

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/21/2018
NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938			
(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 Complaint # 1863154 / IL 102639	S 000			
S9999	Final Observations Statement of Licensure Violations Section 300.610 a) Section 300.1010 h) Section 300.1210 d)2)3)5) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	S9999			

Attachment A
Statement of Licensure Violations

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

TITLE

(X6) DATE

06/09/18

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S9999	Continued From page 1 of notification Section 300.1210 General Requirements for Nursing and Personal Care 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. These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to complete skin risk assessments upon admission and implement appropriate interventions to prevent pressure ulcers, failed to complete pressure ulcer	S9999			

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S9999	Continued From page 2 measurements and wound assessments upon admission and development of a pressure ulcer, failed to complete wound treatments as ordered treatments and failed to assess nutritional requirements upon pressure ulcer development for two of three residents(R1, R3) reviewed for pressure ulcers in the sample of 10. These failures resulted in R3's stage II pressure ulcer deteriorating to a stage IV pressure ulcer within one week. Findings Include: The facility undated Prevention of Pressure Ulcer Policy documents "assess for any special needs of the resident"; a special mattress, foam/gel/aircushion to relieve pressure, position changes every two hours or as needed. This policy also documents that for residents with poor nutrition, the "Dietitian will assess nutrition and hydration and make recommendations based on the individual resident's assessment", notify the physician and "monitor laboratory values", "talk to physician and dietician about supplements. Administer vitamins, mineral and protein supplements" in accordance with recommendations. The facility undated "Assessment to be completed upon admission and readmission" documents the following will be completed upon admission and readmission: Full Body Assessment with vitals, Skin Risk Assessment and if applicable, a Wound Assessment including measurements then clean and redress the wound. The facility Decubitus Care/Pressure Area Policy documents this policy is "to ensure a proper treatment program has been instituted and is	S9999			

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S9999	Continued From page 3 being closely monitored to promote the healing of any pressure ulcers, once identified." This policy also documents the pressure area will be assessed and all areas of a wound assessment should be completed: size, stage, site, depth, drainage, color, odor, and treatment, upon identification and that nursing personnel are to notify dietary personnel of any pressure area to seek nutritional support and monthly reviews by the Registered Dietician. 1.) R3's undated face sheet documents R3 was admitted to the facility on 11/28/17 with the following Diagnoses: Schizophrenia, Muscle Weakness and Cellulites. R3's MDS (Minimum Data Set) dated 2/22/18 documents R3 is alert and oriented and requires extensive assistance with bed mobility and transfers. R3's Skin Risk Assessment dated 11/29/17 documents R3 is at risk for skin breakdown. R3's Care Plan dated 12/6/17 documents R3 is at risk for pressure ulcers related to generalized muscle weakness and decreased mobility and is to use a pressure relieving mattress for pressure reduction when in bed. On 5/16/18 at 9:35 am, 11:40 am and 2:10 pm, R3 was lying in bed on a regular mattress, not a pressure reducing mattress as care planned, with a pillow under R3's hip and buttock. R3's Progress Notes document the following: 12/8/17 - 12/22/17 - R3 has a poor appetite and refuses meals.	S9999			

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S9999	Continued From page 4 1/9/18 - R3 has a "pinpoint opening on coccyx." There is no wound assessment or measurements of this "pinpoint opening on the coccyx." 1/12/18 - R3 was in the dining room for breakfast but stated R3 was not hungry and left without eating. There is no documentation in R3's medical record on the size or condition of the wound from 1/9/18 until 1/17/18. This Progress Note documents, V4 Physician notified of R3's stage IV to mid sacrum, treatment being initiated, V5 Wound Physician to see R3, and a new order for a liquid protein supplement with added vitamins and minerals for advanced wound healing was received. This 1/17/18 Progress Note also documents that V16 Dietary Manager "messed RD (Registered Dietician) r/t {related to} recommendations for open area", {8 days after the wound developed}. R3's Wound History Report documents the first measurement of a "Mid Sacrum" stage IV Pressure Ulcer on 1/19/18 that measures 3.0 cm (centimeters) in length by 1.5 cm in width by 1.5 cm in depth. On 5/21/18 at 1:40 pm, V6 LPN (Licensed Practical Nurse) / Wound Nurse stated the mid sacrum wound, on the History Report, is the same wound that was documented on as "the coccyx", in the Progress Notes. V6 stated V6 remembered seeing R3's wound initially and that it was pinpoint and that the 1/17/18 measurement, on the History Report, is the first time measurements were documented {8 days after the wound developed} and that the wound deteriorated from a stage II to a stage IV and increased in size during those eight days.	S9999			

