

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012165	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/12/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROSEWOOD CARE CENTER OF PEORIA

**1500 WEST NORTHMOOR ROAD
PEORIA, IL 61614**

(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
S 000	Initial Comments First Complaint Certification Revisit to Survey date 3/8/18, Complaint 1821325/IL100659. Statement of Licensure Violations: 300.610a) 300.1210 a) b) c) d) 5) 300.3240 a)	S 000		
S9999	Final Observations 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 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/20/18

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S9999	Continued From page 1 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 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999			

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S9999	Continued From page 2 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 were NOT met as evidenced by: Based on observations, record reviews and interviews, the facility failed to timely implement pressure ulcer interventions, implement physician orders, and provide treatment for three of four residents (R308, R309, R312) reviewed for pressure ulcers in the sample of twelve. These failures resulted in R312 developing a left heel wound which deteriorated to an unstageable pressure ulcer. Findings include: The facility Skin Care Pressure Ulcer/Wound Management policy dated 10/04 documents: To promote healing of pressure ulcers, stasis ulcers and other wounds, (the facility) will use standardized protocols or follow physician's specific orders for wound care: Optimal wound management will include: Assessment of skin and wound, use of standardized protocols, regular reassessment to monitor effectiveness of interventions. Treatment objective to promote optimal wound healing are to relieve pressure. The nurse will implement appropriate Pressure	S9999			

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S9999	Continued From page 3 Ulcer Prevention Protocols per policy. Skin/Wound Care Protocols document suspected Deep Tissue Injury treatment is to protect, relieve pressure or shearing, apply skin prep every shift and if on heel, float the heel when in bed. 1. A Pressure Ulcer Risk Assessment was performed on admission 3/12/18 and then weekly on 3/17/18, 3/26/18 and 4/2/18 with scores indicating R312 is a High Risk for pressure ulcers. The same assessment states to implement appropriate preventative protocols; use draw sheet for positioning, float heels, turn and position at frequent intervals. The April Treatment Administration Record (TAR) for R312 documents staff are to do weekly skin assessments, cleanse coccyx wound with wound cleanser, pat dry, apply 2x2 duoderm, moisture barrier ointment after each incontinence; left heel: cleanse with wound cleanser, pat dry, apply xeroform and ABD pad, wrap with gauze wrap and secure with tape daily, and 1/2 siderails for bed mobility and positioning. On 4/9/18 at 10:40 a.m., R312 was resting in bed, side rails down, flat white bed sheet was hanging off of the mattress with only a small portion of the bed sheet under the resident's lower back area. There was no draw sheet noted and R312's bare feet / heels were lying directly on the mattress with no dressings noted. The mattress area under the left heel was visibly soiled with a dark maroon color. R312's left heel was visibly draining moderate amounts of a maroon colored fluid. On 4/10/18 at 2:20 p.m., R312 was resting in bed with side rails down and heels on mattress. An Admission Nursing Assessment dated 3/12/18	S9999			

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S9999	Continued From page 4 documents R312's left heel was pink and firm and R312 had a Stage II pressure ulcer to his coccyx upon admission. The Wound Documentation documents that on 3/26/18 a left heel wound was identified measuring 5 centimeters (cm) x 5.2 cm x unstageable, 4/2/18 - 6 cm x 7 cm x unstageable and 4/9/18 - 7 cm x 6.5 cm x unstageable with moderate serous drainage. R312's care plan dated 4/3/2018 does not document any interventions or treatments for a left heel wound identified on 3/26/18. An Initial Evaluation performed by V19 (Wound Physician) on 4/9/18 documents an unstageable pressure ulcer to the left heel measuring 7 cm x 6.5 cm x depth immeasurable with moderate serous drainage. It further documents "Wound on heel is very severe and places patient at risk for loss of limb, need to offload heel to prevent further injury." On 4/9/18 at 2:10 p.m., V3 (Wound Nurse) stated that the heels were not being offloaded or floated and there is no dressing on the left heel pressure wound as ordered and the side rails are down. V3 also stated that the left heel wound was identified on 3/26/18 and the wound specialist did not see or treat the wound until 4/9/18. On 4/9/18 at 2:10 p.m., during incontinent care, the Stage II coccyx wound did not have a dressing. V3 applied the dressing to the wound but did not cleanse the wound with wound cleanser as ordered. On 4/9/18 at 3:10 p.m., V3 (Wound Nurse) stated that the Stage II coccyx wound is supposed to	S9999			

