

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/07/2020
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NAME OF PROVIDER OR SUPPLIER RED BUD REGIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 350 WEST SOUTH 1ST STREET RED BUD, IL 62278
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S 000	Initial Comments Complaint # 2045505/ IL124759	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.1210a)b)d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/20/20

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>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 were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to identify and implement preventative treatment for individuals at risk for skin breakdown, accurately identify and treat a pressure area, and identify and implement interventions to prevent decline and promote healing of an area of skin breakdown for 2 of 4 residents (R2 and R3) reviewed for pressure ulcers in the sample of 7. This failure led to R2 developing a stage three pressure area and R3 developing an unstageable deep tissue injury that</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>have not shown consistent improvement.</p> <p>Findings Include:</p> <p>1. R2's admission record dated 8/6/2020 documents R2 was admitted to the facility on 6/11/2020 with diagnoses that include hypertension, dementia, pain, need for assistance with personal care, reduced mobility, and unspecified fracture of the right femur.</p> <p>R2's MDS (Minimum Data Set), section C, dated 6/18/2020 documents R2 has a BIMS (brief interview for mental status) score of 6 which indicates R2 has a severe cognitive impairment. R2's MDS section G documents, R2 requires two-person assist with bed mobility, transfers, and R2 is totally dependent on staff for ambulation. Section M of the MDS documents R2 is at risk of developing pressure ulcers and does not currently have a pressure ulcer/injury. Under treatments in section M it is documented R2 has a pressure reducing device for his chair and bed, surgical wound care, application of ointments, and dressings.</p> <p>R2's Braden Scale- for predicting pressure sore risk dated 6/12/2020 documents R2 has a score of 15 which indicates a low risk for developing pressure ulcers. The Braden assessment documents R2 has no sensory perception impairment, R2's skin is often moist, he walks occasionally, has slightly limited mobility, nutrition is probably inadequate, and friction and shear are a problem.</p> <p>R2's Braden Scale dated 6/18/20, 6/25/2020, and 7/2/2020 documents R2 has a score of 12 which indicates R2 is at high risk for developing a pressure ulcer. The Braden assessment</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>documents R2 has slightly limited sensory perception, his skin is often moist, he is chairfast, has very limited mobility, probably inadequate nutrition intake, and friction and shear are a problem.</p> <p>R2's weekly body audit dated 6/18/2020 documents R2 has a superficial open area on his sacrum measuring 1.4 x 0.3 cm (centimeter) and a 0.2 cm round area and peri area redness that is being treated with calmoseptine. This assessment documents moisture associated skin damage to the groin and coccyx.</p> <p>R2's weekly body audit dated 6/25/2020 documents under general skin condition, "peri area redness, superficial open area 1.8cm wide x 4cm long, and a second open are on left coccyx 1cm round..." This assessment also documents moisture associated skin damage to sacrum, groin, and coccyx.</p> <p>R2's weekly body audit dated 7/2/2020 documents peri area and coccyx redness resolved, "superficial open area and a second open area on left coccyx unchanged."</p> <p>R2's treatment administration record dated 6/1/2020 - 6/30/2020 documents an order to apply mepilex to coccyx change every three days and as needed for protections with a start date of 6/17/2020 and a discontinue date of 6/18/2020.</p> <p>R2's order summary report active orders as of 7/6/2020 document an order for calazime skin protectant paste apply to sacrum buttocks and coccyx topically every day and night shift for redness, open areas with a start date of 6/18/2020.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>R2's progress notes document, R2 arrived at the facility on 6/11/20 was confused and required assist of four staff to slide transfer to the bed. R2's progress notes continue to document the following;</p> <p>6/12/2020-R2 rested in the recliner most of the day.