Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008973	A. BUILDING: _____ B. WING _____	C 01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION SAINT JOSEPH VILLAGE	659 EAST JEFFERSON STREET FREEPORT, IL 61032

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S 000	Initial Comments Complaint Investigation 2310053/IL154919	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 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 300.1010 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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	S9999		

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S9999	Continued From page 2 services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to document wound assessments for a resident (R1), failed to notify a physician of a resident's worsening pressure wound (R1), failed to obtain new treatment orders for a resident's pressure wound (R1), failed to identify signs of infection for a resident's pressure wound (R1), and failed to provide wound care in a manner to prevent infection for a resident (R1). These failures contributed to R1's pressure wound advancing from a Stage 2 to an unstageable wound that became infected and required hospitalization, surgical debridement, and placement of a wound vac (negative pressure wound therapy). The findings include: R1's electronic face sheet printed on 1/12/23 showed R1 has diagnoses including but not limited to pressure ulcer of sacral region, unstageable, Alzheimer's disease, Dementia without behaviors, and type 2 diabetes. R1's facility assessment dated 11/29/22 showed R1 has mild cognitive impairment and has no current pressure ulcers. R1's nursing care plan dated 9/20/21 showed, "Risk for impaired skin integrity due to decreased mobility, urinary incontinence, and moisture under body folds. I also lean in my wheelchair, and this could cause skin breakdown. (R1) has a pressure injury. Daily skin inspection, pressure reducing pad in my recliner if needed. 12/29/22 air	S9999		

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S9999	Continued From page 3 mattress applied." A review of R1's pressure ulcer wound assessments showed: 11/30/22 coccyx wound resolved. Left medial buttock resolved with skin intact. 2.4x2cm (centimeter) dark red/light purple area where wound used to be. Discontinue collagen dressing and use foam dressing daily for protection. 12/7/22 left medial buttock no changes. Apply allevyn dressing for protection and change daily. 12/14/22 left medial buttock resolved. 12/16/22 sacral pressure ulcer 5.5x4.0cm unstageable pressure injury obscured full-thickness skin and tissue loss. Moderate amount of purulent (white, yellow) drainage, 51-75% slough." On 1/11/23 at 2:33PM, V2 (Director of Nursing) and V10 (Clinical Specialist) stated, "Skin assessments should be documented on the resident's shower sheet and entered into the skin inspection report in the resident's electronic medical record. We typically do these weekly and as needed. V13 (Wound Care Nurse) assessed (R1's) wounds on 12/16/22 but we cannot find any other assessments after that one. We have been trying to create our own timeline to determine what happened with (R1's) wound but haven't been able to determine anything yet. After 12/16/22 the only other documentation about (R1's) wound is for her to be a direct admission to the local hospital for an infected decubitus ulcer. We would expect (V13) or floor staff to complete weekly assessments on all wounds. If (V13) is not here, then the floor nurses should be doing it. When staff are performing wound care, they should never put their hand inside the wound and should be cleaning from the center of the wound and wipe to the outer edges to prevent infection. You wouldn't want the bacteria being pushed	S9999		

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S9999	Continued From page 4	S9999		

back to the center of the wound. That is standard practice in wound care and our nurses know that."

R1's wound assessment documentation entered on 1/12/23 showed, "Late entry for 12/16/22 new wound to left buttock, 3.0x1.5cm, purple discoloration, possible deep tissue injury and coccyx, 1.25x0.75cm Stage 2 with epithelial tissue in the bed. (Wound care) representative contacted, and treatment orders received. Resident educated on the importance of relieving pressure to the buttocks and encouraged to lay in bed between meals. However, she does choose to participate in activities in the afternoon. (This wound assessment contradicts prior wound assessment documented on 12/16/22). Late entry for 12/20/22 Wound has deteriorated. Left buttocks is 5.5x2.5cm and is unstageable due to slough. Coccyx is 2.5x1.5cm, Stage 3, slough and granulation. Resident continues to be encouraged to lay down in between meals. Late entry for 12/27/22 Two wounds have now merged into one, measuring 5.5x5.5cm and unstageable to slough. Surrounding tissue has a purple discoloration and appears somewhat blistered." No documentation was present in R1's electronic medical record showing notification to a physician of R1's worsening pressure wound.

