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
	IL6009336	A. BUILDING: ____ B. WING ____	07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLINVILLE REHAB & HCC	**751 NORTH OAK STREET CARLINVILLE, IL 62626**

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S9999	Final Observations	S9999		

Statement of Licensure Violations

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.

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S9999	Continued From page 1	S9999		

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 identify, assess and treat pressure ulcers in a timely manner for 2 of 4 residents (R2 and R3) reviewed for pressure ulcer prevention in a sample of 15 and to identify, develop and manage pain effectively for 1 of 7 residents (R3) reviewed for pain management in a sample of 15. This failure resulted in R3 developing an unsteageable pressure sore that was not timely identified, assessed and treated and failed to follow recommendations for

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S9999	Continued From page 2	S9999		

treatment and supplements that would aide in healing the pressure sore and R3 exhibiting pain during care and treatments.

Findings include:

1. The Admission Sheet indicates R3 was readmitted to the facility on 7/18/14 from the hospital. According to the MDS (Minimum Data Set) dated 3/10/14 and 7/9/14, R3 has cognitive impairment and requires extensive assist of two for activities of daily living. According to the POS (Physician Order Sheet), she is also being seen by the wound clinic weekly for an in house acquired pressure ulcer to her right ischium with current measurements recorded on 7/22/14 by the clinic as 2.2cm x 5.5cm x 5cm deep. The July 2014 POS documents dressing changes to be done twice daily and has an order for Tramadol 50mg every 4 hours and Tylenol 325mg tabs ii every 4 hours as needed for mild pain. The Pain Assessment dated 7/18/14 identifies R3 as having no pain. The care plan dated 6/23/14 does not reflect a pain management plan.

On 7/22/14 at 11:45am, R3 had just returned from the wound clinic. R3 stated "I'm hurting... they took out a lot of bones" on her bottom when she went to the wound clinic. E7 LPN (Licensed Practical Nurse) was giving noon medication and asked R3 if she wanted a pain pill. R3 stated yes, it was "bad" and asked for two. R3 was given pain medication without identifying where the pain was or how it rated on a pain scale of 0-10 scale with 10 being the worst. E7 stated she did not give R3 pain medication prior to her visit to the wound clinic because she denied pain at the time. The Medication Administration Record (MAR) documents she gave 1 tab of Tramadol 50mg at 11:15am and Tylenol tabs ii at 1719 (5:19PM) on

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S9999	Continued From page 3 7/22/14. On 7/24/14 at 1:10pm, E4 and E12 CNA's (Certified Nurse Aides) transferred R3 to bed via a mechanical lift. She cried out as she was lifted from her wheelchair and grimaced and moaned as she was transferred to the bed. E7 stated at 12:30pm, she had just given R3 a pain pill and would do her treatment afterwards. At 2pm, E7 did R3's treatment on her coccyx pressure ulcer. She complained of pain during the treatment. According to the July MAR (Medication Administration Record), R3 has only received the Tramadol 7 times since 7/10/14 even though she's been going to the wound clinic weekly (7/15 and 7/22/14). The Controlled substance proof of use sheet for Tramadol shows it's not been given prior to wound clinic visits and that R3 receives it randomly. The pain scale recorded on the MAR documents R3 rating her pain as 7, 6 and 9 with the other 4 times given, no score documented. The Tylenol is documented as being given one time on 7/22/13 since 7/10/14. There is no evidence the facility adequately assessed R3 for pain especially during treatments and/or trips to the wound clinic. On 7/24/14 at 3pm, E15 CNA was asked if R3 complains of pain during her shift and stated she doesn't complain directly but she sees it when she does care or anything with her. E15 stated R3 has facial grimacing. E15 stated R3 used to do a lot for herself like propel herself back in her chair from the dining room and now is a mechanical lift. The MDS dated 6/3/14 compared to the one dated 7/9/14 shows a decline in outside room mobility, eating, and transfer.	S9999		

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S9999	Continued From page 4	S9999		

On 7/24/14 at 3:20pm, E16 LPN stated she doesn't really complain of pain but she can tell by the expression on her face. E16 states she asks if she wants Tylenol or a pain pill. E16 said "yes" when asked if her ADL's (Activities of Daily Living) declined explaining R3 used to be a slide board transfer and now is a lift but also use to do more of her care too.

