

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9016273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2018
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NAME OF PROVIDER OR SUPPLIER ASSISI HEALTHCARE OF CLARE OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 829 CARILLON DRIVE BARTLETT, IL 60103
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S 000	Initial Comments Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)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 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. Restorative measures shall include, at a minimum, the following	S9999		

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

TITLE

(X6) DATE

05/11/18

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S9999	Continued From page 1 procedures 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 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 These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their pressure sore prevention policy and procedures by preventing the development of a facility-acquired pressure sore and the worsening of another pressure sore for one (R26) of four residents in a sample of 16 residents. This failure resulted in R26 acquiring an avoidable unstageable pressure sore to the right trochanter (right hip) and a worsening unstageable wound becoming a stage 3 pressure sore to the right malleolus (ankle bone). Findings include:	S9999			

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S9999	Continued From page 2 On 4/16/18 at 10:10 AM to 12:17 PM, R26 was observed sitting in a wheelchair in the common area with no staff repositioning R26 in her chair to off load pressure from her buttocks area. On 4/17/18, R26 was observed in the dining area sitting in her wheelchair at 12:10 PM to 2:00 PM for lunch and again was not repositioned or off-loaded in her wheelchair. On 4/18/18 at 9:38 AM wound observation conducted by two surveyors with V3 (Wound Care nurse/Assistant Director of Nursing), V6 (C.N.A.-Certified Nursing Aide) and V7 (C.N.A.) showed R26 in bed fully clothed under a blanket, bed sheets and her mattress set on "stand-by" mode. V6 and V7 proceeded to remove R26's clothing and revealed her to be also wearing an incontinence brief under her clothes. R26 was lying atop a draw sheet that was folded over several times creating multiple layers under her buttocks. Under these multiple layers was a tightly fitted bed sheet that wrapped around the air mattress. V3 proceeded to change the dressing and revealed a small hole (pressure sore) to R26's right upper hip area. Asked to describe the pressure sore, V3 stated, "The wound is at the right trochanter and it's considered unstageable because you can't visualize the wound bed because it's deep. It measures 1.6 centimeters (length) by 0.5 centimeters (width) by 1.0 centimeter (depth). It is also tunneling (a narrow opening or passageway underneath skin that can extend in any direction through soft tissue and results in dead space) measuring 2.4 centimeters." V3 proceeded to do wound dressing changes to the right malleolus (right ankle) and described the	S9999			

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S9999	Continued From page 3 wound as "80% fibrotic and 20 % pink measuring 1.0 centimeters length by 1.1 centimeters width by 0.2 centimeters deep." Asked when she acquired this wound, V3 stated, "She had this wound since 9/26/17 and it started as unstageable but now it's a stage 3 wound." Asked why R26's wound has taken over 7 months to heal, V3 stated, "Well it got better at one point and recently its gotten worse, but she's also seen by the wound doctor." After the conclusion of the wound dressing changes, R26 was again placed back in her incontinence briefs, fully clothed and lay back in bed atop numerous layers of sheets and covered with a blanket. The air mattress remained on standby mode and was not placed on alternating pressure per doctor's orders to assist in off-loading of the wounds. R26's Physician Order Sheet dated 4/18/18 has diagnosis listed in part with "dehydration, depressive disorder, coronary artery disease, and hypertension. Facility wound surveillance report provided by V3 (Wound nurse/Assistant Director of Nursing) on 4/16/18 shows R26 with two pressure related wounds. One of the wounds is a facility-acquired wound identified on 2/20/18. This wound is described as "Unstageable Right hip". The second wound is documented as a hospital acquired (admitted with 9/24/17) "Unstageable Right malleolus wound, Stage 3" . Wound physician initial assessment dated 2/28/18 shows the facility-acquired wound as "Wound location: Right Trochanter; pain level 3;	S9999			