R1's local hospital records showed, "12/29/22 showed, "Yesterday I was contacted about the ulcer and today I saw a picture of the ulcer. It is necrotic and has a gangrenous smell. Unstageable at this time but obviously there is dead tissue on top that needs to be debrided...sacral area has a 7cm ulcer with satellite smaller ulcers of less than a cm... Wound culture shows gram negative bacteria...will continue ceftriaxone and doxycycline as well just

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S9999	Continued From page 5 in case the MRSA (Methicillin-resistant Staphylococcus aureus) from her nares is present in her wound and did not appear in her wound culture. 12/30/22 Ulcer consists of necrotic tissue with possible involvement of sacral bone. Polymicrobial cultures growing Escherichia coli and proteus mirabilis. 1/3/23 Post-operative day 4- ulcer measures 7x11x3.5cm. 1/5/23 infected decubitus ulcer with necrosis secondary to debridement and application of wound vac." On 1/11/23 at 11:06AM, V5 (Licensed Practical Nurse) was providing wound care for R1. V5 removed R1's wound vac dressing, changed her gloves, and then stuck her gloved finger around the inner side of R1's sacral wound wiping drainage from one area to another along the inside of the wound. V5 then measured R1's wound and obtained a measurement of 10.5x11.75cm. V5 stated she was unable to determine the depth of the wound as she did not have the appropriate supplies with her. V5 then poured saline into R1's wound and wiped from the outer edges of the wound towards the center of the wound. V5 made repetitive statements throughout the wound care that she has not changed a wound vac dressing in "at least 3-4 years." V5 stated the staff had not been trained on the care of R1's wound vac and that the wound care nurse has been off on leave. V5 stated, "I just watched a video on my phone before we came in to try and refresh my memory." On 1/11/23 at 1:52PM, V5 stated, "When cleansing wounds, you should always clean from the center of the wound and continue to the outside of the wound to prevent infection. I guess I didn't do it that way because her wound is so big, and I felt like I was just throwing saline in	S9999		

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S9999	Continued From page 6 there and wiping it up with gauze. I definitely should have done a better job." On 1/12/23 at 2:16PM, V12 (R1's Nurse Practitioner) stated, "The wound care nurse should be assessing weekly and if she's not there I would think the floor nurses would do it. New orders should be obtained at the time that they see the wound is worsening. There's not an exact timeline but I would say if a wound isn't improving after a week then new orders should be obtained. (R1's) wound initially started in September with a small open area, we followed her closely through October. Her wound was improving, and we talked to the family about her going to the wound center and they did not want to do that due to it being too hard on her because she would have to go out weekly and be lifted. We talked to (R1) about a catheter, and she wasn't completely on board and then the wound improved so we didn't talk about it again. The wound continued to improve, and I was told at the end of November that it had improved and that it had healed in December. I looked at her wound on 12/19/22 with (V13-Wound Care Nurse) and the wound care consultant. The wound at that time was a dry, yellow slough with dark areas. It was an unstageable wound. When you touched it on top it felt like a scab. I typically call and have a conversation with the family but on that day, I did ask the nurse to contact the daughter to notify her. That is the last time I saw the wound before she went to the hospital. (R1's Physician) went to the facility twice the week I was off, and he did not have a chance to look at the wound and then called (V5-LPN) and based on what she said he had (R1) sent to the emergency room. It would not be my expectation that there would be 10 days between a change in wound care orders if the wound was worsening. I don't know what the	S9999		