</p> <p>6/15/2020- R2 was continent and transfers sit to stand lift with assist of two staff.</p> <p>6/16/2020-R2 complained of bilateral buttock pain and the buttocks were observed to be very red and treatment of calazime cream was ordered.</p> <p>6/17/20-R2 was encouraged to rest in bed and refused.</p> <p>6/18/20-two small superficial areas are noted on R2's sacrum that measure 1.4 x 0.3 cm and a round 0.2 cm area. Mepilex is ordered and then discontinued and calmoseptine is ordered.</p> <p>6/26/2020-R2 refused to lay in bed, educated on wound to coccyx, up in recliner.</p> <p>7/1/2020-R2 spends most of the day and evening sleeping in bed.</p> <p>7/2/2020 it is documented R2 had no incontinent episodes through the night and the peri area and coccyx area redness are resolved. The superficial open areas remain unchanged.</p> <p>7/4/2020 R2 documented as up in wheelchair at nurses' station at 9:00 PM and requested to go to bed at 1:10 AM.</p> <p>7/6/2020 R2 was discharged with son to be transferred to a new facility.</p> <p>On 8/4/2020 at 10:38 AM, R2 was observed at the new facility with V19 (Licensed Practical Nurse/treatment nurse) present. The wound on R2's sacrum was measured at 2.5 x 1.5 x 0.1 cm covered in 100% slough. V19 stated, R2 was admitted to the facility with a stage 3 pressure ulcer on his sacrum that has improved with current treatment.</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>R2's medical record from the new facility documents R2 was admitted on 7/6/20 and assessed to have a stage 3 pressure ulcer on his sacrum that measured 2.1 x 1.5 x 0.2 cm (centimeters) with moderate serous drainage and covered with 100% slough. R2's record documents a treatment ordered to clean with normal saline, pat dry, apply santyl and calcium alginate and cover with a dry protective dressing.</p> <p>On 8/5/2020 at 10:33 AM, V2 (Director of Nurses at previous facility) stated R2 would refuse to lay down for staff and was up in the wheelchair quite a bit. When asked if R2 had any preventative measures in place to prevent development of pressure ulcers V2 stated, they encouraged good nutrition/hydration, heel boots while he was in bed, kept skin clean and dry, peri care when he was incontinent and tubigrips to lower extremities. When asked if R2 was on a program to reposition, V2 stated there was no formal program in place, but they turn all residents when they are in bed. However, R2 would sometimes refuse when they offered. V2 stated all the facility mattresses are pressure rated and R2 did not have a cushion in his chair due to the hip precautions that were in place. V2 stated she had not seen the areas on R2's buttocks. V2 stated the facility had incorporated a wound nurse practitioner who assessed and ordered treatments for all the wounds.</p> <p>On 8/5/2020 at 3:45 PM, V10 (Nurse Practitioner) stated she had classified the area to R2's sacrum as MAD (moisture associated dermatitis). When asked why she had classified as MAD vs a stage three pressure ulcer V10 stated she looked at whether someone was incontinent, if it was a definable wound, if it had defined wound edges,</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>and the location of the wound. V2 stated it had been awhile since she had seen R2, but she did not remember the wound being definable. V10 remembered R2's buttocks being red and rashy with what she would call denuded, small little open areas. V10 stated R2 was incontinent of bowel and bladder while he was at the facility. When asked if the treatment would have been different for a pressure ulcer vs MAD, V10 stated there was no depth to it that you would need to fill, and a dressing would not have been appropriate in that area with incontinence. V10 stated the facility does not have formal turn and reposition program but all residents in bed are turned and repositioned. When asked if she felt the area was preventable V10 stated she felt the area to R10's sacrum/coccyx was related to incontinence, so she did not think it was preventable.</p> <p>On 8/5/2020 at 11:47 AM, V9 (wound specialist) stated, he assessed R2's wounds after R2 was transferred to the new facility. V9 stated he classified R2's wound as a stage 3 pressure ulcer that measured 2.5 x 2.5 x 0.2 centimeters (cm). V9 stated, "I really don't think this is moisture associated dermatitis). When asked if the area was preventable V9 stated if R2 had been turned and repositioned it would have been preventable.