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S9999	Continued From page 5 have a hydrocolloid dressing at all times and further stated that she did not use wound cleanser on the Stage II coccyx wound prior to putting on the ordered dressing. On 4/11/18 at 2:00 p.m., V1 (Administrator) stated, "The wound care and treatments and all wound interventions are to be put in place by the wound nurse and it is also the responsibility of the wound nurse to get that information to the care plan coordinator to update care plans." 2. R309's Pressure Ulcer Risk Assessment, dated 3/6/18, documents that R309 is a high risk for pressure ulcers. R309's Wound Documentation Sheet, dated 3/1/18, documents that R309's left knee wound measures 0.9cm (centimeter) by 1cm, and is a stage two. R309's Wound Documentation Sheet, dated 4/10/18 documents that R309's left knee wound measures 1.7cm by 1.6cm by unable to determine depth. R309's Wound Documentation Sheet, dated 4/10/18, documents that R309's distal left knee wound measures 1.2cm by 1.2cm by unable to determine the depth. On 4/9/10 at 11:30am, R309 was sitting in a reclining chair with R309's left knee resting against the side of her reclining chair. On 4/10/18 at 12:00pm, R309 was sitting in a reclining chair with R309's left knee resting against the side of the reclining chair. On 4/10/18 at 2:00pm, R309 was in bed with R309's left knee resting against the half side rail	S9999			

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S9999	Continued From page 6 and pressed into the mattress. On 4/10/18 at 10:30am, V3, (Licensed Practical Nurse/Wound Nurse), removed R309's left knee dressing and cleansed the area. V3 stated that R309 had a new wound on R309's left knee. V3 measured R309's proximal wound as 1.7cm (centimeters) by 1.6cm by unknown depth, and unstageable. V3 measured R309's distal left knee wound as 1.2cm by 1.2cm by unknown depth, and unstageable. V3 verified that both wounds are unstageable due to the yellow slough in the wound bed. V3 verified that R309's proximal wound has gone from a stage two wound to an unstable wound. V3 verified that R309's current care plan does not have any skin interventions pertaining to R309's left knee wounds. On 4/12/18 at 10:20am, V20, (Regional Coordinator), stated that R309 does not have to have new interventions put into place to prevent further skin breakdown, because R309 has a diagnosis of failure to thrive. 3. R308's written physician's order (POS) dated 3/23/18 orders nursing staff to examine R308's skin daily. The POS also orders for nursing staff to document a skin assessment weekly. R308's Wound documentation sheet dated 3/23/18 documents that R308 developed a facility acquired stage one pressure ulcer to the right upper thigh which measured 1.5cm (Centimeters) long x 1.4cm wide x 0.1 cm deep with an intact peri-wound area. This same sheet has no other weekly entries documenting a description for R308's wound.	S9999			

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S9999	Continued From page 7 R308's Weekly Pressure Ulcer Report dated 4/2/18 documents that R308 is being treated for a stage 2 pressure ulcer to the coccyx which developed on 2/16/18. This same report documents that R308's wound to the right upper thigh had progressed to a stage 2 pressure ulcer measuring 1.4 cm long x 3.0 cm wide x 0.1 cm deep. The weekly pressure ulcer report also documents that R308's current treatment orders for both wounds is an absorbent gel forming dressing which is to be changed every three days. R308's printed compilation of current physician's orders dated 4/2018 orders for staff to perform a skin assessments daily and to also document R308's skin moisture, color, temperature, integrity, and turgor weekly. These printed orders do not include treatment orders for R308's right upper thigh stage 2 pressure ulcer. R308's treatment administration record (TAR) dated 3/23/18 to 3/31/18 documents R308's skin was assessed on a daily basis only four of the nine days during that time period. R308's TAR dated 4/1/18 to 4/11/18 documents R308's daily skin assessment was only performed one time on 4/5/18. This same treatment administration record documents that R308's right upper thigh pressure ulcer dressing was applied one time during that time period, on 4/9/18, instead of every three days. R308's care plan dated 4/5/18 does not include interventions for the treatment of R308's stage 2 pressure ulcers to the coccyx and right upper thigh. R308's care plan does document for nursing staff to complete a daily skin check with weekly and as needed documentation on the treatment administration record.	S9999		

