

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2021
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NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING HIN	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WEST OGDEN AVENUE HINSDALE, IL 60521
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(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	S 000		
	Annual Licensure and Certification			
S9999	<p>Final Observations</p> <p>1) Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in</p>	S9999		
	<p>operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>		<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

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S9999	<p>Continued From page 1</p> <p>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 procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		
	<p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to identify a blister as a pressure ulcer, and failed to prevent a pressure ulcer from becoming infected. This failure resulted in R32 developing osteomyelitis requiring surgery and a toe amputation. This applies to 1 resident (R32) reviewed for pressure areas.</p>			

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S9999	<p>Continued From page 2</p> <p>The findings include:</p> <p>R32's active face sheet showed she was admitted to the facility on 3/27/2020 and had diagnoses including: Osteomyelitis, muscle weakness, and protein-calorie malnutrition.</p> <p>R32's 3/5/2021 Minimum Data Set (MDS) showed that R32 was mildly cognitively impaired, she was not able to walk, she was remaining in bed most days and when she was up, she was using a wheelchair and needed staff to push her. The same MDS shows that she was requiring extensive assistance from staff with all of her Activities of Daily Living (ADL's).</p> <p>R32's skin integrity care plan showed she was at risk for impaired skin integrity, had a history of pressure ulcers and required the use of pillows and positioning devices to elevate her heels. The care plan also showed an additional entry on 6/8/2021 indicating that R32 had a new skin alteration: blister to her right foot 1st hallux (big toe).</p>	S9999		
	<p>A Physician Progress Note for R32 completed on 4/22/2021 stated, "Patient does have a small scab on the right great toe. Wound care nurse is following the patient." There is no documentation in R32's nursing progress notes about a scab or any injury occurring for R32.</p> <p>A wound progress note for R32 completed by V15 (Wound Nurse Practitioner) on 4/26/2021, showed that R32 had a new skin alteration to her right foot 1st toe and stated, "Patient has an acute blister to her right foot plantar 1st toe. Area has skin flap present to the area that is non adherent. Skin flap removed to reveal granular</p>			

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S9999	<p>Continued From page 3</p> <p>tissue. Moist wound bed with no [sign or symptoms] of infection noted."</p> <p>A nursing skin and wound evaluation completed on 4/26/2021 for R32 showed that R32 had a new blister on her right toe that is in-house acquired and measures 0.9 centimeters (cm.) long, x 0.8 cm wide, x 0.1 cm deep. A nursing skin and wound evaluation completed on 5/24/2021 showed the wound on R32's toe is 1.2 cm long, 1.4 wide, 0.2 deep. The same document says nursing was educated on the importance of wound care and hygiene, turning and repositioning, and R32 is being referred to a podiatrist.</p> <p>A wound progress note completed by V15 on 6/7/2021 states, "Chronic blister to patients right foot plantar 1st toe remains open today and has slight increase in size noted today. Wound continues to have mostly granular tissue noted. Bone is palpable but not visible today. Small amount of slough noted to the wound bed today. Patient has small amount of bloody drainage from the area and small amount of purulent drainage from the medical aspect of the right foot great toe nail which is loose today. Patient reports moderate discomfort with wound care."</p> <p>A nursing skin and wound evaluation also completed on 6/7/2021 showed the wound is deteriorating with bloody drainage.</p> <p>A nursing progress note completed on 6/11/2021 showed R32 went out for a appointment with V16 (Podiatrist) and returned with orders to avoid pressure to wounds and edema control as well as dressing change orders. There is no mention in the progress note about an antibiotic or the wound being infected. A nursing progress note dated 6/12/2021 states, "Continues PO (by</p>	S9999		

