STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145387	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement skin care care plan to prevent the worsening of a pressure ulcer for one of three residents (R3) reviewed for care plans in a sample of five. Findings include: The facility's Care Plan Policy and Procedure, undated, documents that an initial care plan is initiated on every resident by the admitting nurse upon admission/readmission. The care plan is then updated with any changes that may occur for example: diet and/or medications. The care plan is updated every three months per policy for residents that may or may not have significant changes in their ADL's (activity of daily living). R3 was admitted to the facility on [DATE] with a 3 inch round stage four pressure ulcer to his coccyx/sacral area. R3's Braden score, dated 5/29/20, documents that R3 is a high risk for pressure ulcers. R3's coccyx/sacral wound measurements on 7/13/20 document 10.2cm (centimeters) by 7cm by 3cm. R3's current care plan does not include a care plan to address R3's pressure ulcer with any wound care interventions in place. On 7/27/20 V1 (Administrator) verified that the care plan provided is R3's current care plan. V1 verified that R3 does not have a care plan in place concerning skin or wound care. On 7/29/20 at 8:45am, V14 (R3's Primary Care Physician) verified that skin and wound care interventions have to be put into place and followed, to prevent pressure ulcers or the worsening of pressure ulcers.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to perform physician ordered wound care, implement interventions to prevent the worsening of a pressure ulcer, and follow the facility's wound policy for one of three residents (R3) in a sample of five. This failure resulted in R3's pressure ulcer worsening, increasing in size and eventually requiring R3 to be admitted to a local hospital for a surgical debridement and care of pressure ulcer. Findings include: The facility's Wound Care Policy, revised October 2010, documents to use a disposable cloth to clean off the overbed table, then place supplies on the table. Then wash and dry your hands thoroughly, put on gloves, loosen tape and remove dressing. Wash and dry hands again, apply PPE (personal protective equipment) as required. Use a no touch technique, sterile tongue blades or applicators to remove ointments from their containers, pour liquid solutions directly onto gauze on their papers. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Place one gauze to cover all broken skin. Remove the dry gauze, then apply treatment as indicated. This policy also documents that the following information should be recorded in the resident's medical record: type of wound care, date and time wound care was given, position the resident was in, person performing treatment, all assessment date (wound bed color, size drainage, ect.), the signiture and title of person recording the data. The facility's Pressure Ulcers/Wounds policy, 11/10/19, documents that a Wound nurse or designee will monitor all wounds and will obtain new treatment orders for wounds which have shown no improvement for two weeks in a row unless expected decline. A care plan will reflect skin issues and interventions will be put into place. R3's Braden score dated 5/29/20 and 6/19/20 document a score of 15, indicating that R3 is a high risk for pressure ulcers. R3's current care plan does not address R3's pressure ulcer at all. There are no interventions or goals put into place to prevent R3's pressure ulcer from worsening. R3's admission skin assessment, dated 5/29/20, documents a three inch round stage four pressure ulcer on his sacral area. R3's wound measurements dated 6/1/20 document the sacral wound measures 3cm (Centimeters) by 3.5cm by 1.7cm depth. On 6/8/20 the measurements were 5cm by 5cm by .5cm depth. On 6/15/20 R3's wound measured 5cm by 3.2cm by 3.5 cm. R3's medical record does not have documented measurements for the weeks of 6/22/20 and 6/29/20. R3's wound measurements on 7/7/20 were 10cm by 4.5cm by 3.4cm. On 7/13/20 the measurements were 10.2cm by 7cm by 3cm. No measurements were documented for the week of 7/21/20. R3's Admission Physician order [REDACTED]. This same form documents to do a body audit three times a day. R3's Treatment Administration Record dated 5/29/20-5/31/20 does not have any documentation that R3's wound care to his coccyx or skin audit was completed as ordered. R3's POS (Physician order [REDACTED]. with an ABD, tape securely, daily. This form also documents to do a body audit three times daily. On 6/8/20 the wound care order was changed to two times daily instead of daily. On 6/15/20, R3's POS documented to continue the same treatment to the wound, but added to check R3 frequently, so stool (feces) does not get on the skin or dressing. R3's 6/1/2020-6/29/2020's TAR (Treatment Administration Record) has no documentation that R3's wound care or skin audit was done at all on 6/1/20, 6/9/20, and 6/30/20. R3's treatment order to his coccyx/sacral wound was changed on 6/8/20 to two times daily; R3's TAR does not have the new treatment orders on it. R3's treatment was only done one time daily instead of the two times as ordered. This form also has only the order to do the skin audit one time daily. R3's Progress Notes dated 6/30/20, document to send R3 to to the emergency room for a rapid COVID 19 test, then to get a total debridement of his sacral wound. R3's emergency room Notes, dated 6/30/20 documents that R3's wound measured 10cm by 8 cm by 3.5cm with necrotic tissue on the top of sacrum/coccyx bone with fascia involved, and the wound is unstageable. R3 was readmitted to the facility on [DATE]. R3's readmission orders [REDACTED]. R3's TAR, dated July 2020, has no documentation that R3's wound was completed on 7/5/20, 7/6/20, 7/9/20 7/16/20, 7/19/20 and 7/25/20 on the 2:00pm - 10:00pm shifts and on 7/11/20, on the 10:00pm - 6:00am shift. R3's body audit was not done on 7/4/20 and 7/6/20. On 7/27/20 at 11:00am, V4 (Licensed Practical Nurse/LPN) removed R3's brief to assess his dressing to his coccyx/sacral area. The dressing was intact but had feces on it; the dressing was not dated or initialed. V4 and V5 (LPN) returned with the supplies to do R3's wound care. V4 and V5 applied PPE before entering the room. V5 set the treatment supplies on the foot of R3's bed (not on a overbed table), then removed the soiled dressing, including the medicated packing, placed in a plastic bag at the foot of the bed. V5 cleansed R3's wound with medicated solution, disposed of the medicated gauze, then with the same gloves on, applied the medicated cream to the outside of the wound with her finger tip. V5 then put an ABD dressing over the top of the wound, initialed and dated the dressing. V5 did not do any hand hygiene any time during R3's wound care and was not wearing sterile gloves as documented in the facility's wound policy. V5 did not follow the physician wound care order to pack R3's wound with the medicated solution on the 4x4's. On 7/27/20 at 2:00pm V3 (LPN/Wound Nurse) verified that hand hygiene is to be done when moving from a dirty area to a clean. V3 verified that at no time is the finger tip used to apply medications. V3 stated the medicated solution is to be packed into R3's wound and left there until the next treatment. V3 stated that if the TAR is not signed out, then the treatment is considered not to be done as ordered. V3 verified that wound measurements are to be done on a weekly basis. On 7/27/20 at 2:30pm, V1 (Administrator) verified that wound care and treatments are to be completed as ordered. V1 stated that if they are not signed out then they are not done. V1 could not provide any wound care measurements for R3 for the weeks of 6/22/20, 6/29/20 and 7/21/20. On 7/29/20 at 8:45am, V14 (R3's Primary Care Physician) verified that wound and physician orders [REDACTED]. V14 also stated that wound care interventions should be put into place and followed to prevent worsening of pressure ulcers. On 7/29/20 at

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 9:00am, V13 (Clinical Wound Care Nurse Consultant) verified that R3's treatment order is to soak 4x4 gauze in medicated solution, pack the wound with it, then cover with a dressing. Cleanse with normal saline prior to using the medicated solution. V13 stated that she is no longer working at the facility because the treatments were not being done as ordered. V13 stated that she was not notified of R3's pressure ulcer worsening between 6/15/20 and 7/7/20.