Progress Note doesn't include any wound information including size and condition of R3's wounds and what treatment was done for R3's leg wounds during this time.

The August 2019 TAR documents no treatments were done to R3's legs being done from admission on 8/24/19 until 8/28/19 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016794	A. BUILDING: _____ B. WING _____	C 09/11/2019

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BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

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S9999	Continued From page 5 documents no Eucerin Cream applied at all. R3's Wound Care Note dated 8/27/19 signed by V8 Facility Nurse Practitioner (NP), ordered "Wash legs daily with saline, apply Xerofoam (a dressing which prevents air from reaching the wound by using mesh gauze impregnated with a petroleum blend formula) to all open wounds including necrotic calves, L (left) heel, bilateral toes then wrap with Kerlix (gauze), then apply (off-loading) boots." This was three days after R3's initials admission to the facility. On 8/28/2019 at 2:23 AM, V7 documents R3 to be on every "2hr (hour) bed checks. Guest has removed (off-loading) boots and dressings unraveled. Attempted to re-secure the dressings without waking guest, as he is now sleeping soundly." There was no documentation V7 applied a new dressing to R3's wounds. At 5:48 AM, V7 documents "Guest had kicked off most of his lower leg wraps. Secured with tube sleeve." On 8/28/2019 at 4:02 PM, V4 RN/Wound Nurse entered the first skin assessment done on R3 since admission. The report documented "Scattered necrotic areas are noted on bilateral lower legs, L heel and all toes. All are clean and dry. (Off-loading) boots are in place at present but guest removes them frequently. All remaining skin is clear and intact. Today's Braden score indicates he is at risk for pressure injury. Pressure reducing mattress and WC (wheelchair) cushion are in place, turning and repositioning are scheduled. Dietary consult is ordered for nutritional support." There was no further assessment on R3's leg wounds such as size, depth, color, drainage, etc. at the time of this wound assessment.	S9999		

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S9999	Continued From page 6	S9999		

The Emergency Note dated 9/1/19 documents R3 was admitted after a change in condition. The ER Note documented "Family was also concerned that he was not getting adequate wound care on his lower extremities as directed by (V12)."

On 9/11/19 at 12:00 PM, V5, LPN, stated V5 stated she never did his leg treatments because whenever she was here, the care giver did them, so she never actually saw his leg wounds.

On 9/11/10 at 9:00 AM, V4, Facility Wound Nurse/RN stated R3 was admitted on 8/24/19 which was a Saturday and she saw him for the first time the following Wednesday, 8/28/19. V4 stated she did not measure the wounds due to them being all over. V4 stated she didn't remember seeing him after that. V4 stated R3's legs were covered with necrotic areas when she saw him and agreed that there is no prior admission assessment in the record. V4 stated the admitted nurse is supposed to assess all wounds and do a skin check for a baseline following up with the physician for wound treatment orders. V4 states she suspects treatments were not done as ordered. She stated she removed the dressing she applied (the dressing had the date and her initials on it) from the previous week. V4 stated she understood R3 had an order for Xeroform with wraps and would have expected the nurses to redo the treatments rather than "rewrap" them if they came loose. V4 was unaware that R3 was a candidate for amputation prior to coming to the facility for "good wound care."

On 9/11/19 at 1:33 PM, V8, Nurse Practitioner (NP), stated R3's leg dressings were hanging off both legs and he had no dressings on his feet or heels when she saw him on 8/27/19. V8 stated

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	IL6016794	A. BUILDING: _____ B. WING _____	C 09/11/2019

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BRIDGE CARE SUITES	3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704

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S9999	Continued From page 7	S9999		

the dressings were dry kerlix and he had numerous necrotic areas on the front/back of both legs and on his toes. V8 stated R3 also did not have his protective boots on when she entered the room. V8 stated she is concerned that treatments were not done as ordered because she's taken off dressings that are up to three days old (dressings are dated) when they should have been changed daily. V8 stated she would expect the nurse to clean and redress the wounds instead of "rewrapping" them if the dressings were no longer intact. V8 stated she would have expected the nurses to call for treatment orders immediately following admission since he didn't seem to have orders sent with him from wound care which would just be standard practice of care and would have expected them to assess all wounds upon admission for a baseline.

B. Based on interview and record review, the facility failed to perform on-going assessments, monitor, recognize a change of condition and timely notify a physician of pertinent information for one of one resident (R3) reviewed for a change of condition in the sample of 5.

