Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001176	A. BUILDING: ______ B. WING ______	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HEALTH CENTER	4538 NORTH BEACON CHICAGO, IL 60640

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S9999	Final Observations	S9999		

Statement of Licensure Violation:
1 of 1 Violation

300.610a)
300.1210b)
300.1210d)2)3)5)
300.1630a)2)
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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1 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: 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 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. Section 300.1630 Administration of Medication	S9999		

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a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.

2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.)

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)

These Requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to follow their policy and procedures to prevent the development of avoidable pressure sores. The facility also failed

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to follow physician orders by not consistently treating and managing these facility-acquired pressure sores for six of six residents (R2, R3, R4, R5, R6, R7) reviewed for pressure sores from a sample of 10 residents. These failures resulted in all 6 residents developing facility-acquired pressure sores ranging in severity from stage 3 and stage 4 pressure sores to unstageable pressure sores.

Findings include:

On 5/1/19, V2 (Director of Nursing) presented surveyor a list of all wounds being treated by the facility. Surveyor asked who treated the wounds in the facility, V2 stated, "We have a wound nurse (V8), but she called off sick today."

On 5/1/19 at 2:00 PM, surveyor asked V4 (RN) to accompany surveyor inside R2's isolation room. As the door opened, a strong pungent odor of feces and urine presented itself. The resident was in bed with brown, stained and crumpled sheets strewn about his bed. To the left of the bed were 2 large red isolation bins overflowing with garbage to the floor surrounding these bins. Surveyor asked R2 if he needed a nurse, R2 stated, "I've been waiting all morning and no ones's come in so I guess I just fell asleep." V4 called in V9(CNA-Certified Nurses Aide) to help change R2's sheets and undergarments. R2 was turned over to his side to reveal a golf ball sized hole above his anus. Surveyor asked V4 if there was any type of treatment for the observed pressure sore, V4 stated, "I think there should be a bandage dressing on it but I'm not sure because the wound nurse does that and she hasn't been here for awhile." R2 was then turned on his other side revealing an even larger softball-sized gaping hole on the right hip. V4

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stated, "I don't know why there is nothing to cover that either but I will find out." On R2's right ankle there was a beige colored bandage wrapped several times around the ankle. Surveyor asked V4 to show the wound under the bandages. The bandages appeared moist with dried blood that bled through them. Upon bandage removal, there was an undated covering that was under the bandages which was saturated with dried blood. R2 was asked if anyone came in to change any of his bandages, R2 stated, "I haven't seen that nurse that did them before over a week ago when she was with some doctor."
Surveyor asked V4 to show the treatment administration record for R2. Surveyor accompanied V4 to her station to bring up the treatment records on her computer. V4 stated, "I don't know how to get the treatment records." Surveyor asked V4 how she can do the wound care without knowing how to get to the treatment records, V4 replied, "We don't do the treatments. It's just the wound nurse(V8) that does them."

R2's physician order for wound care dated 3/26/19 calls for 3 separate orders for his pressure sores: 1. "Silver Collagen Gel every day shift for wound care; Cleanse right medial ankle with 0.9 normal saline; Apply Gel, Cover with a dry dressing change daily and as needed. 2. Dakins solution 0.5% apply to right hip with 0.5% solution pack loosely with Silver Calcium Alginate; Cover with a gauze, pads and secure with tape. Change daily and as needed. 3. Silver Calcium Alginate every day shift for wound care Cleanse Right Hip with 0.5% Dakin's solution packed loosely with Silver Calcium alginate, cover with a gauze, ABD (abdominal) pads and secure with tape. Change Daily and as needed."
These wound orders did not appear to have been conducted as observed by the surveyor with V4

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on 5/1/19.

Surveyor approached another nurse on the same floor about wound treatments, V5 (LPN-Licensed Practical Nurse) stated, "It's my second day here. I wasn't shown how to do them." Asked if she did any her first day here, V5 stated, "I was told the wound nurse did them all."

Surveyor went to the third floor and interviewed V6 (LPN) about wound treatments. V6 stated, "We don't do the treatments here. There's a wound nurse that comes and does them." Asked what she would do if resident had to have their wound dressings changed if they got soiled or wet, V6 stated, "I guess I'd have to change it but no one's ever asked me to."

