

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2022
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NAME OF PROVIDER OR SUPPLIER ST PAUL'S SENIOR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 WEST E STREET BELLEVILLE, IL 62220
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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.1210d)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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</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.</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>2) All treatments and procedures shall be administered as ordered by the physician.</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>These requirements were Not Met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to assess and monitor pressure ulcers, ensure pressure ulcer treatments/services are administered per standards of practice and orders are administered per physician's orders (PO) for 1 of 7 residents (R8) reviewed for pressure ulcers in the sample of 40. This failure resulted in R8's unstageable pressure ulcer to right buttocks/thigh worsening and becoming infected.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R8's Face Sheet documents R8 was admitted to the facility on 6/2/22 with diagnoses including osteomyelitis of vertebra, sacral and sacrococcygeal region, pressure ulcer of sacral region: Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle; slough or eschar may be present on some parts of the wound bed; often includes undermining and tunneling) pressure ulcer, moderate protein-calorie malnutrition, Alzheimer's disease, muscle weakness, unspecified abnormalities of gait (ambulation) and mobility, and need for assistance with personal care.</p> <p>R8's Care Plan dated 6/7/2022 documents, "R8 has actual impairment to skin integrity r/t (related to) (nothing else listed)." R8's Care Plan Interventions document to administer treatments as ordered and monitor for effectiveness."</p> <p>R8's Revised Care Plan, dated 6/15/2022 documents, "R8 has actual impairment to skin integrity r/t (related to) being admitted with need of assist with ADLs (activities of daily living), transfers and meals. Admitted stage 4 pressure ulcer to coccyx. R8 is currently on IV (intravenous) ABT (antibiotic) for osteomyelitis (infection in the bone) to wound. V11 (R8's daughter) involved with care and assist with teaching on wound care." R8's Care Plan documents "Interventions: avoid shearing while repositioning when in bed use assist, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, float heels while in bed as tolerated, inform the resident/family/caregivers of any new area of skin breakdown, low air mattress: check for placement and function every</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>shift, monitor dressing to coccyx when providing care to ensure it is intact and adhering, report lose dressing to nurse, supplements to promote wound healing, teach the resident/family/caregiver to avoid risks for skin injury and decreased circulation, the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested, treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort."</p> <p>R8's medical record documents R8 was being seen by a Consultant Wound Physician for the Stage IV sacral pressure ulcer beginning in June 2022.</p> <p>R8's Physician Order, dated 7/31/22, documented she was admitted to Hospice Care.</p> <p>R8's Minimum Data Sheet (MDS) dated 8/8/2022 documents R8 is severely cognitively impaired and requires extensive 2+ person assistance with bed mobility and transfers. The MDS documents R8 is incontinent of bowel and bladder and is at risk for developing pressure ulcers. The MDS documents R8 had a Stage IV pressure ulcer present upon admission.</p> <p>R8's Revised Care Plan, dated 8/11/2022, documents that "R8 has actual impairment to skin integrity r/t being admitted with need of assist with ADLs, transfers, meals. Admitted stage 4 pressure ulcer to coccyx. R8 is currently on IV ABT for osteomyelitis to wound. V11 (R8's daughter) involved with care and assist with teaching on wound care. Continue for preventive/Unstageable right buttock wound. Intervention documented: use pillows/wedges for repositioning."</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R8's Physician's Order Sheet (POS) dated 8/1/2022 through 8/30/2022 documents weekly skin assessment every Thursday evening.</p> <p>R8's medical record had no documented weekly skin assessments from facility staff from 8/5/2022 through 8/31/2022, although R8 had a Stage IV sacral ulcer.</p> <p>R8's Consultant Wound Physician's Note, dated 9/21/22, documents R8 had a right buttock pressure wound. The Note had no documentation/description in the section "Wound type". The Note documented the wound measured 4.5 centimeters (cm) by (x) 6.5 cm x 0.1 cm depth. The Note document the wound had moderate drainage present. The Note documented that the Treatment was Calcium Alginate and "honey".