

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6012322</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/06/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MOWEAQUA REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>525 SOUTH MACON STREET</b> <b>MOWEAQUA, IL 62550</b>
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S 000	Initial Comments  Complaint Investigation #2065867/IL125169	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.1210 b) 300.1210 d)5) 300.1220 b)3) 300.3240 a)  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.	S9999	<b>Attachment A</b> <b>Statement of Licensure Violations</b>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</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.</p> <p>These regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to assess an existing Stage III pressure ulcer and failed to implement individualized, resident specific interventions for one resident (R1) of three residents reviewed for wounds in a sample of 15 residents. As a result of this failure, R1's existing Stage III pressure ulcer became significantly worse (Stage IV with visible muscle and bone), and R1 developed a new, facility acquired, unstageable pressure ulcer on his left heel.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R1's Care Plan, last updated 6/7/20, includes the following diagnoses: Atherosclerotic Heart Disease, Obesity, Obstructive Sleep Hypertension, Hypothyroid, Chronic Kidney Disease Polyneuropathy, Neuromuscular Dysfunction of Bladder, Hereditary Ataxia, Muscle Wasting and Atrophy, Methicillin Resistant Staphylococcus Aureus, Muscle Weakness, Cognitive Communication Deficit, Colostomy, Severe Sepsis with Septic Shock , Pressure Ulcer of Sacral Region. R1's wound Care Plan, last updated 6/7/20, documents "The resident has potential/actual impairment to skin integrity related to debridement of coccyx wound, immobility, dependent on staff for repositioning." A problem is documented on 6/7/2020: "Stage 1 blister left heel." This description includes a blister which would indicate at least a Stage II as per current standard of practice. Wound clinic documentation, dated 6/17/20, documents this wound as "unstageable."</p> <p>R1's Care Plan includes the following generic interventions:" Wound clinic as ordered. Date Initiated: 06/09/2020 Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date Initiated: 03/04/2020 Follow facility protocols for treatment of injury. Date Initiated: 03/04/2020 Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD (medical doctor). Date Initiated: 03/04/2020 The resident needs pressure relieving/reducing mattress, pillows to protect the skin while in bed. Date Initiated: 03/04/2020 The resident needs pressure relieving/reducing cushion to protect the skin while up in chair. Date Initiated: 03/04/2020 Revision on: 06/07/2020 The resident needs</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>protective heel boots Date Initiated: 06/07/2020 Wound vac (vacuum) as ordered Date Initiated: 06/09/2020." R1's Care Plan includes no additional interventions.</p> <p>R1's progress note, dated 3/3/20 at 4:02pm, documents that R1 was admitted on 3/3/20. At that time, R1's skin assessment documents R1 as "high risk" for breakdown. The facility's "Nursing Admission/Readmission Data Collection", dated 3/3/20, documents R1 was admitted with a "stage III Pressure Ulcer measuring 6x3x3.5 centimeters (Length x Width x Depth) to his sacrum. There is no assessment of the appearance of the wound or whether there is any drainage from the wound or any odor. No wound assessment is documented until 3/5/20 at 2:08pm. No wound treatment is documented on Treatment Administration Sheet as completed until evening shift on 3/5/20.</p> <p>Wound Assessment on 3/5/20 at 2:08 pm, documents the measurements of R1's pressure ulcer on Sacrum as 6x4x1.5 centimeters (cm.) (length x Width x Depth). At that time a treatment order is received from physician and initiated for: Cleanse wound with normal saline, apply alginate to wound bed, and cover with foam border dressing. On 3/31/20, the wound assessment states the wound measures 3x2.5x2.5cm. A dressing is signed off the treatment sheet as done daily beginning 3/5/20. The wound is not assessed except for weekly wound sheets. On 4/21/20, even though the wound was improving at this point, the wound care order is changed to: Cleanse wound, apply Santyl ointment to wound bed, cover with Dakin's solution and dry dressing. Although the wound treatment is signed off on the treatment sheet as done daily, no assessment of the wound is completed except for the weekly</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>wound tracking.</p> <p>On 5/20/20, R1 was seen by the local hospital wound clinic. The wound clinic documents the sacral wound measurements are 10 x 8 x 5.5 centimeters with 34%to 66% necrosis (eschar) and exposed muscle. At that visit, a wound vacuum was ordered. The wound vacuum is documented as placed on 5/21/20, at 125 millimeters of suction. At that time, the wound clinic ordered Low air loss mattress, inflatable cushion for wheelchair, turn and position every two hours, and float heels off bed and chair. However, R1's care plan was not personalized to include these interventions, and it is not documented whether they were initiated or not. From the time the wound vacuum was placed, until 6/12/20 when R1 went for a surgical debridement of the sacral wound, there is no documentation of the appearance of the wound, how much drainage the wound vacuum is collecting, or whether the wound vac is even functioning. On 6/7/20, the heel wound was documented on R1's progress notes. On 6/10/20, the wound clinic documented the wound on R1's Coccyx measured 10 x 9. x 5.9 centimeters, with exposed muscle and bone, had "foul odor" and 67-100% necrosis . On 6/10/20, the wound clinic documented the facility acquired heel wound had progressed to 4.5 x 5.5 x 0.1 and was documented at unstageable. On 6/17/20, the wound clinic documents the wound to R1's sacrum has increased to 11 x 14 x 5 centimeters following surgical debridement.</p> <p>On 8/5/20 V2, Director of Nursing (DON), verbalized R22, Registered Nurse (RN) former wound nurse, had been responsible for wound care until he ended his employment with the facility recently. The facility did not know how to</p>	S9999		
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S9999	Continued From page 5  contact R22. V2 stated, "I thought he was doing a good job of wound care and documentation until I discovered his documentation was not up to my standards. I agree that there should have been better wound documentation. I realize our care plans aren't what they should be, and I am working with corporate to improve that." R1 was hospitalized during the onsite portion of this survey.  On 8/5/20 at 12:45am, V20, Wound Care Nurse Manager at the wound clinic caring for R1's wound, verbalized that in her opinion R1 was not being "off loaded" as recommended related to the rapid deterioration of the sacral wound and the development of the unstageable heel wound. V20 stated, "It's really sad. (R1) was positive and kidded around with us when he first came to us. But the last few times I've seen him, he just hangs his head and cries. I think there was some issue at the facility with the function of the wound vacuum. I remember (V22) the wound nurse talking to us about having to get a replacement pump."  On 8/5/20, V21, Wound Care Medical Doctor, stated, "They (the facility) didn't take very good care of (R1). I can say that if (the facility) had followed the wound care recommendation that I made (R1's) sacral (Coccyx) wound would not have deteriorated as rapidly as it did, and if (the facility) had floated (R1's) heels on a low air loss mattress he would not have developed the second pressure area on his heel."  (B)	S9999			