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S9999	Continued From page 4 type: pressure; stage: non-stageable; wound size: 1.0 centimeters (length) x 1.5 centimeters (width) x 0.7 centimeters (depth)." Physician wound assessment dated 4/11/18 states in part, "Assessment: Right ankle DTI (deep tissue injury); Right trochanter-new 2/28/18. Plan: "offload; use heel protectors; low air loss overlay for bed." MDS (minimum data set) dated 1/2/18 shows R26 with a BIMS (Brief Interview of Mental Status) score of 2 for severe cognitive impairment; Section J for Health Conditions shows no weight loss; Section M for Skin Conditions shows R26 at risk for pressure ulcers; skin and ulcer treatments with pressure reducing device for chair and bed, pressure ulcer care, application of ointments/medications, however does not list R26 with any turning/repositioning program to coincide with R26's physician endorsed care plan. R26's Braden Scale for Predicting Pressure Sore Risk dated 4/18/18 show the facility considered R26 for eight consecutive months being "At risk for pressure ulcer development" for the period of assessments from 8/13/17 through 3/23/18. R26's Care plan dated 3/6/18 documents in part, "Impaired skin integrity. Admitted with unstageable/DTI (Deep Tissue Injury) Right Malleolus unstageable; Right hip stage 2 (facility-acquired 2/22/18) now Right hip unstageable; Risk for impaired skin integrity related to Primary medical history for dementia, anxiety, depression, and psychosis. Alert to self unable make request known to staff, staff to anticipate needs; (R26) requires assist with ADL (activities of daily living) functions receives from	S9999			

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S9999	Continued From page 5 nursing staff. She is often resistant to care and untrusting/paranoid with staff; Incontinent of Bowel and Bladder. Care Plan Goal: (R26) will have measurable wound healing and improvement of wound beds and have no further impaired skin integrity through next review. Care Plan Approach: Staff will assist with turning and positioning as needed (start date: 3/6/18) Night turning schedule every two hours. Keep off of right side (start 3/6/18); Pressure reducing mattress to bed. Low air loss mattress (start date: 2/26/18); Pressure reducing cushion in wheelchair (start date 2/7/18); Right lateral positioned on wheelchair (start 4/2/18)." 4/18/18 telephone interview conducted by two surveyors at 2:40 PM with V5 (Wound care physician) states, "I was brought on to see (R26) because she had a wound on her sacral area. I believe she got it at the facility I'm told and another is on her malleolus (ankle bone). That one I was told came from the hospital but we've been treating for quite a while. V5 was reminded of the date of 9/24/17, in which she replied, "That sounds about right." Asked if this was an unavoidable wound, V5 struggled to answer and stated, well she's malnourished." Asked if she had any diagnoses or condition that would make R26 have an unavoidable wound, V5 stated, "Well, sometimes wounds just happen. We're really providing comfort measures for her."Reminded that (R26) was not on hospice care, V5 stated, "Well she should be but the family can't afford it. Asked again whether the wound could have been prevented, V5 stated, "Perhaps but she's malnourished like I said and it's difficult to prevent her wounds with her	S9999			

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S9999	Continued From page 6 condition." Asked how other wounds R26 had were healed, V5 stated, "Well that was before she declined." Asked about her expectations of the facility to prevent pressure sores, V5 stated, "Well they should be following their protocols, (R26) should be on an air mattress and they should check the mattress for bottoming out, etc. the mattress is very important and needs to be checked for proper inflation. The "standby" setting is not the correct setting, it should be on "alternating pressure"; they should be turning and repositioning the patient but the bed is more important than the positioning. The type of bed they are on is more important and watching incontinence. Beds they are on, barrier cream, turning every two hours is important but if that's the only strategy, that isn't enough." Asked about the impact of linens and over padding of the air mattress to manage heat dissipation, V5 stated, "I don't get involved with that. The facility should follow their protocols on how to make their beds on those type of mattresses. They should know this." Policy and procedure dated September 2013 titled "Support Surface Guidelines" states, "The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. General guidelines: Redistributing support surfaces are to promote comfort for all bed or chair bound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. Support surfaces alone are not effective in preventing pressure ulcers, but studies indicate that the use of appropriate support surfaces with interventions	S9999			

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S9999	Continued From page 7 such as turning, repositioning and moisture management can assist in reducing pressure ulcer development. Elements of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution, moisture control, shear reduction, heat dissipation/ temperature control, friction control, infection control. Interventions: Any individual at risk for development of pressure ulcers should be placed on a redistribution support surface when lying in bed. For residents that recline and depend on staff for repositioning, change positions at least q 2 hours. Reposition residents who are in chair at least q 2 hours. Avoid placing resident on the greater trochanter for more than momentary placement." (B)	S9999			