</p> <p>R8's Physician's Order (PO), start date of 9/23/22, documents "Cleanse areas rt. (right) lower buttock with wound cleanser. Apply thin layer of medihoney to wound bed, cover with calcium alginate and dry dressing. Change daily and PRN (as needed) every day shift."</p> <p>R8's September 2022 Treatment Administration Record (TAR) had no documentation that R8 received the treatment to right buttock on 9/27 and 9/28/22.</p> <p>R8's October 2022 TAR had no documentation that R8 received the treatment to R8's Right Buttock on 10/6 and 10/18/22.</p> <p>R8's Consultant Wound Physician's Note, dated 10/8/22, documents R8's right buttock wound measuring 2.0 cm x 7.8 cm x 0.1 cm. The note documented the wound type as MASD</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>(incontinence-associated dermatitis, perspiration, drainage).</p> <p>R8's Consultant Wound Physician's, dated 10/21/22, documents R8's right buttock wound description was now "Trauma". The Note documented the measurements as 4 cm x 3.8 cm x .5 cm. The Note documented 40% slough (non-viable yellow, tan gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture). The Note documented treatment of 0.125% NaClO (Dakin's solution) moist gauze light pack or Vasche (wound cleanser solution).</p> <p>R8's PO, dated 10/22/22, document to cleanse areas rt (right) lower buttock with Dakins or Vashe, lightly pack wound bed with Vashe or Dakin's moistened gauze, cover with dry dressing. Change daily and prn every day shift. R8's October 2022 TAR had no documentation that R8 received this treatment on 10/29/22.</p> <p>R8's Consultant Wound Physician's Note, dated 10/28/2022 documents right buttock wound measuring 3 cm x 3 cm x 0.3 cm. On this Note, the wound type was documented as "MASD". The Note documented 30% slough.</p> <p>R8's Consultant Wound Physician's Note dated 11/4/22 documents right buttock wound measuring 2 cm x 4 cm x 1 cm. The Note documented the wound type as pressure and unstageable. The Note documents the pressure ulcer was 70% neurotic (dead tissue). The Note documented, "Needs wound culture order for Monday morning (right buttocks)".</p> <p>R8's Significant Change MDS dated 11/7/2022 documents, R8 is incontinent of bowel and</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>bladder, is at risk for developing pressure ulcers, and has one unstageable pressure ulcer that was not present upon admission.</p> <p>R8's Wound Physician's Note dated 11/11/22 documents right buttock wound measuring 3 cm x 8 cm x 2 cm. and the wound type documented as pressure.</p> <p>R8's Progress Note, dated 11/11/2022 at 8:35 PM, documents, "Wound culture result received this PM with moderate growth of Enterococcus faecalis, and light growth of Streptococcus agalactiae-Grp B. MD (physician) and wound physician made aware. New order obtained to start resident on Augmentin 500/125 milligrams (mg) BID (twice a day) x 7 days for wound infection. CBC/CMP/Pre-Albumin to be drawn on 11/14/2022. POA informed of wound culture results and new orders. POA is in agreement with plan of care."</p> <p>There were no further Consultant Wound Physician's Notes in R8's medical Record after 11/11/22.</p> <p>The facility's Skin Check Weekly & PRN (as needed) Note, dated 11/12/22, documents R8 had an unstageable pressure ulcer on the right buttock measuring 3 cm x 8 cm x2 cm with 50% slough and 50% granulation. The Note documented the treatment as to pack with Dakins and cover with dd (dry dressing) daily and prn.</p> <p>R8's PO, start date 11/12/22, documents "Cleanse Right buttock wound cleanser, pat dry. Apply collagen and Calcium Alginate. Cover with foam dressing every day shift for wound care."</p> <p>R8's November 2022 TAR has no documentation</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>that R8 received the treatment on 11/14/22.</p> <p>R8's Skin Check Weekly & PRN Notes dated 11/18/22 documented "no new changes this week."</p> <p>R8's Skin Check Weekly & PRN Note, dated 11/25/22 documented "Right posterior thigh: 4 (cm) x 7.4 (cm) x 3 cm, heavy yellow-brown and wet slough covering 95% of wound bed, moderate serosanguineous drainage noted. The Note documented "no new changes this week."</p> <p>R8's TAR dated 11/15/2022 through 11/25/2022, documents physician's treatment order to treat the pressure ulcer on R8's right gluteal fold/right posterior thigh.</p> <p>R8's Physician Order, start date 11/29/22, documented "Cleanse with NS (normal saline) and hibiclens [sic], rinse with NS, pat-dry and apply thin layer of Santyl to wound bed, then cover with cut-to fit calcium alginate to wound bed. Cover with Dry dressing daily and PRN for soiling/loosening. One time a day for Wound Care."