

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005961	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/23/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ELMWOOD NURSING & REHAB CENTER

**152 WILMA DRIVE
MARYVILLE, IL 62062**

(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 #1842944/IL102428 Complaint #1843123/IL102618 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		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

06/14/18

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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 interview, observation and record review, the facility failed to timely identify and adequately assess pressure ulcers following development for 3 of 3 residents, (R1, R2 and R3) reviewed for pressure ulcers in a sample of 3. This failure resulted in delayed treatment as some were identified as unstageable on first assessment for all three residents Findings include: 1. The Minimum Data Set (MDS) dated 03/10/18 identifies R3 to be severely cognitively impaired and dependent on staff for all activities of daily living. The MDS documents R3 having a urinary catheter and is always incontinent of bowel.	S9999			

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S9999	Continued From page 2 The Care Plan dated 03/10/18 documents R3 at risk for pressure ulcer development due to immobility with interventions for staff to complete weekly skin assessments, keep clean and dry, keep off left side and monitor skin daily in part. The care plan documents R3 to currently to have a pressure ulcer on his right hip and coccyx. The May 2018, Physician's Order Sheet (POS) documents R3 to be on Hospice services. Lab results dated 02/14/18, document a low Total Protein 8.2 (normal 6.3 - 8.2) and Albumin 3.2 (normal 3.5 - 5.1.). The Weekly Pressure Log dated 05/16/18 documents, R3 to have an in house acquired pressure ulcer on his left hip on 01/01/18, right hip on 05/06/18 and an ulcer on his sacrum. He was readmitted to the facility with on 02/23/18. The facility has failed to identify ulcers on R3 in a timely manner which delayed treatment. The Left hip ulcer identified on 01/01/18 was documented on the Treatment Administration Record (TAR) as a stage II when found measuring 2cm (centimeters) x (by) 1cm x < (less than) 0.1cm, 100% pink, no odor with moderate yellow drainage. The TAR dated 01/24/18 documents a newly developed pressure ulcer on R3's Right Buttock that measured 4.5cm x 3cm x UTD (unable to determine depth), with no odor, moderate yellow drainage and 80% slough. The Nurse Notes dated 05/06/18 documents a newly developed in house acquired pressure	S9999			

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S9999	Continued From page 3 ulcer was identified measuring 1.2cm x 0.5cm x UTD with 100% yellow wound base, no odor and minimal yellow drainage. On 05/17/18 at 10:10am, V9 Restorative Aide/Certified Nurse Aide (CNA) stated she was going to turn R3 to his left side. R3's pressure ulcer dressings were in place, dated 05/17/18 and dry/intact. R3 had an irregular shaped dark brown area on his right lateral malleolus (outer ankle) and a circular area on his right heel that had peeling skin along the circumference. The base of the circular area on his heel was normal colored skin with no redness noted. R3 was left on his left side when V9 left the room even though his pressure ulcer prevention plan specifically stated not to lay him on his left side. R3's outer ankle ulcer was not documented on the most recent skin report dated 05/16/18 nor on his TAR or in his Nurses Notes. R3 had urinary catheter At 1:10pm on 05/17/18, V2 Director of Nurses (DON) was unaware R3 had any pressure ulcers on his ankle or that he did have any concerns with his right heel in the past. V2 confirmed the documentation of R3's above areas were accurate and when asked why these areas were not identified/reported to nursing or seen prior to when they were determined to be stage II's or UTD (unstageable) V2 stated they measure them as soon as they are aware of them. V2 agreed that R3 is dependent on staff for all cares, but V2 insisted that the wounds were reported as soon as they were found. On 05/17/18 at 2pm, V4 Licensed Practical Nurse (LPN) provided documentation on R3's heel stated she was made aware of R3's ankle ulcer earlier "this morning" and didn't inform V2 at the	S9999			

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S9999	Continued From page 4 time. V4 was asked why staff did not identify R3's outer ankle ulcer prior to this morning, given R3's dependency for care, stated she couldn't say or not if it occurred in the last 24 hours since the last weekly skin report was done. V4 stated she usually did treatments when there were 3 nurses on the shift. V4 provided documentation of the lateral malleolus. V4's TAR entry dated 05/17/18 (no time) documents "new area noted to R (right) outer ankle, 100% eschar (scabbed area) 2.1 x 2.5 x UTD, no odor or drainage." The documentation lacks color of surrounding tissue and color of the eschar, this ulcer was not found timely. The facility's policy/procedure entitled "Wound Prevention Policy and Procedure" undated documents it is the policy of the facility "to provide care to prevent the development of pressure ulcers in all residents." Under Procedure, it documents "residents will be placed on preventative protocols based on their perspective risk assessment scores." "Any new areas of concern will be reported to the physician immediately and treatment orders obtained." The facility failed to follow their policy by identifying the pressure ulcers as soon as they developed. R3's Braden Scale - For Predicting Pressure Sores Risk documents his last risk assessment as 02/28/18 and identifying him as a "12." According to the Scale, "total score of 12 or less represents HIGH RISK." 2. R1's MDS dated 02/16/18 documents his BIMS score of 4 - severe cognitive impairment. The MDS documents, R1 is independent in bed	S9999			