On 5/1/19 at 2:26 PM, R4 was observed in bed. Surveyor asked V13 (CNA-Certified Nurses Aide) to turn R4 to his side to reveal his wound. V13 removed the incontinence pad from R4 but there was no dressing on R4's buttock as ordered by the physician. Review of R4's physician orders states "Silver Calcium Alginate as needed for wound care. Cleanse right buttock with 0.9 normal saline, pack loosely with silver calcium alginate; Cover with a dry dressing, pads, and secure with tape. Change daily and as needed when negative pressure therapy is unavailable."

Surveyor asked V7 (LPN) about R4 and about negative pressure therapy, V7 stated, "I haven't seen the wound nurse and I haven't seen a wound vac (negative pressure therapy) that's done here for awhile. I can't even remember when."

On 5/1/19 at 2:50 PM, R3, was observed on an

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extra-wide (bariatric)bed that occupied one side of the room with two wheelchairs to the left of his bed filled clothes. A waste basket with two urine-filled urinals hung inside the waste basket. The room was pungent with strong urine and body odor. Surveyor asked R3 if any staff came to assist him to go to the bathroom. R3 stated, "I've been having the hardest time here and I've talked to everyone, you name it. They tell me that I have to get out of bed to shower before they can do anything like doing my sores on my back and butt but they don't even have anyone to help do that. They'll tell you I refuse, but I refuse because I don't feel safe with anyone of them trying to transfer me. Surveyor to clarify who he spoke to, R4 stated, "I spoke to the director of nursing (V2) and any nurse that I see. Speaking of which, the last time I saw V8(wound nurse), I can't even tell you because I can't remember when she was last here. If I had to guess it was over a week ago. (V8) said to me she can't do my wound care unless I get a shower. That's fine but who's going to get me on a shower chair? They just give excuses to not help me or do what they're suppose to do. I want to go back to the VA hospital."

Surveyor asked V9 (CNA-certified nurses aide) to assist in turning R3 over to observe his wound. When turned, R3 was laying atop bunched up and crumpled sheets that were stained with dried blood. There was a strong and dank smell that was piercing to the nose. On R3's left upper hip area appeared a large golf-ball sized hole. The skin around the hole was reddened and had dried blood surrounding the hole. There was no bandage cover and the crater-like hole remained exposed and appeared untreated.

R3's Physician orders for the his sore on his hip

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show "Hydrocolloid dressing every day shift every 3 days for skin care. Cleanse left ischium (hip) with 0.9 normal saline; Apply a Hydrocolloind dressing and Change every 3 days and as needed."

On 5/1/19 at 3:10 PM, Surveyor went in to R5's room who was in bed asleep. Surveyor asked V7 (LPN) to see R5's wounds, V7 stated, "I think he used to have sores but not anymore." Review of facility wound report show R5 acquiring two stage 3 pressure sores on each thigh on 2/12/19. Per wound records, R5's stage 3 to the right medial thigh measured 2 centimeters long by 2.3 centimeters wide and 0.2 centimeters deep. The other facility-acquired wound is a stage 3 to the left medial thigh measuring 3.0 centimeters long by 1.5 centimeters wide and 0.2 centimeters deep. Surveyor asked V2 (DON) if R5's wounds were considered unavoidable wounds, V2 stated, "Well we heeled them, so I guess not. Does that count?" Surveyor asked for any assessment to show R5's wounds were unavoidable, V2 stated, "I don't have anything to show you on that."

On 5/1/19, Surveyor reviewed the facility's wound report provided by V2 (Director of Nursing). Per this report, R6 obtained a facility-acquired stage 3 pressure sore to the left buttock on 2/12/19 measuring 3.6 centimeters in length by 2.1 centimeters wide and 0.2 centimeters deep. Surveyor asked V2 if he could provide any documentation to show R6's wounds were unavoidable, V2 stated, "She was a hospice patient and she died just this last April." Asked if she was placed on hospice before or after obtaining her wound, V2 stated, "I think she got them before because she went on hospice in April.." Asked again to provide any clinical assessments to show R6's wounds were

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unavoidable, V2 could not present any to the surveyor.