</p> <p>R8's November 2022 TAR treatment, with start date of 11/26 and discontinued date of 11/29/22, documented "Right posterior thigh: cleanse with NS (normal saline) and hibiclens [sic], rinse with NS, pat-dry and apply thin lay of Santyl to wound bed, then cover with cut-to-fit calcium alginate to wound bed. Cover with dry dressing daily and PRN for soiling/loosening. One time a day for Wound Care." R8's TAR has no documentation that R8 received this treatment on 11/27 or 11/28/22, 11/29, and 11/30 although R8's PO (Physician Order) was not written until 11/29/22.</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>On 12/1/2022 at 11:45 AM V8 (Certified Nurse Aide/CNA) and V4 (Wound Nurse) entered R8's room and explained to her that they were going to change her dressings. V4 removed the dressing from R8's sacral pressure ulcer. V4 then removed the dressing from R8's right thigh. Immediately after removing the dressing, there was a very foul odor coming from R8's thigh pressure ulcer. The pressure ulcer bed was pink but had some yellow slough present. V4 then hand sanitized after removing the dressings and donned new gloves. V4 cleansed both areas with normal saline. She removed her gloves and used hand sanitizer. V4 donned new gloves and applied Santyl and Ca Alginate to R8's thigh pressure ulcer wound bed and covered with a dry dressing. V4 hand sanitized again and donned new gloves. V4 did not cleanse R8's thigh pressure ulcer with Hibiclens during the observation of pressure ulcer treatment per order.</p> <p>On 12/1/2022 at 11:52 AM, V4 (Wound Nurse) stated "R8 was on Augmentin (antibiotic) from 11/11/22 to 11/18/22. R8's family wants to give another round of antibiotics. We are planning to culture wound today." V4 stated "R8's daughter (V11) requested to do the dressing changes when she is here and was doing them prior to when I started here."</p> <p>On 12/1/2022 at 1:45 PM, V4 (Wound Nurse) stated, "We are walking a fine line between curative and palliative care. If we order the wound culture, they (Hospice) will consider it curative rather than palliative and it will not be covered by insurance. R8's family are not able to pay out of pocket for it, so they don't want it. Hibiclens was ordered but not used for dressing change." V4 stated she ran out of it on 11/29/2022. V4 stated it's supposed to be delivered to the facility on</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>11/30/2022. When questioned regarding V11 completing the treatments for R8, V4 responded "R8's daughter (V11) is a wound nurse, an LPN (Licensed Practical Nurse), I believe. She is not currently working in the medical field. I have not asked to see her license."</p> <p>On 12/1/2022 at 3:34 PM, V2 (Director of Nursing /DON), stated, "All I know is the nurse's do the dressing changes. I was not aware the daughter was changing any dressings here, and I do not think she is a nurse. If I had known a family member wanted to change dressings, I would have gotten an order and gone about the proper documentation."</p> <p>On 12/2/22 at 10:07 AM, V2 (DON) stated, "The previous wound nurse said she and the wound doctor showed (R8)'s daughter how to do dressing changes with return demonstration. If the doctor does change the order, the nurse should be there with them, and the nurse would sign off that the dressing was done."</p> <p>R8's Progress Note dated 12/2/22 at 8:13 AM documents, "Late entry 6/10/22: This nurse spent time with daughter (V11, R8's Daughter), educating her on wound treatment to coccyx. Daughter was able to return demo and verbalized understanding of wound care to coccyx."</p> <p>On 12/2/2022 at 10:07 AM, V2 stated, "There are no wound reports (from Wound consultant physician) after 11/11/2022 because the family does not want R8 to be seen by him anymore. The family just wants her followed by the wound nurse. The previous wound nurse said she and the wound doctor showed R8's daughter how to do dressing changes with return demonstration. If the doctor does change the order, the nurse</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>should be there with them, and the nurse would sign off that the dressing was done."</p> <p>On 12/2/2022 at 12:17 PM, V2 stated "I would expect staff to follow physician orders for treatments. If we have done some teaching with the family member, we should be able to do the wound treatment. Family members who have preference we have to obey their wishes, but it is not best practice. I would expect family members to be retrained if the orders change. I would expect them to be documenting each time orders change, because how else would the family member know. The expectation would be we educate, someone is there each time, and ensure proper documentation."