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	IL6011571	A. BUILDING: _____ B. WING _____	08/26/2020

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ACCOLADE HC OF PAXTON ON PELLS	1001 EAST PELLS STREET PAXTON, IL 60957

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S9999	Final Observations Complaint # 2066711/IL126139 A Focused Infection Control Survey/COVID-19 Focused Survey was conducted by Illinois Department of Public Health on August 26, 2020. Statement of Licensure Violation: 1 of 1 Violation: 300.610) 300.1210b) 300.1210d)3)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	S9999		

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S9999	Continued From page 1 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: 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 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		

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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)

This Requirement is not met as evidenced by:

Based on observation, record review and interview, the facility failed to assess a new pressure ulcer, implement pressure relieving interventions, prevent cross contamination of the pressure ulcer, and failed to perform hand hygiene for three of three residents (R1, R2, and R3) reviewed for pressure ulcers on the sample list of six. This failure resulted in R2 developing three unstageable pressure ulcers.

Findings Include:

The facility Pressure Ulcer Prevention, Identification and Treatment Policy dated February 20 documents a "Prevention program will be utilized for all residents who have been identified of being at risk for developing pressure ulcers. The facility will initiate an aggressive treatment program for those residents who have pressure ulcers." "A pressure ulcer is defined as any lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over bony prominence's and are graded or staged to classify the degree of tissue damage observed." Suspected Deep Tissue Injury is a purple or maroon localized area

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of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage II pressure ulcer is a partial thickness of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. It may also present as an intact or open/ruptured serum-filled blister. Unstageable ulcers are full thickness tissue loss in which the base of ulcer is covered by slough (yellow, tan, gray or brown) and/or eschar (tan, brown, or black) in the wound bed. When a pressure ulcer is identified, whether in-house, or upon a resident's admission, the area will be assessed and an initial treatment started per physician's orders. Documentation of the pressure ulcer must occur upon identification and at least once a week until healed. Assessment is to include: characteristics: (size, depth, color, drainage), presence of granulation tissue/necrotic tissue, treatment and response to treatment, and prevention technique (turning and repositioning, skin care, protective devices).

1. R2's undated face sheet documents R2 was admitted to the facility on 6/16/20 with the following Diagnoses: Diabetes Mellitus with Foot Ulcer, Obesity, and Diabetes Mellitus with Neuropathy. R2's MDS (Minimum Data Set) documents R2 is alert and oriented, independent with decision making, and requires limited assist of one for bed mobility and transfers.

R2's Skin Risk Assessment dated 6/16/20 documents R2 is at risk for skin breakdown.

R2's Weekly Skin Assessment dated 6/17/20 documents R2 has a surgical incision "as toes

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have been amputated." R2's Weekly Skin Assessment dated 6/18/20 documents R2 has an unstageable pressure ulcer to the left heel measuring 2.6 cm (centimeters) by 2.1 cm by UTD (unable to determine), that was found on 6/18/20.

R2's Progress Notes dated 6/18/20 by V15 IP/WN (Infection Preventionist/Wound Nurse) documents, R3 complained of pressure to the left heel. V15 noted a hard metal splint in place to the back of R2's leg. Foam placed to help relieve pressure. Discolored area is dark purple and measures 2.6 cm by 2.1 cm. R2 states the foam dressing has helped.

R2's Wound Notes by V28 APRN (Advanced Practice Registered Nurse) dated 6/22/20 documents R2 has a deep tissue pressure injury to the heel. This note documents new orders: add extra padding to the heel, ensure heel is floated and offloaded at all times, boot on when using wheelchair or traveling for protection, and strict non-weight bearing to the left lower extremity.

R2's August 2020 Physician Orders document an order to apply skin prep every shift to the right heel and float heel while in bed, along with V28's orders from 6/22/20 for the left heel.

R2's Weekly Skin Assessment dated 7/24/20, documents R2's left heel pressure ulcer measures 3.0 cm by 2.9 cm by 0.2 cm {an increase in size}, and remains unstageable as 90% of the wound bed is covered in eschar with 10% slough. This Weekly Skin Assessment also documents R2 has a new unstageable pressure ulcer found on 7/24/20 to the right heel measuring 1.0 cm by 0.8 cm by UTD.