The Policy entitled Pain Management dated 8/27/01 documents the policy is to maintain a resident as free as it is possible with the least amount of medication possible. The policy indicates residents are to be assessed based on complaints of pain, diagnosis, non-verbal communication of pain such as facial grimace, body posturing, affirmation by nodding, eye contact, written confirmation, or selecting on of the 1-10 scale, verbal, or non verbal, or 1-5 facial expression, "faces", pain scale.

According to the MDS (Minimum Data Set) dated 3/10/14 and 7/9/14, R3 is a double amputee readmitted to the facility on 10/27/12 with diagnoses of Diabetes, depression, Urinary tract infection, and Schizophrenia. The MDS indicates she requires extensive assist of two staff for mobility, bathing and hygiene. The MDS also documents her to have a urostomy and be always continent of bowel. The July 2014 POS (Physician Order Sheet) includes diet order for pureed regular with thin liquids and shows no nutritional supplements ordered. According to the POS, she is also being seen by the wound clinic weekly for a in house acquired pressure ulcer to her right ischium. The order dated 7/19/14 was for a Mesalt Rope, cover with mepilex border daily and PRN (as needed.)

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S9999	Continued From page 5	S9999		

The Weekly Pressure Ulcer Assessments document the date R3's ulcer was initially found was 4/27/14. It was first assessed/measured on 4/30/14 as being unstageable and measured 7cm x 7cm x 0.5cm deep with slough/eschar, necrotic tissue 90% granulation 10%, moderate amount of pink/yellow exudate. The treatment order was obtained on 4/29/14, two days after it was found. There is no documentation as to why the facility staff did not find this pressure ulcer until it measured 7cm x 7cm with eschar/slough.

On 7/22/14 at 11:45am, R3 had just returned from the wound clinic. Her dressing was intact but drainage soaked. The Wound Clinic's note dated 7/22/14 documented that the wound still had necrotic tissue that is not improving and "really needs a wet to dry" dressing. The measurements were 2.2cm x 5.5cm x 5cm deep with 75% slough. The treatment was changed to wet to dry changes BID (twice daily.) The wound clinic also checked "continue with current vitamin therapy." Review of R3's POS as of the morning of 7/24/14 shows no vitamins and/or nutritional supplements to aid healing.

The Registered Dietician's (RD) E11 notes document "Second Request" - Resume MVI (Multiple Vitamin) daily for general support. Some decline noted in wound. Being seen in wound clinic also rec (recommend) Prostat AWC 30ml TID (three times a day) for wound support due to size." On 7/24/14 at 1pm, E7 LPN stated she did not see any vitamins on R3's Medication Administration Record (MAR) and that the Prostat was just added on 7/24/14.

On 7/24/14 at 10:15am, E2 DON (Director of Nursing) stated she could not explain why staff

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S9999	Continued From page 6	S9999		

did not identify it sooner but agreed that was a problem.

On 7/24/14 at 11:45am, E7 LPN (Licensed Practical Nurse) was asked if she'd done R3's treatment yet and responded that she didn't know if she needed to do one or not but after looking, stated no. At 1pm, E7 stated she had premedicated R3 so she could do the treatment. At 1:10pm, E4 and E12 CNA's (Certified Nurse Aides) transferred R3 to bed via a mechanical lift. Her dressing over the left thigh was loose on two sides with the some of the packing hanging out of the wound. The wound had an odor. The dressing was dated 10-6 7/24. There is no indication the nurse on duty, E7, LPN checked and/or was informed that the dressing wasn't intact and in good condition when R3 was transferred to the wheelchair for lunch.