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STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	<p>Continued From page 4</p> <p>mouth) ABT (antibiotic) for right great toe wound..." The facility was asked by the surveyor for copies of the podiatrist consult report for this date, but were unable to locate or obtain one.</p> <p>A wound progress note completed on 6/14/2021 by V15 showed R32 was having purulent drainage from the toe wound and antibiotics will continue for 10 days total.</p> <p>An nursing progress note completed on 6/24/2021, showed R32 went to a out patient wound care appointment and needs debridement of the toe wound, but it was not able to be done due to no power of attorney consent.</p> <p>An nursing progress note showed that R32 went for an out patient appointment on 7/15/2021 to see V16 (Podiatrist).</p> <p>A wound care initial visit report completed by V16 on 7/15/2021 states, "Patient has a history of dementia and has an ulcer on the right great toe supposedly from trauma but no history provided. Unable to get history from {the facility}. Patient does not ambulate or stand. There is exposed bone that is palpable through the ulceration." The same report also says R32's diagnoses include: Suspected deep tissue injury of unknown depth to toe, right foot ulcer with fat layer exposed, open wound of the right great toe, exposed bone distal phalanx right great toe with likely osteomyelitis. The report shows that a wound culture was obtained, and surgical intervention would most likely be required due to exposed bone at the digit. There was no documentation in R32's medical record that the results of the wound culture results were obtained by the facility.</p> <p>Hospital records from a local community hospital show on 8/6/2021. R32 underwent surgery for an</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 08/18/21 at 10:36 AM, V13 (R32's Physician) said he took over as R32's primary care physician shortly before her surgery and the toe amputation. R32 said, basically this resident was bed bound and had some protein calorie malnutrition, and yes unfortunately this was a pressure injury that started as a deep tissue injury that never healed, became infected, developed osteomyelitis, and resulted in a toe amputation. V13 said even though she was wearing boots unfortunately that was not enough of an intervention to prevent the pressure ulcer. He said that the cause of R32's wound infection could be from bacteria exposure during the dressing changes.</p> <p>(B)</p> <p>2) Statement of Licensure Violations:</p>	S9999		
	<p>300.610a) 300.696a) 300.696c)2)7) 300.1210b)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance</p>			

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S9999	<p>Continued From page 7</p> <p>with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.696 Infection Control</p> <p>a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.</p> <p>c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):</p> <p>2) Guideline for Hand Hygiene in Health-Care Settings</p> <p>7) Guidelines for Infection Control in Health Care Personnel</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>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 procedures:</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to implement infection control policies and recommendations from the Center for Disease Control (CDC) regarding staff donning personnel protective equipment (PPE) when entering a Person Under Investigation (PUI) for COVID-19 resident rooms.</p> <p>This failure has the potential to effect all residents in the facility and has the potential to infect high risk residents with COVID-19 and spread the disease of COVID-19 to negative residents.</p> <p>The findings include:</p> <p>The CMS 672 form (Resident Census and Conditions Report), dated August 17, 2021 showed 129 residents in the facility.</p> <p>A list provided by the facility on August 16, 2021 showed 84% of residents and 74% of staff have been fully vaccinated against COVID-19.</p> <p>The facility Daily Census list dated August 16, 2021 showed R32 and R132 were on airborne/droplet transmission based precautions (isolation) and were considered to be PUI (patients under investigation), to rule out COVID-19.</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>Outside of R32 and R132's rooms were isolation carts and isolation signage indicating R32 and R132 were each on droplet isolation/transmission based precautions. The droplet isolation signage showed any staff entering the room was required to wear a gown, N95 mask, gloves, and eye protection when in the room.</p> <p>R32's Order Summary Report dated August 10, 2021 showed a physician order for R32 to be on airborne/droplet precautions.</p> <p>On August 16, 2021 at 10:20 AM, R32 was observed lying in bed in her room. V3 LPN was standing directly next to R32, to the right of R32's bed. The door to R32's room was open. V3 LPN had no isolation gown or gloves on, only a N95 mask and personal eye glasses. A droplet isolation sign hung on the door frame outside of R32's room. At 10:21 AM, V3 LPN exited R32's room. Upon exiting R32's room, V3 LPN was asked if R32 was on isolation, V3 LPN stated, "I don't know."</p>	S9999		
	<p>On August 16, 2021 at 12:34 PM, V5 Certified Nursing Assistant (CNA) entered R32's room wearing only a surgical mask. R32 did not don an isolation gown, face shield, N95 mask, or gloves prior to entering R32's room. Upon exiting R32's room, V5 CNA was asked about R32's isolation precautions, V5 stated, "We are supposed to wear a N95 mask, face shield, a gown, and gloves when going into (R32's) room. I was just moving too fast and forgot."</p> <p>On August 16, 2021 at 10:25 AM, V4 Registered Nurse (RN) stated, "(R32) is on droplet isolation to rule out COVID-19 because (R32) was recently readmitted to the facility from the hospital. Staff</p>			

