STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005615	A. BUILDING _____ B. WING _____	C 06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME, THE	6901 NORTH GALENA ROAD PEORIA, IL 61614

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S 000	Initial Comments Complaint Investigation 1823783/IL103300 Statement of Licensure Violations: 300.610a) 300.1210b)d)5) 300.3240a)	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 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	S9999	Attachment A Statement of Licensure Violations	

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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:

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. (A, B) (Section 2-107 of the Act)

These requirements were NOT met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure one resident (R1) was removed from the bed pan in a timely manner. This failure resulted in R1 remaining on a bed pan for over five hours, resulting in a deteriorating stage IV pressure wound on the sacrum and the development of a new stage II pressure ulcer. R1 is one of three residents reviewed for skin injury in the sample of three.

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Findings include:

The facility "Skin and Wound Management Policy dated 1/11/2018 documents, "General Guidelines: Pressure injuries are usually formed when a resident remains in the same position for an extended period of time, causing increased pressure or decreased circulation to that area and subsequent destruction of tissue. Pressure injuries are often made worse by continual pressure, heat, moisture, and irritating substances on the resident's skin." The policy further documents, "Interventions and Preventative Measures: General for a person in bed 1. Change position at least every 2 hours or more frequently if needed."

On 6/12/2018 at 5:58 PM, V3 CNA(Certified Nurse Aide) stated, " I put (R1) on the bed pan at 9:45PM on (6/2/18) at R1s request. I told (V4 CNA) that (R1) was on the bed pan and I left. (R1) uses a 'fracture' bed pan (Mosby's Textbook for Nursing Assistants 8th Edition defines a 'fracture pan' as, "A fracture pan has a thin rim. It is only about 1/2 inch deep at one end . The smaller end is placed under the buttocks. Fracture pans are used by person by persons with limited back mobility, hip fractures, in casts, in traction.") R1 never refuses to be repositioned. I was off on Sunday (6/3/18) and returned on Monday. (R1) had a red line "U-shaped " on his bottom when I returned on Monday."

On 6/12/2018 at 6:00PM, V4 CNA stated, "No one told me (R1) was on the bed pan when I came onto the shift (on 6/2/18). I checked on (R1) at 11:00PM, 1:00AM and 3:00AM on (6/3/18). (R1) stated was comfortable at 11:00 PM and again at 1:00AM so I did not turn or reposition (R1). We (the nurse and V4) found

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him at 3:00AM. We are supposed to turn and reposition (R1) every 2 hours. Sometimes (R1) will say he is comfortable and does not want to reposition. We do not chart (R1s refusals)."

On 6/12/2018 at 6:30 PM, V5 Licensed Practical Nurse (LPN) stated, "I found (R1) early Sunday morning (June 3, 2018) around 3:30AM - 4:00AM when I usually do treatments. (R1) was lying on the bed pan when I found him. I went to get the V4 CNA because I wanted to know how long (R1) had been on the bed pan. (V4) said she was not aware (R1) was on the bed pan. There was an imprint of the bed pan on (R1s) skin. It was not blistered at that time but it was red. (R1) did not complain of pain or seem to know that he was on the bed pan. The bed pan had blood in it and was clean of BM (a bowel movement). I asked (V3 CNA) the next day if she knew (R1) was left on the bed pan the night before (6/2/18 10:00PM). (V3) told me she forgot she put (R1) on the bedpan and remembered when she got home." V5 stated that V3 told V5 she was going to call back to the facility but did not because she "assumed (R1) would be repositioned every 2 hours." V5 LPN states, "(R1's) wound was clean and looked really good the last time I saw it, about 3 days before this happened. When I found (R1) that night the wound was full of eschar (non-viable) tissue. (R1) is supposed to be turned and repositioned every two hours. I have never seen (R1) refuse to turn. (R1) is always good and allows me to when I do his treatments."

The Wound Specialist Physician's (V8) report on 6/1/2018 documented R1 has one lower sacral pressure ulcer wound Stage IV measuring 4.5 centimeters (cm) x 4.5 cm x 0.3 cm with heavy (clear) exudate and 100% granulation tissue. The wound progress is documented as

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unchanged from the previous visit. The "Clinical Practice Guideline for the National Pressure Ulcer Advisory Panel (NPUAP) defines 'granulation tissue' as 'the pink/red, moist shiny tissue that glistens and is composed of new blood vessels, connective tissue, fibroblasts, and inflammatory cells that fills an open wound when it begins to heal."

V8 Physician notes dated 6/8/18 document R1 has one Stage IV lower sacral wound measuring 6 cm x 3.2 cm x 0.3 cm with heavy clear drainage, thick adherent devitalized necrotic tissue at 75% of the wound bed and granulation tissue at 25% of the wound bed. V8 documented "the necrosis (was) resulting from injury from recurring pressure injury. Nurse reports patient had extended time on (a) bed pan 4 or 5 days ago." V8 documented he cleansed the wound and used a curette to surgically excise the devitalized tissue, necrotic subcutaneous fat and surrounding connective tissue at a depth of 0.5 cm. Healthy bleeding tissue was observed. The "wound progress" is documented as "deteriorated due to pressure." The same notes documents a new stage 2 pressure ulcer measuring 16.5 cm x 1 cm x not measurable. "linear band with red areas of serous blistering. Result of prolonged time on bed pan. Red band noted in symmetric area to right buttock as well but is blanching."

On 6/12/2018 at 6:15 PM, R1 was observed in bed lying on the left side. V6 LPN removed the sacral wound dressing to reveal a stage IV sacral wound with a defined and irregular shaped boarder. The irregular shape was circular with the exception of at 3 o'clock (using the face of a clock for reference) and 7 o'clock there were "v-shaped" wound extensions outward 1.5 centimeters (cm). The area at 7 o' clock had

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slough (non-viable) tissue in the wound bed. The wounds extended in a semi-circle 16 cm to R1's right buttock from the "3 o'clock extension. The 7 o'clock extension extended to the left side of R1's bottom in a semi-circular pattern . V6 stated she had not seen R1's wound in awhile but it was "definately worse."

On 6/13/2018 at 11:15AM V2 Director of Nursing stated she went down and assessed R1's wound on 6/3/2018. She found the red marks consistent with a bed pan. A fracture bed pan that had been placed in the backward position. V2 stated the areas were red at that point and had not blistered.

On 6/15/2018 at 7:20 AM V8 Physician stated, "(R1's) wound deteriorated from 6/1/18 to 6/8/18 resulting from the pressure of being left on the bed pan for an extended period of time. This is my 30th visit with (R1) and prior to last week we had finally achieved 100% granulation. Last week (6/8/2018) I had to debride the necrosis of the Stage IV wound. I had to debride it again this week. I staged the large semi-circular ring from the bed pan as a Stage II because there were fluid filled blisters in areas of that red ring."

(C)