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S9999	Continued From page 5 mobility, but requires extensive assist of two staff for transfers. The MDS documents R1 as being continent of both bowel and bladder. The care plan dated 02/16/18 documents R1 was admitted with a pressure ulcer on his coccyx. Interventions include: apply dressings as ordered, assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization and condition of surrounding skin, encourage fluids, skin checks daily with cares and showers, report any signs of any further skin breakdown (sore, tender, red or broken areas) and head to toe skin assessments weekly and as needed. R1 has no recent labs of Albumin or Total Protein. The May 2018, POS documents weekly skin checks and Hospice care. The TAR dated 02/06/18 and 02/13/18 identify no skin issues for R1. On 02/15/18, the TAR documents R1's center of his back had a "red area." The pressure ulcer documentation failed to include size and stage. On 02/21/18, the TAR documents R1's back ulcer now presented a "2.5 x 2 x UTD area. 2 dark areas, Open area within of 1 x .4 x .1 100% pink, no odor, scant yellow drainage" a marked change from the previous week where it was documented as "red." There is no documentation as to why R1's back ulcer declined or when the decline started between when it was first noted as "red" on 02/21/18 R1's and two weeks later when it was identified as "unable to determine depth." The note continues to document R1's " Rt (right) side is sl (slightly) red." but again fails to include measurements, depth of redness or stage. The	S9999			

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S9999	Continued From page 6 TAR documents R3's "L (left) side new open 8 x 2 x UTD 2 areas. 80% brown slough et (and) 20% pink, no odor with mod (moderate) yellow drainage" with no explanation as to why this area was not identified before developing 80% brown slough and being UTD. On 05/17/17 at 10:30am, V2 DON stated the back ulcer, documented on 02/21/18 as UTD documents the "whole area as measuring 2.5 x 2 x UTD", but it actually had 2 dark areas within the full circumference with a smaller open area in the middle that which measured 1. x .4 x .1." V2 stated they were using foam covering on R3's back so "maybe the slough came off when the foam was removed." V2 also, stated the left buttock was documented as "8 x 2 x UTD", but was when the ulcers merged into the coccyx area so seems larger, but it was actually both areas. V2 provided no insight as to why the ulcers were not found, until they were unstageable and/or of significant size/change with slough. The TAR dated 04/23/18 documents R1's left buttock "now open" measuring 8 x 2 x UTD with 2 areas of slough back ulcer measured 4 x 3.5 x UTD and starting to tunnel." V2 stated on 05/16/18 at 1:08pm that the slough "came off" and provided a better view of the wound base, but again, was unable to state why the decline in wound status was not identified earlier in the week. The TAR dated 05/16/18 documents R1's back ulcer currently measures 3.2cm x 2 x 1 with undermining of 1.9cm at 12 o'clock, 1.5cm at 12 o'clock, and 1cm at 6 o'clock with 70% pink, 30% slough. His right buttock measures 3.2 x 2.7 x 0.3, and the coccyx measured 2 x 2.5 x 0.3 80% pink with 20% slough.	S9999			

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S9999	Continued From page 7 The weekly Pressure Log dated 05/16/18 documents R1's back as measuring 3.2cm x 2cm x 1cm no odor, but drainage. R1's coccyx wound was documented as a stage III measuring 2 x 2.5 x 0.3cm with no odor, some drainage and Santyl (debriding agent) used in treatment. R1's pressure ulcer on his right hip documents as 3.2cm x 2.7cm x 0.3cm, no odor with some drainage again, using Santyl for treatment. The DON stated on 05/18/18 at 1:08pm that both R1's coccyx and left buttock "reopened." On 05/18/18 at 2:35pm, V13 Nurse Practitioner (NP) stated R1 and R3's pressure ulcers are showing some signs of improvement since her involvement with the care. V13 stated she doesn't know what status the original wound is in, but only moves forward from when she's called in to consult on the wounds. V13 stated both R1 and R3 are Hospice patient, so treatment is not as aggressive as it may be, but did stated the earlier you identify a pressure ulcer, the better the chance of healing it without complications. V13 stated she was unaware of R3's ankle ulcer and added that she does not do skin assessments when she sees a resident. V13 stated "Obviously, it is ideal to catch them earlier, treatment is better." V13 also, stated V3's non-compliance should be addressed in the care plan for pressure ulcers since it has an impact on his ulcer. On 05/17/17 at 9:50am, R1 was on his back in bed. He has a fluctuating air mattress on his bed and independently moved about in his bed. The dressings on his pressure ulcers were intact and dated 05/17/18. He was incontinent of bowel and bladder.	S9999			