Finding include:

On 8/28/2019 at 1:32 PM, V9, Licensed Practical Nurse (LPN), documents she "Held B/P (Blood Pressure) medications in the AM due to blood pressure 102/48 and rechecked it 98/40 (normal blood pressure range is 120/80)." There was no documentation the physician had been notified of his blood pressure being low. There was no documentation the facility was monitoring R3's blood pressure after this.

R3's Progress Note, dated 9/1/19 at 6:04 AM, written by V10, Registered Nurse (RN),

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S9999	Continued From page 8	S9999		

documents "Pt (patient) had a big diarrhea episode HS (hour of sleep)." V10 documented R3 struggled to swallow HS medicine, so she gave him his pills one at a time. V10 documented that R3 "was able to successfully consume medication after big pills were broken in half and instructed to swallow with force. Made AM shift nurse aware that pt had massive diarrhea episode x (times) 1 and that speech therapy needed to do a swallow eval (evaluation) AM 09/01." There was no documentation V10 notified the physician of R3's diarrhea and/or condition change of R3 having difficulty swallowing his medications.

R3's Progress Report, dated 9/1/19 at 3:23 PM, written by V5, LPN, documents "Does take all medications crushed w/o (without) difficulty swallowing. Lung sounds are clear, bowel sounds are present x 4. Guest has refused to get out of bed during this shift today informs writer that he just does not feel well, currently having loose stools and staff continue to check and change frequently to prevent further skin and scrotal breakdown." V5 documented "Son did request that personal home care assistant come in and assess both areas and make decision on what should be done. Will await return call from son. Continent of urine, incontinent of bowel, abdomen is soft, non-distended. Vital signs: 97.0 (temperature; normal 98.6), 90 (pulse), 20 (respiration), 122/60 (blood pressure). Resting in room with call light in reach. Will monitor." Again, there is no documentation V5 assessed R3's complaints of not feeling well, having loose stools or having difficulty taking his medications and notified the physician of R3's significant change in condition.

R3's Progress Note, dated 9/1/19 at 6:00 PM,

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S9999	Continued From page 9	S9999		

written by V5 noted R3's physician was called with a message left due to condition change and guest is being sent to hospital due to change in mental status.

R3's Progress Noted, dated 9/1/19 at 6:08 PM, documents "Guest continues to decline at this time. Family informed (son) really does not wish to have father sent out at this time, believes he will be fine for the rest of the evening. Writer informs son that guest condition continues to decline and should be evaluated. Call made to (V2, Director of Nurses/DON)), at this time, informed that guest continues to decline and that he is being sent out due to diarrhea, decrease in fluid intake this shift, color pale gray, not responding to staff unable to get temp, pulse 76 blood pressure 82/50. Medics First called at this time to transport to (local Hospital)."

An entry dated 9/2/19 at 6:09 AM by V10 documents R3 was admitted to the hospital with diagnoses of sepsis, Clostridium difficile infection (C. diff), and urinary tract infection (UTI).

The Hospital History and Physical (H&P), dated 9/1/19 documented R3 had Sepsis secondary to UTI and Clostridium difficile diarrhea upon arrival. The H&P continued to document R3 presented in the Emergency Room (ER) with diarrhea, dehydration and poor nutrition. The H&P documented the family were concerned R3 had poor nutrition and decreased oral intake and was having diarrhea about 3-4 days ago. The H&P documented R3 was given IV fluids and had good response to the treatment but was admitted.

On 9/11/19 at 12:00 PM, V5, LPN, stated she was told in report the morning of 9/1/19 that R3 had diarrhea. V5 stated she saw R3 for the first time

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	IL6016794	A. BUILDING: _____ B. WING _____	C 09/11/2019

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S9999	Continued From page 10	S9999		

on 9/1/19 around 9:00 AM and that she noted a condition change then as he was unable to take whole medications and she had to crush them. V5 stated she wanted to call the physician, but the son insisted on R3's home care giver coming in and checking him out first. V5 stated R3 continued to decline as the day progressed and finally she just told the family that she was going to send him out for evaluation.

On 9/11/19 at 12:25 PM, V15, Certified Nurse Aide (CNA), stated she was working on 9/1/19 and remembered R3 being incontinent of stools. V15 stated R3 didn't want to get out of bed but family was here and did anyway

On 9/11/19 at 1:33 PM, V8, Nurse Practitioner (NP), stated she did not see R3 after 8/27/19 and was not contacted regarding his change of condition at all.

The facility policy/procedure entitled "Notification and Significant Change of Condition Policy" undated documents the purpose as "to ensure that the facility immediately inform the guest; consult with the guest's physician; and notify, consistent with his or her authority, the guest representative when there is: a significant change in the guest's physical, mental, or psychological status and/or the need to alter treatment significantly."

(A)