STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145045	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL OF NAPERVILLE, THE	200 MARTIN AVENUE NAPERVILLE, IL 60540

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders to provide resident wound care. This applies to 2 of 4 residents (R1 and R4) reviewed for wound care in the sample of 11. The findings include: 1. According to the Electronic Health Record (EHR), R4 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], showed R4 needed extensive assistance of one person for toilet use; and limited assistance of one person for dressing. R4 was always continent of bowel and bladder. The MDS showed R4's cognition was intact. A care plan showed R4 had behavior of refusing care; was at risk for complications due to [MEDICAL CONDITION], peripheral chronic; had the potential for pressure ulcer development related to immobility; and was at risk for complications related to [MEDICAL CONDITION] and [MEDICAL CONDITION], with interventions including to monitor and document and report to MD symptoms of [MEDICAL CONDITION] (red, swollen tender skin, fever, spreading reddened area, small blisters, swollen lymph glands), observe dressing, and change dressing per physician order and record observations of site; at risk for further alterations in skin integrity with history of refusing compression dressing/wraps in the past and refused dressing changes and removed dressings despite education with interventions including to keep the skin clean and dry, use lotion on dry skin. The Physician Order Sheet (POS) showed R4 should have dressing changes to the lower extremities once a day, cleanse with mild soap and water, pat dry, cover with ABD pads then wrap with gauze wrap and secure with ace wraps every day and as needed. On 03/03/2020 at 11:38 AM, R4 said the nurses do not change his dressings to the lower extremities on the weekends. R4 said he could not recall who the nurses were, but was told by the nurses that they don't do the wound treatments, it would be the wound nurse who would do them. R4 said the facility will say I refuse care, but often on the weekends the wound care was not offered. R4 said the [MEDICAL CONDITION] and drainage from his legs have a foul odor. When the legs are covered with a new dressing the odor was not bad until they are removed for the dressing changes. R4 said if the dressings are not changed everyday then the odor will come thorough even with the dressings on. R4 said he tried to keep a blanket over his legs when the dressings aren't changed to keep the odor down. The February 2020 Treatment Administration Record (TAR) did not show any documentation for R4's wound care on: Saturday 02/08/2020; Sunday 02/16/2020; Sunday 02/23/2020; and Saturday 02/29/2020. The (NAME)2020 (TAR) did not show documentation for R4's wound care on: Sunday 03/01/2020. The TARs and the nursing progress notes did not show R4 had refused wound care treatments on those dates. 2. According to the EHR, R1 had [DIAGNOSES REDACTED]. The MDS, dated [DATE], showed R1's cognition was severely impaired. R1 needed extensive assistance of two or more staff for bed mobility, was totally dependent on one staff member for toilet use and hygiene. R1 had an indwelling catheter and was always incontinent of bowel. The POS showed R1 was on hospice and had treatments to multiple skin concerns including: to cleanse right ear with normal saline solution, pat dry, apply [MEDICATION NAME] ointment and apply protective foam padding to the right ear once daily and as needed; cleanse sacrum wound with half strength dakins solution and apply dressing every day shift; apply [MEDICATION NAME] and cover left bunion with dry dressing every Tuesday, Thursday, and Saturday; cleanse left lateral leg with normal saline solution, apply xeroform to site and secure with dressing and gauze wrap every Tuesday, Thursday, and Saturday; cleanse left medial buttock with half strength dakins solution, pat dry, apply [MEDICATION NAME] to wound bed, pack loosely with gauze and cover with dry dressing every day and as needed; and cleanse right heel with normal saline solution, pat dry, apply calcium alginate, cover with dressing and secure with gauze wrap every Tuesday, Thursday, and Saturday. A care plan showed R1 is on a turning and repositioning program due to limited ability to move independently and has alteration in skin integrity. The February 2020 TAR did not show any documentation for R1's wound care on: Saturday 02/08/2020; Tuesday 02/11/2020; Saturday 02/15/2020; Sunday 02/16/2020; and Sunday 02/23/2020. The (NAME)2020 TAR did not show any documentation for R1's wound care on Sunday 03/01/2020. On 03/03/2020 at 2:36 PM, V14 (Registered Nurse, RN), said she does not do the dressing changes for the residents because the wound nurse will do them. V14 said usually on the weekends the treatment nurse or V18, the weekend supervisor, will do the wound care. V14 could not recall if either the treatment nurse or V18 did the wound care for R4 or R1. On 03/03/2020 at 4:40 PM, V2 (Regional Consultant), said the treatment nurses and V18 have access to the resident's EHR for documentation. On 03/04/2020 at 12:41 PM, V18 (RN) said she does not do the resident's wound care on