</p> <p>https://www.inspirahealthnetwork.org/upload/docs/Distinguishing_between_Pressure_Injury_and_IA_D_Becky%20Scharf.pdf documents the definition of a pressure injury as localized damage to the skin and/or underlying tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.</p> <p>https://oska.uk.com/journal/managing-moisture-le</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>sions-or-moisture-associated-dermatitis-mad-1 documents moisture lesions as skin damage due to exposure to urine, feces, or other body fluids. Location is generally in the peri-anal, gluteal cleft, groin, or buttock area, not usually over a bony prominence. It has diffuse irregular edges with no necrosis or slough unless an infection is present.</p> <p>2. R3's admission record dated 8/6/2020 documents admission to the facility on 5/24/19 and diagnoses that include pulmonary fibrosis, type 2 diabetes mellitus, muscle weakness, and reduced mobility.</p> <p>R3's MDS (Minimum Data Set) significant change assessment dated 5/15/2020 documents R3 has a BIMS (Brief Interview for Mental Status) score of 14 which indicates R3 is cognitively intact. Under section G the MDS documents R3 requires two person physical assist for bed mobility and transfers. Under section M the MDS documents R3 is at risk for developing pressure ulcers and should have a pressure reducing device for the bed and chair as preventative measures.</p> <p>R3's MDS dated 5/15/20 documents under triggering conditions on the CAA (care area assessment) worksheet, resident requires extensive assistance with bed mobility and is at risk for pressure ulcers. Under extrinsic risk factors the assessment documents R3 needs a special mattress or seat cushion to reduce or relieve pressure.</p> <p>R3's Braden Scale- for predicting pressure sore risk dated 5/22/2020 documents a score of 18 which indicates R3 is at low risk of developing a pressure ulcer/injury.</p> <p>R3's Braden Scale- for predicting pressure sore</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>risk dated 5/29/2020 documents a score of 16 which indicates R3 is at low risk of developing a pressure ulcer/injury.</p> <p>R3's Braden Scale- for predicting pressure sore risk dated 6/5/2020 documents a score of 10, which indicates R3 is at high risk of developing a pressure ulcer/injury.</p> <p>The facility wound log dated 6/16/2020 documents R3 had a facility acquired deep tissue injury (DTI) to her left heel that measured 1.5 cm x 1.5 cm (centimeters) on 6/1/2020.</p> <p>R3's treatment administration record dated 6/1/2020-6/30/2020 includes orders for heel protectors to bilateral heels with a start date of 6/2/2020. And an order for skin prep to bilateral heels with a start date of 6/1/2020.</p> <p>R3's care plan documents R3 is at risk for pressure ulcer development which includes the following interventions; skin prep to bilateral heels with a revision date of 11/25/19 and initiation date of 6/7/2019, staff to provide pressure reducing device for bed and chair (6/6/2019), not to wear shoes unless transferring (8/6/2020), low air mattress to bed due to DTI (6/8/2020), and heel protectors to both heels when in bed (6/8/2020).</p> <p>R3's progress notes document a decline in condition related to a diagnosis of pneumonia and hospitalization from 5/4/2020-5/9/2020. R3 is assessed as being weak and requiring restorative programs for bed mobility and transfers. R3 is documented as improving on 5/26/2020 and stood and sat up longer on this date. R3's progress notes document she sits in the wheelchair at times.</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>R3's pressure ulcer care and treatment assessment dated 6/3/2020 documents R3 has a deep tissue injury (DTI) to the left heel measuring 1.2 cm x 1.2 cm.</p> <p>R3's pressure ulcer care and treatment assessment dated 6/9/2020 documents a DTI to the left heel measuring 1.5 cm x 1.5 cm.</p> <p>R3's pressure ulcer care and treatment assessment dated 6/30/2020, 7/7/2020, 7/14/2020, and 7/21/2020 document the measurements of the DTI on her left heel as 1cm x 1 cm.</p> <p>R3's pressure ulcer care and treatment assessment dated 7/29/2020 documents the DTI to R3's left foot has increased in length and measures 1.5 cm x 1.5 cm.