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S9999	Continued From page 7 staffing was like during that time or if it was consistent or not that they would notice a difference in her wound. Someone should have seen that it was different with the daily dressing changes and notified me or (R1's Physician). Her wound got very bad, very fast so it should have been closely monitored." On 1/12/23 at 3:44PM, V13 (Wound Care Nurse) stated, "(R1's) pressure ulcer prevention measures were repositioning, dietary consult, liquid protein, encouraging her to lay down in bed to offload pressure as much as possible. At one time she was a safety concern, so she didn't have an air mattress applied. She had a wide bed, and we couldn't give her an air mattress. The staff were concerned when they rolled her for repositioning and incontinence care she would roll out of bed. She finally got her air mattress on 12/29/22. She is now in a regular bed with the air mattress and is doing fine with it. (R1) had a few wounds and she actually healed out on 12/12/22 but I kept her in wound assessment manager just to track her. On 11/30/22 her wounds measured 0x0, but I wanted to keep tracking her due to her high risk for pressure ulcers. Then on 12/16/22 it looked like she had a 3x1.5cm purple area that I thought possibly could be a deep tissue injury on the left buttock and what looked like a stage 2 on her coccyx. I called the wound care rep and told her what was going on and she gave me recommendations. (V12-Nurse Practitioner) signed off on 12/16/22 for the orders. On 12/19/22, (V12) and the wound care representative came in to look at the wound with me. I did not document that assessment. I did go into (R1's) chart and put in late entries today for the wound assessments I did in December. I was lax in doing my documentation in a timely manner. I usually wait 2 weeks at least before I	S9999		

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S9999	Continued From page 8 change the treatment orders. (V5-LPN) contacted (R1's physician) on the 29th or 30th I'm not sure which date. I didn't talk to (V12) or (R1's physician) from 12/19-12/29. I don't feel like anything could have been done differently with (R1)." On 1/13/22 at 8:39AM, V13 (Wound Care Nurse) stated, "On 12/29/22 we noticed purulent drainage coming from (R1's) wound. Up until then it wasn't anything unusual. I don't know why the documentation was different on the wound assessment for 12/16/22. As far as I know the physician was not contacted from the 19th to the 29th. When I do my assessments and the wound is worsening, I would notify the provider. It was getting bigger, but we were using the silver and covering with the antimicrobial. I wanted to give the new treatment a chance to work before I contacted the provider and obviously it didn't work. When you go from a stage 2 to a stage 3 there is a presence of granulation tissue and slough. It doesn't necessarily mean the wound is getting deeper. I haven't seen a wound go from a stage 3 to an unstageable because usually when the wound is a stage 3 the resident will go for a debridement and then there's slough and eschar. I did document that (R1's) wound had deteriorated because it did. I really wanted the treatment to work for her but in this case it did not. I know I should have documented (R1's) wound assessments when I did them and there's no excuse for why I didn't, I was just lax about it. I was keeping an eye on her wounds, so I knew when it was worsening, the floor staff didn't really need to see that documentation because I was there." The facility's policy titled, "Wound care/dressing change" revised on 12/2017 showed, "The	S9999		

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S9999	Continued From page 9 purpose of this procedure is to provide guidelines for dressing changes of wounds in a sterile and non-sterile technique to promote healing ...M. Cleanse wound with damped gauze using the one swipe method. One circular motion with each gauze 4x4 starting at the center and working to outer edge of wound ...The following information should be recorded in the resident's medical record: ...E. Any change in the resident's condition. F. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. Complications related to the wound." The facility's policy titled, "Prevention of Pressure Injuries Protocol" revised on 01/2018 showed, "The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors ...General Guidelines ...E. Once a pressure injury develops, it can be extremely difficult to heal. Pressure injuries are a serious condition for the resident. F. The community should have system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family ...J. Routinely assess and document the condition of the resident's skin per community wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury to the supervisor ...Interventions and Preventive Measures: SKIN. A. Surface selection ...1. Select surface based on resident/clinical assessment ...b. Preventable surface/foam mattress for all residents, including Stage 1 and Stage 2 wounds." (A)	S9999		

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