At 2pm, E7 LPN had R3 roll to her right side. R3's dressing was still loose. E7 pulled the loose dressing off and then removed two pieces of packing that were still wet from inside the gaping wound at the right gluteal fold. E7 kept holding R3's left buttock up and holding the wound open with her left hand. E7 rolled the dirty dressing into her gloves and applied alcohol gel to her hands and regloved. E7 then sprayed wound cleanser into the interior of the wound patting the exterior parameters of the wound but did not cleanse the wound bed itself. E7 sprayed it twice then packed the wound with saline soaked 4 x 4 gauze dressings and covered it with a larger dressing. E3 Wound Nurse/Assistant Director of Nursing agreed that the wound bed was not cleansed afterward at 2:10pm.

On 7/24/14 at 2:20pm, E13, Corporate Nurse also agreed in interview that the interior of the wound

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S9999	Continued From page 7	S9999		

or the wound base needed to be cleansed with the cleanser and 4x4 gauze.

2. The MDS dated 6/18/14 identifies R2 to be a 60 year old female readmitted to the facility on 3/18/13 with diagnoses of Multiple Sclerosis, Hemiplegia, Urinary tract infection (UTI), and muscle wasting. The MDS documents that she requires extensive assist of two staff for transfers and bed mobility. The MDS also documents R2 as having a suprapubic catheter and colostomy.

R2's care plan dated 7/23/14 indicates R2 has a history of pressure ulcer due to immobility with interventions for staff to turn/reposition every two hours and more often if needed, assess skin with all care and report problems to nurse as needed (PRN), encourage to lay down between meals, and obtain orders as needed.

The July 2014 POS includes an order dated 7/9/14 for skin prep to upper left anterior thigh every shift for prevention. R2 is on a regular diet. There are no current labs for Protein and/or Albumin.

On 7/22/14 during initial tour of the building at 9:30am, R2 was sitting in her wheelchair at bedside and asked if someone could look at the sore on her upper left thigh as it was "hurting real bad." R2 stated she had told the nurses and the CNA's about the sore several times but no one had done anything about it.. R2 was transferred to bed via a mechanical lift by E4 and E5, CNA's with E6, Licensed Practical Nurse (LPN) present. R2 had an elongated irregular shaped open sore on her upper posterior left thigh which was beefy red. E4, CNA, stated in interview that R2 was gotten out of bed into her wheelchair at 7am, 2 1/2 hours prior.

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S9999	Continued From page 8 At 1:35pm on 7/22/14, R2 stated she still had no treatment to her thigh and that she wanted to lay down but staff told her she had already laid down earlier that day. Progress notes fail to reflect this area even though R2 stated she had informed and asked staff to look at it previously. At 3:50pm on 7/22/14, E8 LPN was asked if the facility had previously identified R2's sore and stated there was no documentation on it but the wound nurse was looking at it. At 3:55pm on 7/22/14, the Administrator, E1 also stated the wound nurse was looking into it. On 7/22/14 at 20:18pm (9:18pm) a telephone order was received to cleanse upper left thigh with wound cleanser, apply optifoam then tegaderm every day til healed every evening. The progress notes refer to the same information. Weekly Pressure Ulcer Assessment dated 7/22/14 documents R2's left buttock as measuring 5.4 centimeter (cm) x 0.8cm wide x < 0.1cm depth, stage II, Pink. On 7/24/14 at 10:20am, E2, DON agreed that the CNA's and/or nurses doing the skin prep every shift for prevention should have picked up the area more timely before R2 complained of pain associated with it. The facility policy entitled "Wound healing and treatment" dated November 2010 under assessments indicates that weekly skin checks will be done for all residents, "Daily observation of skin and identification during routine care giving by CNAs, findings will be given to the licensed Nurse for assessment and further follow up.", Licensed Nurses will assess and document skin	S9999		

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S9999	Continued From page 9 problems initially, upon admission or identification, The assessment should include specific findings on each wound, location, size, depth, stage, exudate, odor, pain, presence of necrotic tissue, wound bed, wound margins and periwound skin condition.", in part. The Wound Assessment policy dated November 2010 also documents that each wound will be assessed initially either at time of admission or at the time the wound is identified. (B)	S9999		