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S9999	Continued From page 5 On 8/20/20 at 9:39 am, R2 was sitting up in a wheelchair in R2's room, with both feet/heels resting on the metal base of the overbed table. R2 did not have a boot on the left foot or offloaded {as ordered}. On 8/20/20 at 10:00 am, V29 LPN (Licensed Practical Nurse) entered R2's room to complete the ordered pressure ulcer treatments. R2 was lying in bed, on a regular mattress, with R2's left foot resting on a pillow and R2's right foot/heel resting on the mattress. V29 donned gloves after washing hands and removed the dressing to R2's left foot. V29 changed gloves but did not wash V29's hands or use ABHR (Alcohol Based Hand Rub). V29 then cleansed R2's left heel ulcer with soap and water, rubbing back and forth over R2's ulcer, then applied R2's new dressing without changing gloves or performing hand hygiene. V29 then removed gloves, and washed hands prior to donning gloves and removing R2's right foot dressing. R2 stated, "this is what hurts", while pointing to an area on the posterior heel, that appeared to be a resolving blister that had two black, eschar areas within it. V29 measured the blistered area as 2 cm by 0.5 cm. V29 stated, "it was a lot squishier," it's getting better. V29 then measured an eschar area on the bottom of R2's right heel as 1 cm by 0.8 cm. V29 washed the entire heel with NS, wiping back and forth over the blistered area and eschared wounds several times, then completed the wound treatment without changing gloves or performing hand hygiene. At this time, R2 stated R2 has always been on a regular mattress and hasn't used any heel protectors. R2 stated, I try and keep my left foot up on a pillow but sometimes I wake up in the middle of the night and the pillows are on the floor, and R2's heels are on the bed.	S9999		

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On 8/20/20 at 10:16 am, V29 confirmed that V29 wiped back and forth across R2's wounds several times when cleaning them, potentially contaminating the wounds. V29 also confirmed V29 did not perform hand hygiene after removing the dressing, cleaning the wounds, or applying the new dressings.

On 8/20/20 at 10:45 am, V2 DON (Director of Nursing) stated wound prevention interventions like a low air loss mattress or heel booties are individualized based off of the residents Skin Risk Assessment, nutritional status, history of wounds, and presence of wounds, but they would do R2 good. V2 stated V2 expects V15 IP/WN to get into contact with V30 Wound Physician to address the fact that a current intervention isn't working and to implement further interventions. V2 also stated, staff should be cleansing wounds from the inside out, not rubbing back and forth across the wound.

On 8/25/20 at 10:07 am, V25 NP (Nurse Practitioner) stated staff need to re-evaluate pressure relieving interventions if the current intervention isn't working, and try something else, to prevent further pressure ulcers from developing. V25 also stated with R2's sensory impairment due to the neuropathy, and possibly not being able to feel the discomfort from pressure, interventions such as a low air loss mattress could help with R2.

The facility Hand Washing Policy dated July 2019 documents, "this facility considers hand hygiene the primary means to prevent the spread of infections. All staff will properly wash hands after direct contact with any contaminated substances, after direct resident care, and as instructed." Employees must wash their hands for fifteen to

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twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents, after contact with blood, body fluids, secretions, mucous membranes, or non intact skin, after removing gloves, and after handling items potentially contaminated with blood, body fluids or secretions.

2. R3's Ulcer/Wound Documentation dated 6/15/20 documents on 6/15/20, R3 was found to have a stage II blister to the left heel measuring 2.0 cm by 1.0 cm by UTD (unable to determine).

R3's August 2020 Physician Orders document a wound treatment to the left heel: cleanse with wound cleanser, apply calcium alginate and bordered foam daily.

On 8/20/20 at 9:19 am, V27 LPN (Licensed Practical Nurse) and V26 CNA (Certified Nursing Assistant) entered R3's room to complete R3's ordered treatment. V27 removed R3's dressing to reveal a 0.1 cm (centimeter) by 0.1 cm open wound to R3's left heel. V27 cleansed the wound with wound cleanser and a gauze pad by rubbing back and forth over R3's wound, potentially contaminating the wound. V27 then completed the treatment as ordered.

On 8/20/20 at 10:45 am, V2 DON (Director of Nursing) stated, staff should be cleansing wounds from the inside out, not rubbing back and forth across the wound.

3. R1's Progress Notes document R1 was seen on 8/6/20, 8/10/20 and 8/13/20 by V5 NP (Nurse Practitioner) for blisters to the right foot that R1 states appears intermittently and limits R1's ability for transfers and mobility. V5's notes do not

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S9999	Continued From page 8 document the size, number or exact location of the blisters. R1's August 2020 Physician Order Sheet does not document any treatment orders for the blisters on R1's right foot. R1 has no initial or weekly Skin/Wound Assessments that documents the characteristics of the blisters, presence of granulation or necrotic tissue, a treatment or prevention techniques used. On 8/19/20 at 2:44 pm, V5 NP stated V5 was suppose to see R1 again on 8/19/20 to monitor R1's foot blisters however R1 ended up in the hospital due to a wound developing on the left foot. V5 stated R1 had two blisters, side by side, on the outer distal plantar portion of R1's foot. "It looked like a friction issue, from the area rubbing against (R1's) shoe." On 8/20/20 at 10:45 am, V2 DON (Director of Nursing) stated, when a new pressure area develops, the staff should assess and measure the wound and document the size. They also need to call the physician and obtain a treatment for the new wound. (B)	S9999		