</p> <p>R3's pressure ulcer care and treatment assessment dated 8/4/2020 documents the DTI to R3's left heel as measuring 1cm x 1cm.</p> <p>On 7/30/2020 R3 was observed watching television, sitting in her room in her wheelchair with a bedside table in front of her. She had socks on both feet, no preventive devices in place and both feet flat on the floor. V4 (Registered Nurse) removed her socks and observed an area of darker discoloration to R3's left heel. V4 stated R3 wears the heel protectors while she is in bed.</p> <p>On 8/5/2020 at 10:33 AM V2 (Director of Nurses) stated the area to R3's heel was first noted on 6/1/2020. V2 was unable to remember if R3 had a history of skin breakdown to her heels and stated the skin prep to heels intervention listed on the care plan in 6/2019 was used for prevention. When asked if there were any interventions</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>specific to preventing breakdown to R3's heels implemented when she had the decline in condition related to pneumonia, V2 stated she would not have expected heel protectors to be in place at that time but possibly another intervention should have been implemented. V2 stated she was unsure why R3's significant change MDS dated 5/15/2020 showed her at risk for skin breakdown but her Braden assessment did not document she was at risk until 6/5/2020 which was after she developed the DTI to her left heel. V2 stated the different assessors must have seen things differently. When asked if any new interventions had been implemented after the area increased in size on 7/29/2020, V2 stated there was no change in the interventions. V2 stated R3 sits in the wheelchair for meals and lays down to rest between meals. When asked if R3 should have an intervention in place for offloading pressure to the heels when she is up in the wheelchair, V2 stated they don't typically put shoes on because that causes pressure and they don't use foot pedals because they rest their feet/heels on the edge of the pedal causing pressure. V2 stated she couldn't think of anything else they should be doing to prevent pressure to R3's heels when she is sitting in the wheelchair.</p> <p>On 8/5/2020 at 3:45 PM V10 (nurse practitioner) stated she is the one who usually implements new interventions for residents with pressure ulcer/injuries. When asked if R3 should have had interventions implemented prior to the development of the DTI to her left heel, V10 stated staff usually float the heels with pillows. When asked if they were floating R3's heels prior to the DTI developing V10 stated she wasn't sure but R3 told her yesterday they were. When asked if she would have expected offloading of pressure for R3's heels when she is sitting up in the</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>wheelchair, V10 stated, she knew R3 was on diuretics and went to the bathroom frequently and she wanted her to have a solid footing and typically people who wore the offloading boots while in the wheelchair were immobile. V10 stated she hadn't felt as if R3's shoes were causing pressure but when she saw R3 yesterday (8/4/2020) the nurse told her the area had decreased in size. V10 stated the nurse told her when the area increased in size on 7/29/2020, they had R3 stop wearing her shoes. When asked, if she felt the DTI could have been prevented if there had been other interventions implemented when R3 had the decline in her condition, V10 stated, "Quite possibly, yes." V10 stated she couldn't give a definitive answer and did not feel as if offloading of pressure while R3 was sitting in the wheelchair would have prevented the area from getting bigger or would make a difference in the healing process.</p> <p>On 8/5/2020 at 11:47 AM V9 (wound specialist) stated the best intervention for preventing deep tissue injuries on heels is to float the heels. V9 stated they won't typically do that, so the next best thing is the big pillow heel protectors. V9 stated a resident who has a DTI on the heels and sits in a wheelchair should have the pressure to the heels offloaded. V9 stated without offloading the pressure that person would be at risk of developing a stage four pressure ulcer or an unstageable area to the heel.</p> <p>(B)</p>	S9999		
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