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S9999	Continued From page 5 R3's January 2018 POR (Physician Order Report) documents an order from V4 Physician on 1/9/18 for "Barrier Cream to buttocks with each incontinence episode" as needed. R3's January 2018 TAR (Treatment Administration Record) documents the order for the Barrier Cream but there is no documentation that the treatment was initiated as this treatment was never signed off as being completed. R3's Progress Notes document the following: 1/20/18 - R3 had a change in condition, is lethargic and hard to arouse. Order received to send R3 to the Emergency Room. 1/21/18 - R3 has been admitted to ICU (Intensive Care Unit) with a Diagnosis of Sepsis. The Hospital Course Summary dated 2/10/18 documents: R3 was admitted to the hospital with "worsening confusion and septic shock due to an infected decubitus ulcer." R3 was found to have "polymicrobial bacteremia with a source relating to {R3's} infected decubitus ulcer." R3 "had visible speculated bone to {R3s} coccyx. Therefore, {R3} had osteomyelitis." R3's Progress Notes document R3 returned to the facility on 2/10/18. The Wound History Report documents the first time R3's Mid Sacrum wound was measured and assessed, post hospitalization, was on 2/16/18 {6 days after re-admission to the facility} and was a stage IV pressure ulcer measuring 8.5 cm by 7.0 cm by 3.0 cm. On 5/21/18 at 1:40 pm, V6 LPN / Wound Nurse	S9999			

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S9999	Continued From page 6 stated R3 has never been able to reposition herself. V6 also stated that since R3's wound treatment order was not signed off as being completed back in January, during the time that the wound deteriorated from a stage II to a stage IV, it is hard to tell if it was done or not. V6 stated that when wounds start to deteriorate, the floor staff is to tell V6 so that V6 can get V5 Wound Physician to see the resident. V6 stated V6 "could not recall" if staff alerted V6 to R3's deteriorating wound or not. V6 stated that residents with a stage IV pressure ulcer usually get put on a low air loss mattress and confirmed that R3 had a regular mattress, not an air mattress. On 5/21/18 at 1:50 pm, R3 was lying in bed with a pillow under her hip and buttock. R3 stated, "I {R3} have never had an air mattress but I wish I did. This bed has springs that poke my bottom, that's why I'm laying on this pillow. It's more comfortable this way." R3 stated R3 can not remember if staff were putting the ordered cream on her open area before she was admitted to the hospital. On 5/21/18 at 2:00 pm, V7 RN (Registered Nurse) who works with R3 stated, V7 remembers doing a treatment of a debriding agent for a few days prior to R3 going to the hospital but does not ever remember putting just a barrier cream on R3. On 5/21/18 at 2:55 pm, V4 Physician stated, facility should have completed the ordered treatment and notified V4 about the wound getting worse, before it deteriorated to a stage IV. V4 stated that with R3 being at risk for breakdown, the facility should have taken extra precautions like having R3 on an air mattress. V4 also stated hydration and nutrition are important	S9999			

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S9999	Continued From page 7 for skin healing and R3 should have been see by an RD for recommendations. "Prevention is key. If a resident is at risk {for breakdown}, skin should be checked all the time and they need to be turned frequently. I {V4} am very aggressive when it comes to wounds, even if they are very small. If I was aware of this getting worse, I would have ordered for (V5) to see (R3)", before V4 did. On 5/21/18 at 4:00 pm, V3 ADON (Assistant Director of Nursing) stated that R3 was not seen by V5, for the sacral wound, until after returning from the hospital. 2.) R1's Nursing Progress Notes document R1 was admitted to the facility on 3/6/18 with a surgical site to the left hip, an open area on the coccyx and "several open areas" to bilateral feet. There are no wound assessments or measurements documented in the progress notes or on the admission assessment. R1's Skin Risk Assessment completed on 3/7/18 documents R1 is at moderate risk for skin breakdown. The facility provided a Wound History Report for all of R1's wounds by V6 LPN (Licensed Practical Nurse) / Wound Nurse that documents the following : Right heel Deep Tissue Pressure Injury wound was first measured on 3/9/18 (3 days after admission) and measured 3.0 cm (centimeters) in length by 2.0 cm in width by 0 cm in depth. Mid Sacrum, a stage III Pressure Wound, was first measure on 3/16/18 (10 days after admission) and measured 0.5 cm by 0.6 cm by 0.1 cm.	S9999		

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S9999	Continued From page 8 Medial Plantar Top of Right Foot, stage II Pressure Wound, was first measured on 3/6/18 (3 days after admission) and measured 3 cm by 1.5 cm by 0.1 cm. Right Achilles Wound, stage II Pressure Wound, was first measured on 3/16/18 (10 days after admission) and measured 1.7 cm by 0.6 cm by 0 cm. Left Medial Ankle, stage II Pressure Wound, was first measured on 3/9/18 (3 days after admission) and measured 1.0 cm by 2.0 cm by 0.1 cm. Left Metatarsal, stage III Pressure Wound, was first measured on 3/9/18 (3 days after admission) and measured 2.5 cm by 1.5 cm by 0.2 cm. R1's Care Plan dated 3/12/18 documents R1 was admitted to the facility with pressure ulcers related to a displaced fractured left femur and that R1 should have a pressure relieving mattress on the bed. On 5/16/18 at 10:15 am, R1 was lying in a bed that had a regular mattress. On 5/21/18 at 2:05 pm, V3 ADON (Assistant Director of Nursing) stated, when a resident has a stage III or stage IV wound, they are placed on an air mattress to help with their wounds. V3 confirmed that R1 did not have an air mattress. (B)	S9999			