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S9999	Continued From page 8 3. The Admission Sheet, documents R2 as a 95 year old female admitted to the facility on 04/15/14. The MDS dated 04/02/18 documents, R2 as being severely cognitively impaired with a BIMS score of 6 and dependent on staff for all activities of daily living (ADL), and the MDS identifies R2 to have a urinary catheter. Nurse Note's document pressure ulcers/wounds on R2 were not found timely as such: On 12/30/17 at 10:30am, the nurse notes document "during cleansing of L hand, noted 1 x 1 x .1 open area to inner (left) side of 3 fingers at first knuckle stage II. Res (resident) needs splint on. min ser/sang (serosanguinous) drainage, 100% pink continually trying to remove sponges." There is nothing in the Nurse's Notes regarding splint use and/or monitoring for pressure ulcers within the hand and/or from the splint to prevent pressure ulcers from occurring. On 01/16/18 at 1pm, the Nurse Notes documents "called to PT (patient) room. L great toe 2 x 2 x SDTI (suspected deep tissue injury), no odor, and no drainage", but no color documented. The report documents "L buttock et coccyx 4 x 5 x < .1 stage II, R inner buttock 2. x 1. <.1 stage II, Pt has had a couple of episodes of diarrhea." On 01/21/18 at 1:15pm, the nurses notes documents "when assessing resident noted L (left) inner heel 1.5 x 2cm DTI no odor, no drainage, skin intact. NO (new order) received to clean heel, apply skin prep" with no color documented and no explanation as to why this area, given R2's dependency on staff for all activities of daily living, wouldn't have been	S9999			

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S9999	Continued From page 9 identified by care givers prior to becoming an unstageable pressure ulcer. There is no indication in the Nurse Notes that heel protectors were used prior to development of the heel ulcer. On 01/22/18 at 10am, the Nurse Notes document consulting wound nurse "here at 7:10am, Dev (developed) area to tip of 2nd finger. 100% no odor with scant seri sang (serosanguinous) drainage. New hand splint too big for pt (patient)" and "2nd and 3rd L (left) hand fingernails lose (loose) d/t (due to) splint." Again, there is no plan for splint or monitoring toward the use to deter the development of ulcer in R2's hands. Hospital records dated 03/06/18 document, R2's contracted hand developed cellulitis and elevated temperature and following an emergency room visit, was admitted, for assessment. Hospital records dated 03/13/18 document "patient has a contracted hand with long finger nails digging into other fingers and palm. Dr. at bedside doing assessment. Plan for possible surgery tomorrow wound is at the 1st knuckle. Patient clasping a foam roll covered with clean wash cloth to help control exudate. (R2) Patient expressing pain, when fingers are pried open." The Note also documents "3rd fingertip to first knuckle open and has exposed bone." The note documents "the tip of 2nd finger open area noted, medial finger open areas measure 0.2cm in length by 0.2 in width by 0.3 in depth, both with 100% pink wound bed. The note identifies R2's heel as unstageable, measuring 3.0 x c 5.0cm by 0.3cm depth 10% pink tissue with 90% eschar (black.) with debridement of the area done during hospitalization. History and Physical Records documents R2's first to three fingers were amputated and the last finger had a tendon release surgery done prior to returning back to	S9999			

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S9999	Continued From page 10 the facility. On 04/18/18, the TAR for R2 documents R2's right toe was identified measuring 0.2 x 0.4 x <0.1 and the left great toe 3.5cm x 0.9 x 0.1, 75% pink, 25% intact eschar." There is no explanation as to why this ulcer was not found before Eschar developed. On 05/23/18 at 1:10pm, V14 LPN identified the entry into the nurse notes on 01/18/18 at 1:15pm as hers and stated R2's heel ulcer was brownish on that dated when found. Hospital Records dated 03/06/18 documents R2 was hospitalized with fever. The History and Physical with date of admission on 03/06/18 documents R2 had a 103.0 fever and has been under the care of a Wound Management at the nursing home. The report documents "The patient had redness and swelling to the left index finger. There is a foul smell coming from the middle digit and the right thumb. The patients hand is contracted." R2 was documented as being admitted for cellulitis of the left hand in part. Under lower extremities, the H&P documents R2's hand X-ray shows overall "moderate Polyarticular Osteoarthritis of the left hand with advances Osteoarthritis in the radiocarpal joint likely chronic contractures of the fingers and erosions along the ulnar styloid process." The H&P documents R2's index and middle finger were amputated on 03/09/18. The DON, V2, stated on 05/17/18 at 1:36pm that R2 had a splint on her hand since the prior summer and they were trying a new splint as her hand was contracted when she developed pressure ulcers inside her fingers from the contractures. V2 stated they had a Wound Clinic manage the wounds, until R2 started to run a	S9999		

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S9999	Continued From page 11 fever and her hand was swollen. V2 stated R2 was transferred to the hospital where they amputated her two fingers and released tendons. V2 stated R2 also had her left heel debrided while there and the top of her toe. V2 stated the ulcer identified on R2's left great toe was "brown" in color when found, not hard like eschar, but soft. V2 stated R2's heel was also brown when found, soft not hard. (B)	S9999			