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S9999	Continued From page 8 A Non-Sterile Dressing Change policy dated 3/2018 states, "Prepare clean, dry work area at bedside. Use disinfectant solution to prepare work surface." The policy also instructs to remove gloves and perform hand hygiene after removing the soiled dressing and before applying new dressing. On 4/9/18 at 12:40p.m., V9 (Registered Nurse) entered R308's room in order to change R308's stage 2 coccyx pressure ulcer dressing. V9 was carrying several pieces of opened gauze, a bottle of wound cleanser, and an absorbent gel forming dressing. R308 was lying in bed with a bedside table next to R308 which had a glass of juice, a bag of cookies and soiled tissues sitting on it. V9 placed the dressing supplies directly on R308's bedside table without first removing the drink, cookies or the soiled tissues, and without disinfecting the table. V9 assisted R308 to turn to the right side to begin R308's dressing change. V9 noted that R308 had a dressing to coccyx but also a wound to R308's right upper thigh, which was not covered with a dressing. V9 stated she was not aware that R308 had this wound. R308's right upper thigh wound was approximately 2.5cm long x 2cm wide with a dark red wound bed. V9 realized she needed some additional supplies so V9 exited R308's room leaving the dressing supplies on R308's bedside table. At 1:50p.m, V9 and V3 (Wound Nurse) entered R308's room to perform R308's dressing change. V3 assisted R308 to turn to the right side while V9 removed R308's soiled coccyx dressing. V8 used the open gauze which had been placed on R308's soiled bedside table earlier to cleanse R308's coccyx wound then V9 placed the soiled gauze on R308's bed linens. V9 used the soiled gauze a second time to wipe around R308's coccyx	S9999			

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S9999	Continued From page 9 wound. Without removing her soiled gloves or performing hand hygiene, V9 opened a clean absorbent gel forming dressing and held it so her soiled gloves were touching the portion of the dressing that touches the wound. V9 then placed the dressing onto R308's coccyx wound. V3 stated R308's right upper thigh wound was considered a stage 2 pressure ulcer and should have had a dressing on it. V9 removed the soiled gloves and performed hand hygiene then reapplied gloves. V9 used the remaining open gauze from the soiled bedside table to cleanse R308's right thigh wound, then without removing the soiled gloves or performing hand hygiene V9 applied an absorbent gel forming dressing to R308's wound. On 4/9/18 at 2:00p.m. V9 verified that V9 placed R308's dressing supplies including open gauze onto R308's soiled bedside table then used that gauze to cleanse R308's coccyx wound. V9 also verified that V9 did not remove the soiled gloves or perform hand hygiene after removing R308's soiled dressing, cleanse R308's coccyx wound and right upper thigh wound, or before applying R308's clean dressings. V9 verified that R308's TAR dated 4/1/18 to 4/9/18 does not have documentation that R308's right upper thigh wound had any treatments applied prior to 4/9/18. V9 verified that R308's TAR only had weekly skin assessments scheduled. V9 verified that only one skin assessment was documented from 4/1/18 to 4/9/18 which was on 4/5/18. V9 stated that nurses use residents' physician's orders and treatment administration records to determine what treatments need to be performed for residents and also for documentation that those treatments were completed. On 4/10/18 at 12:00p.m. V3 stated that when	S9999			

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S9999	Continued From page 10 R308's right upper thigh pressure ulcer developed V3 notified R308's physician who ordered for R308's wound to have dressing changes every three days using an absorbent gel forming dressing. V3 verified that no such orders were documented on R308's physician's orders sheet or treatment administration record. V3 verified that R308's physician's orders do instruct for R308 to have daily skin assessments and weekly documentation to describe the wound. V3 verified that R308's treatment administration record does not show documentation that any dressing changes have been performed to R308's right upper thigh pressure ulcer. V3 also verified that there is no documentation that R308's daily skin assessments were performed for R308 from 4/1/18 to 4/9/18. On 9/11/18 at approximately 1:00p.m., V1 (Administrator) verified that R308's treatment administration record for daily skin assessments dated 3/23/18 to 3/31/18 was documented that the skin assessments were performed only four out of nine possible days. (B)	S9999			