

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005888	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2020
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NAME OF PROVIDER OR SUPPLIER MATTOON REHAB & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 2121 SOUTH NINTH MATTOON, IL 61938
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S 000	Initial Comments Complaint Investigation 2066846/IL126293	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)5) 300.1220b)3) 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 care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	Attachment A Statement of Licensure Violations	

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

TITLE

(X6) DATE
10/06/20

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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>2) All treatments and procedures shall be administered as ordered by the physician.</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 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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</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 are not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to prevent the formation of five facility acquired pressure injuries (multiple Stage II and Stage III pressure ulcers) by not documenting physician orders timely and not implementing pressure relieving interventions to prevent pressure injuries for two (R1, R8) of three residents reviewed for pressure ulcers. The facility also failed to prevent cross-contamination during pressure injury wound dressing change for one (R1) of three residents reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>1. R1's undated face sheet documents diagnoses of: Sepsis, Cellulitis, Pressure Ulcer of Unspecified site, Legally Blind, Alzheimer's, Hemiplegia and Hemiparesis.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>R1's Care Plan dated 7/16/20 documents R1 to wear heel protector boots at all times. This same Care Plan documents staff are to float R1's heels while in bed. This same Care Plan instructs staff to administer treatments as ordered and monitor for effectiveness.</p> <p>R1's Minimum Data Set (MDS) dated 8/31/20 documents R1 as requiring total dependence of two staff for bed mobility, transfers, and toileting. This same MDS documents R1 of being at risk for pressure injuries. This same MDS documents R1's Brief Interview for Mental Status score of 9/15 (moderate cognitive impairment).</p> <p>R1's Pressure Ulcer Risk Assessment dated 9/2/20 documents a score of 14 (moderate risk).</p> <p>R1's Hospital Discharge Summary dated 8/25/20 documents R1 as being hospitalized from 8/18/20 - 8/25/20 with admitting and primary discharge diagnoses of: Hypotension Secondary to Septic Shock, Acute Kidney Injury and Infection of Decubitus Ulcers.</p> <p>Wound Clinic Physician Orders dated 8/28/2020 document physician orders for R1's Stage 3 Pressure Injury to Left Back - cleanse wound, apply puracol and cover with foam daily; R1's Stage 3 Pressure Injury to Left Gluteus - cleanse wound, apply puracol and cover with foam daily; and R1's Stage 2 Pressure Injury to peri-anal area - antifungal cream to be applied three times per day.</p> <p>There is no documentation on R1's Physician Order Sheet (POS) or Treatment Administration Record (TAR) for August 1-31, 2020 and September 1-9, 2020 of treatment orders for R1's Stage 3 Pressure Injury to Left Back, Stage 3</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Pressure Injury to Left Gluteus and Stage 2 Pressure Injury to peri-anal area. This same POS dated September 1-30, 2020 documents a physician order for Keflex (antibiotic) 500 milligrams (mg) three times per day for ten days for coccyx wounds from 9/10/20-9/20/20.</p> <p>Weekly Pressure Ulcer Report dated 8/12/20 documents R1's facility acquired Left Heel Deep Tissue Injury as resolved (healed). This same report dated 9/2/20 did not include documentation related to R1's Stage 3 Pressure Injury to Left Back, Stage 3 Pressure Injury to Left Gluteus and Stage 2 Pressure Injury to peri-anal area.</p> <p>Pressure Ulcer Weekly Wound Evaluations dated 8/28/20 and 9/8/20 did not include documented assessment of R1's Stage 3 Pressure Injury to Left Back, Stage 3 Pressure Injury to Left Gluteus and Stage 2 Pressure Injury to peri-anal area.</p> <p>Skin Check Weekly Assessments dated 9/3/20 and 9/9/20 did not include documentation related to R1's Stage 3 Pressure Injury to Left Back, Stage 3 Pressure Injury to Left Gluteus and Stage 2 Pressure Injury to peri-anal area.