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S9999	<p>Continued From page 10</p> <p>must wear full PPE (personal protective equipment) when in her room which includes a face shield, gown, gloves, and a N95 mask."</p> <p>On August 17, 2021 at 8:25 AM, V7 (Licensed Practical Nurse/LPN) entered R32's room wearing only a surgical mask (not an N95), face shield, gown and gloves. Sitting on top of the medication cart that V7 was using, was a brand new N95 mask. At 8:35 AM, when V7 was asked by the surveyor what type of isolation R32 was on, V7 replied R32 was on contact isolation for an infection in a wound. V7 said this is her first day working at the facility and the report sheet that she was given does not list that R32 is considered a PUI or on isolation for anything else. V7 said she would have put on a N95 mask before she entered the room had she known that R32 was a new admission and on droplet isolation to rule out COVID-19.</p> <p>R132's Order Summary Report printed August 16, 2021 showed a physician order for R132 to be on airborne/droplet precautions.</p>	S9999		
	<p>On August 16, 2021 at 12:27 PM, R132 was lying in bed. The door to his room open. A droplet isolation sign hung on the door frame outside of R132's room. V5 CNA entered R132's room wearing a surgical mask, an isolation gown, and gloves. V5 CNA's surgical mask was down below her nose. V5 did not don a N95 mask or face shield prior to entering R132's room.</p> <p>On August 16, 2021 at 12:59 PM, V6 RN/Infection Preventionist stated, "(R32) and (R132) are on droplet isolation to rule out COVID-19 because they are a new admission or readmission to the facility. All staff must wear a N95 mask, an isolation gown, a face shield, and gloves while in</p>			

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S9999	<p>Continued From page 11</p> <p>droplet isolation rooms."</p> <p>On August 16, 2021 at 2:00 PM, the Illinois Department of Public Health website was reviewed and showed the Dupage County COVID-19 positivity rate for the period of August 1, 2021 to August 7, 2021 (the most recent posting) to be 5%.</p> <p>The CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic last updated March 29, 2021 shows, "2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection. The IPC recommendations described below also apply to patients who have met criteria for a 14-day quarantine based on prolonged close contact with someone with SARS-CoV-2 infection. Patients in this 14-day quarantine period should be isolated in a single-person room and cared for by HCP using all PPE recommended for a patient with suspected or confirmed SARS-CoV-2 infection."</p> <p>The Centers for Disease Control Preparing for COVID-19 in Nursing Homes-Create a Plan for Managing New Admissions and Readmissions updated 11/20/2020 shows, "HCP (Healthcare personnel) should wear an N95 or higher-level respiratory mask, eye protection, gloves, and gown when caring for new admissions and readmissions."</p> <p>The facility's Transmission-Based Precautions and COVID-19 policy dated July 1, 2020 showed, "In our facilities, because aerosol generating procedures are rare, we are utilizing transmission based precautions in caring for known or</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>suspected patients with COVID-19. Because the organism can be spread by droplets through the air, we are utilizing a combination of droplet and airborne transmission-based precautions. The same level of precautions are utilized regardless of whether the patient is on a special COVID-19 Airborne Isolation Unit (CAIU) or is in a private room with their own bathroom anywhere else in the facility. *N-95 respirator/mask *Eye protection (face shield, goggles, or safety glasses with attached side shields) *Gown *Gloves ..."</p> <p>(B)</p>	S9999		