Review of R6 show the MDS (Minimum Data Set) admission assessment dated 12/11/18 show no pressure ulcers upon admission however was considered "at risk for pressure ulcers/injuries". The facility did not place R6 on any turning/or repositioning program nor on any nutrition or hydration intervention despite this risk. Two months later, on 2/12/19, R6 sustains a facility-acquired stage 3 pressure sore to the left buttock. Surveyor asked V1(administrator) for the latest skin assessment conducted for R6 on 4/17/19 by V6 (wound nurse). V1 presented surveyor with a blank and empty assessment initiated by V6 however, all treatments that day were all allegedly completed per the treatment administration records. Asked to comment on this, V1 replied, "We are in the process of finding another wound care nurse."

Another resident on the facility-acquired wound list show R7 acquired an Unstageable Pressure Sore on 2/12/19 to the superior Sacrum measuring 1.0 centimeters long by 1.0 centimeters wide by undeterminable depth. Per V2(director of nursing), R7 was transferred to another facility late April. Surveyor asked to provide any clinical assessments that support R7's wounds to be unavoidable, V2 stated, "I don't know about that but I will check." Surveyor never received any assessments from V2 except for R7's treatment administration records for April which showed wound treatments conducted daily by the nurses. Further review however contradict actual treatments that were conducted with progress notes documenting that R7 frequently refused wound care. For example, on 4/18/19, nursing documentation by V8 (Wound Nurse)

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writes three separate entries on 4/18/19 showing R7's refusal of the wound treatment. However on the treatment administration record of 4/18/19 both R7's treatment orders were initialed as completed by V8 contradicting her own progress note written for the same day.

On 5/6/19 at 10:55 AM, Surveyor asked V1 (Administrator) to contact the wound care nurse (V8). V1 stated, "She is not here again today, she texted and said she had an emergency but we've been trying to get a hold of her and she doesn't respond until days later with a text. We're considering no longer having her work here."

On 5/6/19 at 11:05 AM, Surveyor obtained TARs (treatment administrations records) for R2. Per R2's treatment records, V2 (Director of Nursing) performed 3 separate wound treatments on Sunday 5/5/19 as per his initials. Upon interview V2 affirmed conducting treatments and stated, "I came in and did all the wound treatment including (R2).
At 11:15 AM, Surveyor requested V4 (RN) to accompany him to view R2 who was asleep in his room. V4 turned R2 turned over to his side and showed the golf ball sized hole above his anus with no dressing cover or indication of treatment that was ordered by the doctor. R2 was then turned on his other side revealing the larger softball-sized gaping hole on the right hip. V4 stated, "I don't know why there is nothing to cover that it must have come off. Surveyor asked what staff should do if a resident requires additional treatments due to them coming off or soiled, V4 stated, "I would call the wound nurse but I guess I can try to change it." On R2's right ankle there was a beige colored bandage wrapped several times. Surveyor asked V4 to show the wound under the bandages. Upon bandage removal,

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there was an undated and unmarked covering that was under the bandages to show when and who conducted the treatment. R2 was asked if anyone came in to over the weekend to change any of his bandages, R2 stated, "I remember you from last week but I still haven't seen the other nurse (V8). Some nurse wrapped my ankle I think on Friday." Surveyor asked R2 if he knew what day it was, R2 correctly responded, "It's Monday."

Interview with V16 (Medical Director) on 5/6/19 at 2:15 PM states, "I can't recall when I've been to a quality assurance meeting at that facility but I can tell you the director of nursing and the wound team talk to me regularly about any issues however, I am not aware there is a problem there with wounds. Surveyor asked V16 to clarify his statement about a wound care team as there is only one wound nurse. V16 stated, "I mean all the nurses are responsible for the treatments there. Is there a problem with them there?" Surveyor asked V16 about facility-acquired wounds,V16 stated, "Yes, but I'm not aware we had as many facility-acquired wounds as you say we have. If that's true then moving forward I need to set up a meeting with the administration right away to discuss what we need to do. I also need to meet with the administrator because we do need to address the staffing problem because it would affect the quality of care there." Surveyor asked expectation of the staff at the facility, V16 stated, "I expect that wound care is conducted but that is under the wound doctor who I know goes there regularly."