</p> <p>As of 12/6/22 at 11:17 AM, the Illinois Department of Financial and Professional Regulation License Lookup documents V11's, Licensed Practical Nurse/LPN, license expired on 1/31/21.</p> <p>On 12/6/22 at 11:40 AM, V2 stated, "Skin checks should be done weekly and documented on the weekly skin assessment. If there is an issue, it should be documented, and the physician and wound nurse will be notified. The right gluteal wound popped up in September 2022. R8 had a specialty wound physician assessing her coccyx pressure ulcer in September 2022 but the specialist didn't assess the right gluteal fold wound until 9/21/2022 and that's when he started documenting the wound assessments."</p> <p>On 12/6/22 at 2:06 PM, V11 (R8's daughter) stated, "I started changing my mom's dressings because they were not being done in a timely manner. There were several days there were no dressings on, and I could tell some days they were not being changed."</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>The Facility did not provide any documentation that V11 was trained after right buttock wound developed or after subsequent orders were changed.</p> <p>On 12/6/2022 at 3:00 PM, V2 stated, "There are no weekly skin checks documented for 9/2022. When staff document the weekly skin assessment was completed, she expects to be able to find the skin assessment in the resident's electronic medical record, but they are not there. The physician's order dated 9/1/2022 through 9/16/2022 was for R8's left leg/buttocks not her right buttocks she didn't know what staff were treating because she was not working at the facility at that time, but she expected staff to document what the wound/skin breakdown was in the nurse's notes and to notify the physician when a new skin wound was initially identified and include in the assessment the size of the wound, wound bed description, drainage and if there was odor and get a wound treatment order from the physician as soon as possible." V2 also didn't know what was on R8's right gluteal fold/right upper posterior thigh on 9/16/2022 through 9/22/2022. V2 was certain that R8's right gluteal fold wound was not assessed by staff until 9/21/2022 and that was by the specialty wound physician.</p> <p>On 12/6/22 at 11:58 AM, V9 (Medical Director) stated, "I expect wound treatments to be administered as ordered, and they should be documented in the resident's treatment administration record. I have not seen V11 (R8's family) changing her dressing, but she should not be doing that. Hygienically, we don't know if good practices are being followed or even where the wound supplies are coming from. It should be the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2022
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NAME OF PROVIDER OR SUPPLIER ST PAUL'S SENIOR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 WEST E STREET BELLEVILLE, IL 62220
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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
S9999	<p>Continued From page 12</p> <p>wound doctor or wound nurse or an experienced nurse doing the dressing changes. If there is an odor coming from a wound, they should be informing us, the provider, so we can order labs and cultures. The NP (Nurse Practitioner) is currently on maternity leave, but she was previously here 5 days a week, so this should have been communicated. The wound needs to be clean because it is a constant source of infection. Perhaps she needs a rectal tube to keep the wound clean and dry. I would expect weekly skin assessments to be completed. I cannot say whether weekly skin checks would have found the wound sooner. The right gluteal wound is classified as an unstageable pressure ulcer. One time I was here and V11 had R8 sitting up in her wheelchair without a pressure cushion, so I had to tell her why it was important to use it. Not having that cushion could make the wound worse. R8 is on hospice, but that should not stop them from treating her wounds and doing the necessary tests."</p> <p>On 12/6/22 at 3:58 PM, V1 (Administrator) stated, "I do not have a policy regarding who is able to perform dressing changes."</p> <p>The facility's "Wound Assessment" Policy revised 3/2022 documents, "It is the policy of the facility to assess each wound initially, either at the time of admission or at the time the wound is identified. Each wound will be assessed weekly thereafter or with any significant noted change in the wound. Identify the etiology of the wound if possible. Is it a pressure ulcer/pressure injury, venous stasis ulcer, arterial ulcer, or diabetic ulcer? Accurate etiology is important to ensure correct MDS (Minimum Data Set) coding."</p>	S9999		

Illinois Department of Public Health

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S9999	Continued From page 13 (B)	S9999		