</p> <p>On 9/9/20 at 1:45 PM A new Deep Tissue Pressure Injury to R1's Left Heel was noted during R1's dressing change of R1's Stage 3 coccyx pressure injury. R1 was not wearing heel protector boots and did not have heels floated off of bed. Both of R1's bare heels were laying directly on fitted sheet on mattress. V5 (Licensed Practical Nurse/LPN) and V6 (LPN) acknowledged R1's new Left Heel Unstageable Pressure Injury and did not measure or assess area.</p> <p>On 9/10/20 at 10:55 AM V5 (Licensed Practical</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>Nurse/Wound Nurse) stated R1 went to offsite wound clinic on 8/28/20 and was to return in three weeks for next appointment. V5 stated offsite wound clinic where R1 had appointment called facility on 9/1/20 to review R1's wounds. V5 stated V5 forgot to look in R1's electronic medical record to ensure physician orders from wound clinic visit were entered. V5 stated when R1 returned from wound clinic appointment on 8/28/20 the list of physician orders for R1's wounds were never transcribed to R1's medical record.</p> <p>On 9/11/20 at 8:50 AM V20 (Advanced Practice Nurse/Wound Clinic Specialist) stated R1 was seen at wound clinic on 8/28/20. V20 stated R1 had ten separate wounds. V20 stated that R1 smelled of body odor and urine. V20 stated R1 also had an abundance of yeast in skin folds that needed to be cleaned up before any wound assessment could be completed. V20 stated facility should have entered orders the same day as wound clinic visit on 8/28/20 and not wait until 9/10/20. V20 stated all of R1's wounds could deteriorate without assessment and treatment. V20 stated new pressure injuries could result from facility not following physician orders and resident care plan. V20 stated waiting 13 days to enter physician orders was "absolutely unacceptable."</p> <p>On 9/10/20 at 12:30 PM V3 (Medical Director) stated facility staff should follow Care Plan for each resident. V3 stated a physician order should be entered into the electronic medical record on the same day it was received. V3 confirmed that not entering physician orders for 13 days could also cause degradation to R1's new pressure injuries noted at wound clinic appointment on 8/28/20.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>2. R8's undated Face Sheet documents diagnosis of: Wedge Compression Fracture of Thoracic Vertebrae.</p> <p>R8's Minimum Data Set (MDS) dated 8/21/20 documents R8 as being at risk for pressure injuries. This same MDS documents R8's Brief Interview for Mental Status score of 11/15 (moderate impairment).</p> <p>Hospital After Visit Summary notes dated 8/21/20 documents R8's TLSO (Thoracic-Lumbar-Sacral-Orthosis) brace to be on at all times when sitting upright and out of bed.</p> <p>R8's Physician Order Sheet (POS) dated August 1-31, 2020 and September 1-30, 2020 did not document a physician order for R8's TLSO brace.</p> <p>R8's Treatment Administration Record dated August 1-31, 2020 and September 1-30, 2020 did not document a physician order for R8's TLSO brace.</p> <p>On 9/10/20 at 10:00 AM V14 (Certified Nurse Aide) and V5 (Wound Nurse/Licensed Practical Nurse/LPN) assisted R8 with perineal care and transfer in to R8's bed. R8 complained of back pain due to Thoracic-Lumbar-Sacral-Orthosis (TLSO) brace repeatedly during cares. R8 stated TLSO brace has been hurting his back for days. V5 removed TLSO brace to reveal a previously unidentified and unassessed Stage 2 pressure injury to R8's left lower back where R8's TLSO brace had been resting directly over bony prominence. R8's TLSO brace left a red line across entire width of lower back. V5 measured area at 1.8 cm long (height) by 4.7 cm wide open and reddened with minimal amount of clear</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>drainage.</p> <p>On 9/10/20 at 10:30 AM V5 stated a medical device such as R8's Thoracic-Lumbar-Sacral-Orthosis (TSLO) brace could cause a pressure injury if not monitored. V5 stated R8's TLSO brace had caused a pressure injury to R8's lower left back.</p> <p>3. R1's undated face sheet documents diagnoses of: Sepsis, Cellulitis, Pressure Ulcer of Unspecified site, Legally Blind, Alzheimer's, Hemiplegia and Hemiparesis.</p> <p>R1's Care Plan dated 7/16/20 instructs staff to check R1 every hour and as needed for incontinence.</p> <p>R1's Minimum Data Set (MDS) dated 8/31/20 documents R1 as requiring total dependence of two staff for bed mobility, transfers, and toileting. This same MDS documents R1's Brief Interview for Mental Status score of 9/15 (moderate cognitive impairment).</p> <p>R1's Hospital Discharge Summary dated 8/25/20 documents R1 as being hospitalized from 8/18/20-8/25/20 with admitting and primary discharge diagnoses of: Hypotension Secondary to Septic Shock, Acute Kidney Injury and Infection of Decubitus Ulcers.