On 5/6/19 at 3:00 PM, Surveyor asked V2 (Director of Nursing) to provide additional TARs (Treatment Administration Records) for R2, R3, R4, R5, R6, and R7. Surveyor asked what a blank space on the day shown of the treatment

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S9999	Continued From page 11 administration record meant, V2 stated, "It means that the treatment was not done or the resident was out." Upon receipt of the TARs on 5/6/19 at 4:00 PM, the treatment records show that the blank spaces that were originally blank on 5/1/19, were now filled-in with the initials of V2. Surveyor asked to identify whose initials were written in the original blank spaces, V2 stated, "That's me, I did the wound treatments." Surveyor asked to clarify whether he came in every weekend to do the wound treatments in April, V2 stated, "Yes, I live nearby." Surveyor asked about the March treatment blanks and why he didn't do those, V2 stated, "I have a life too." Surveyor asked for the administrator to come in to discuss V2's claims. V1 (administrator) stated to V2, "I was not aware he(V2) came in to do the treatments." Surveyor asked V2 if wound treatments were all done on the weekend by him, why the records were blank when initially viewed by the surveyor. V2 then affirmed, "I inputted my initials this past weekend and went back a month and added them." Asked if he should be going back a month to input a treatment he did over a month ago was acceptable practice, V2 stated, "I don't know, but I came in to do them but I just didn't sign off on them." Surveyor asked V1 if this was acceptable practice by the facility, V1 stated, "No this is not and I will have to terminate V2 for this. We do not do this here. If he did the treatment, he should have signed off on them right then and there and not go back a month to show that he did because this is highly improper." Asked privately if their electronic system allowed changes to the record, V1 stated, "You can go back about a month to make changes, but it won't allow you to do that past 30 days. That's probably why March was unchanged." Surveyor asked if he believed V2 conducted all the treatments he claimed to do in April, V1 stated, "I don't believe that at all. I know	S9999		

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he came in this past weekend but certainly not all those he signed."

V10 (Wound Care Doctor) at 3:30 PM stated, "I usually come there every week to see all the wounds the facility needs me to see. I try to come there on Tuesdays but it all depends on the availability of the wound nurse."
Surveyor asked about negative pressure therapy, V10 stated, "They really needed a wound vacuum device for some of the wounds there but the only person who knows how to operate one is no longer there. I've asked the director of nursing to train someone but they already have staffing problems there so I try to keep my wound orders as simple as possible so even the weekend nurses can do the wound dressing changes."
Asked if she was aware of any staffing issues, V10 stated, " I know they have staffing problems because just last week when I came to do my rounds, I was told the wound nurse wasn't there again. I asked for any nurse to round with me and I couldn't even find anyone willing to do that."
Surveyor asked V10 her expectations on wound care, V10 stated, "I expect that they off-load the wound and at a minimum every two hours. They should minimize the sheets to avoid it getting saturated and bunched up under the skin. I've told the staff and director of nursing to even avoid using those cotton pads that go under the resident because they can become saturated with moisture and you end up with worsened wounds. I think I will contact the medical director along with the administrator moving forward because staffing definitely impacts the care and certainly whether my orders get carried out or not. If you don't have enough staff, how can you expect them to turn or reposition the resident. Surveyor asked what the risks are in not doing wound care treatments for the residents, V10 stated,

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001176	A. BUILDING: ______ B. WING ______	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HEALTH CENTER	4538 NORTH BEACON CHICAGO, IL 60640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

"Infection of the wound, deterioration of the wound, and if it's a highly compromised resident then sepsis and death."

Facility's undated Policy and procedures titled "Pressure Ulcer Prevention and Managing Skin Integrity" states, "Nursing in collaboration with the health care team, will assess and manage skin integrity for all patients throughout the hospital stay. Risk for pressure ulcer development will be evaluated upon admission to a nursing unit and on a routine basis for all adult patients using the Braden Scale. Risk assessments will be done more often when the patient condition warrants more frequent assessment. Skin inspections will be completed on admission and daily for all hospital patients. Any patient with a Braden score < 12 or when nursing assessments indicate a patient need, skin inspections will be done every 8 hours.

(B)