the weekends. V18 said she will help fill in the spots that are short over the weekend but was not the treatment nurse. V18 said the nurse caring for the resident on the weekends would be the person responsible for doing the resident's wound care. It is part of the nurse's assessment in the computer as it would show up on the Treatment Administration Record and the nurses would be responsible for those treatments. The facility's Dressing Non-Sterile (Aseptic) policy, dated January 2017, included to verify that there is a physician's order for this procedure; review the resident's care plan, current orders, and [DIAGNOSES REDACTED]. The policy also includes the date the dressing was changed and the initials of the individual changing the dressing should be recorded in the resident's medical record or TAR.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure hand hygiene during wound care. This applies to 1 of 4 (R1) residents reviewed for wound care in a sample of 11. The findings include: According to the Electronic Health Record (EHR), R1 had [DIAGNOSES REDACTED]. The EHR shows R1 has 10 different wound areas. A care plan showed R1 had an alteration in skin integrity was admitted to the facility with pressure ulcers and had a terminal prognosis, on hospice care with a nutritional decline. On 3/02/2020 at 3:48 PM, V4 (Registered Nurse, RN) Wound Nurse, was performing R1's wound care with V2 (Regional Nurse Consultant), and V11 (Director of Nursing, DON) was present and assisting. V4 donned gloves and removed R1's soiled right leg wound dressing and cleaned the wound with the same gloves. V4 removed the gloves and donned new gloves without washing hands or doing hand hygiene, then moved rapidly to cleaning wound areas on R1's foot and toes. V4 removed the gloves and donned new gloves without hand hygiene and proceeded to place a clean dressing onto R1's right leg and foot wounds. V4 continued doing wound care to R1's left leg in the same manner of sporadically changing gloves without hand hygiene in between glove changes. V4 sometimes kept the same gloves on between removing the soiled dressing and cleaning the wound; other times would keep the same gloves on between cleaning the wound, applying a new dressing, then removing a soiled dressing from another wound. This writer asked V4 if she does any hand hygiene between glove changes. V4 responded saying yes she does but some times she gets into a groove of all the multiple wounds, she doesn't always do hand hygiene with each glove change. V4 said she will definitely do hand hygiene after she does R1's sacral wound and before she does R1's ear wound. V2 reminded V4 she could use hand sanitizer between glove changes. V4 continued to remove gloves and don new gloves without hand hygiene to R1's sacral area. After completing R1's sacral wound care, V4 washed her hands with soap and water and donned new gloves. V4 removed R1's soiled dressing from the

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) mid back. V4 looked for a garbage bag to place the soiled dressing in and when she couldn't find one, placed the soiled dressing onto the over the bed table next to the clean wound dressing supplies. V4 then saw the garbage can at the foot of R1's bed and removed the soiled dressing from the table and placed it in the garbage can. V4 then cleaned R1's back wound and placed a new dressing on with the same gloves. V4 removed the soiled gloves and donned new gloves without hand hygiene and proceeded to complete R1's ear wound and shoulder wound dressing with the same gloves. After completing R1's dressing change, V4 applied R1's boots, pulled blanket up, repositioned R1's head on pillow before removing gloves and performing hand hygiene. On 3/02/2020 at 4:50 PM, V2 said she was aware of V4 not following the handwashing protocol between glove changes. On 3/03/2020 at 4:00 PM, V2 said between glove changes the nurses should be performing hand hygiene with sanitizer or washing their hands with soap and water. Also, if the nurse pokes through a glove such as from a fingernail poke, then they should wash their hands with soap and water not hand sanitizer. The facility's Dressing Non-Sterile (Aseptic) policy, dated January 2017, includes place a plastic trash bag within easy reach of the work-site; remove soiled dressing and place in plastic trash bag; remove soiled gloves and place in plastic trash bag; wash hands, or if hands are not visibly soiled, an alcohol based hand gel may be used to decontaminate the hands; apply clean gloves. The policy also shows, In the event more than one wound is present, each wound site is considered a separate treatment. A new pair of non-sterile gloves will be used for the cleansing of each site, as well as washing hands or disinfecting hands using hand gel between each site. The facility's Handwashing/Hand Hygiene policy, dated (NAME)2019, includes hand-washing/hand hygiene should be performed before donning gloves, before performing any non-surgical invasive procedures; before handling clean or soiled dressing, gauze pads, after handling used dressings or potentially contaminated equipment, and after removing gloves. The use of gloves does not replace compliance with hand-washing/hand hygiene procedures.