</p> <p>R1's Physician Order Sheet (POS) dated September 1-30, 2020 documents an order for R1's Coccyx/Sacral Stage 3 pressure injury to cleanse with wound cleanser, apply puracol and cover with bordered foam daily and as needed. This same POS documents a physician order beginning on 9/10/20 for Keflex (antibiotic) 500 milligrams (mg) three times per day for ten days</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>for wounds to coccyx.</p> <p>On 9/9/20 at 1:45 PM V5 (Wound Nurse/Licensed Practical Nurse/LPN) and V6 (LPN) completed R1's pressure ulcer dressing change to Stage 3 coccyx area pressure ulcer. V5 and V6 positioned R1 for dressing change. At this time R1 was laying on incontinence pad heavily saturated with urine over the entire pad with brown ring around edges of incontinence pad. V5 and V6 did not cleanse R1's lower back, buttocks or thighs that had been laying directly on urine saturated incontinence pads and did not provide perineal care after R1's urine incontinence episode and before completing R1's pressure injury dressing change to coccyx/sacral region. R1's prior dressing to Stage 3 coccyx pressure injury was saturated with urine. R1's Stage 3 coccyx pressure injury was open with approximately one third of tissue pink, one third of tissue white, soft and adherent to wound and one third tissue dark brown and dry. R1's skin surrounding coccyx wound was dark red over lower half of buttocks and upper half of back of R1's thighs. R1's open Stage 3 coccyx pressure injury had been in direct contact with incontinence pad heavily saturated with urine. Throughout R1's Stage 3 pressure injury dressing change V6 did not change gloves, wash hands or use Alcohol Based Hand Rub (ABHR) for five separate times that it was indicated between cleansing and dressing R1's coccyx/sacral. V6 did not treat each wound separately.</p> <p>On 9/9/20 at 2:45 PM V6 stated V6 should have washed hands or used Alcohol Based Hand Rub (ABHR) between caring for each of R1's wounds. V6 stated V6 should have treated each wound separately instead of cleansing all of them at once, then dressing all of them at once. V6 stated</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>V6 should have provided perineal care after urinary incontinence episode before dressing pressure injuries. V6 confirmed the dressing was not adhered to R1's wounds and R1's pressure injury on coccyx was laying directly on urine saturated incontinence pad.</p> <p>On 9/9/20 at 3:30 PM V5 stated R1 should have been checked for urinary incontinence because R1 "should not be laying on urine-soaked pads. That's bad for R1's wounds and skin." V5 stated urine can create or worsen pressure injuries. V5 stated R1 should not have been laying on two incontinence pads. V5 confirmed R1 was laying on incontinent pads approximately two feet long and width of bed that was heavily saturated with urine and had brown ring at edges of incontinence pad.</p> <p>The facility policy titled 'Pressure Ulcer/Pressure Injury Prevention (PUP)' revised 4/2018 documents the following:</p> <p>"A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A facility must: Implement, Monitor and Modify interventions to attempt to stabilize, reduce or remove underlying risk factors. If a PU/PI is present, provide treatment to heal it and prevent the development of additional PU/PI's.</p> <p>Planning: An individual plan of prevention will be developed to meet the needs of the resident. It will include the consideration of: mechanical support surfaces, nutrition, hydration, positioning, mobility, continence, skin condition and overall clinical condition of the resident as well as the risk factors as they apply to each individual.</p> <p>Implementation: Interventions for the prevention</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>of pressure ulcer/pressure injury will be individualized to meet the specific needs of the resident.</p> <p>Moderate Risk (13-14): protect heels, float if possible. Manage moisture by providing prompt incontinent care. Daily observation of skin during care given by Certified Nurse Assistants (CNA's).</p> <p>High Risk (10-12): Manage friction and shear by utilizing positioning and repositioning.</p> <p>Manage incontinence: Cleanse skin gently at each time of soiling with a pH balanced cleanser."</p> <p>The facility policy titled 'Clean (Aseptic) Treatment Technique' revised 4/2018 documents the following:</p> <p>"Remove the soiled dressings: Wash or sanitize your hands per your policy. Apply gloves.</p> <p>Cleansing the wound: Wash or sanitize your hands per your policy. Apply gloves. After cleansing the wound, discard cleansing tools and gloves.</p> <p>Apply a clean dressing: Wash or sanitize your hands per your policy. Apply clean gloves.</p> <p>After applying new dressing, discard soiled gloves.</p> <p>Miscellaneous: If there are multiple wounds, treat each wound separately."</p> <p style="text-align: center;">(B)</p>	S9999		
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