| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145636** | A. BUILDING _____ B. WING _____ | **08/19/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CHARLESTON REHAB & HEALTH CC** | **716 EIGHTEENTH STREET CHARLESTON, IL 61920** |

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

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| F 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to notify the Power of Attorney of new wounds and Physician orders [REDACTED]. Findings include: R2's Physician order [REDACTED]. R2's Wound Evaluation and Management Summary, dated 11/26/2019, documents initial evaluations of Right second toe arterial wound and Right calf arterial wound. Minimum Data Set (MDS), dated [DATE], documents R2 Brief Interview for Mental Status (BIMS) score as one out of a possible 15, rating R2 as severely cognitively impaired. This same MDS documents R2 as requiring extensive assist of one staff for bed mobility, dressing, personal hygiene and total dependence of two staff for toileting and transfers. Care Plan intervention, dated 11/14/19, documents to cleanse both feet with wound cleanser, apply [MEDICATION NAME] (antifungal) cream to both feet. This same Care Plan documents a skin intervention, dated 10/10/15, to lotion skin each morning with cares. This same Care Plan documents a skin intervention, dated 9/3/16, to assess new areas for size and injury, report findings to Physician and family. R2's Nurse Progress Note, dated 11/6/19, documents R2's Physician assessed R2's toes and feet with new orders obtained for treatment and antibiotic. This Nurse Progress Note does not document Power of Attorney notification of new wounds or new physician orders. R2's Nurse Progress Note, dated 11/7/19, documents new antibiotic initiated with no notification documented to Power of Attorney. Nurse Progress Noted, dated 11/8/19, documents R2 continues on antibiotic therapy for [MEDICAL CONDITION], both feet red with moderate pitting and swelling. This same Nurse Progress Note, dated 11/8/19, also documents R2 had an open lesion on skin. There is no documentation that Power of Attorney was notified of open lesion, continued antibiotic therapy, or swelling. Nurse Progress Note, dated 11/19/19, documents R2's skin as discolored which is a change from previous documentation with no notification to Power of Attorney. R2's Nurse Progress Notes, dated 11/6/19-11/22/19, do not document any notificiation of Power of Attorney for new wounds, wound related medications, or treatments, or general decline in wounds. R2's Treatment Administration Record (TAR), dated 11/1/19-11/30/19, documents a Physician order, dated 11/6/19, to cleanse area between right first and second toe with normal saline, apply calcium alginate and cover with gauze daily. This same TAR documents a Physician order, dated 11/7/19, to apply [MEDICATION NAME] (antifungal) cream to both feet twice per day. R2's Assess Intercommunicate Manage (AIM) form, dated 11/23/19, documents R2's right foot red, warm to touch. R2's second toe purple/black color and wound on back of right calf white with pus drainage. R2's Hospital records document R2 was hospitalized from [DATE]-11/25/19, for treatment of [REDACTED]. This same hospital record, dated 11/24/, documents R2's hospital admission [DIAGNOSES REDACTED]. R2's Medication Administration Record [REDACTED]. Treatment Administration Record (TAR), dated 11/25/19-11/30/19, documents new physician ordered treatments to paint right third and fifth toe with [MEDICATION NAME] daily and treatment to back of right calf of cleanse with normal saline, apply foam, change weekly and as needed. On 8/13/20 at 2:10 PM, V21, Licensed Practical Nurse (LPN)/Wound Nurse, stated, Any new wound should have an initial assessment completed. The physician, Power of Attorney, and wound nurse should be notified. V21 further stated, Anytime a resident has a new wound the wound physician is notified timely to provide physician assessments, treatment orders, etc 8/14/20 at 11:35 AM, V2, Director of Nursing, stated, When a new area is noted the physician, wound nurse and Power of Attorney should be notified. The facility policy titled 'Notification for Change in Resident Condition or Status' revised 12-7-17 documents the following: Policy: The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA (Health Care Power of Attorney), etc) of changes in the resident's medical/mental condition and/or status. Procedure: 1 The nurse supervisor/charge nurse will notify the resident's attending physician or on- call physician when there has been: a.Any symptom, sign or apparent discomfort that is: 1. Sudden in onset 2. A marked change (i.e. more severe) in relation to usual signs or symptoms 3. Unrelieved by measures already prescribed b. An accident or incident involving the resident; c. A discovery of injuries of an unknown source; d. A reaction to medication; e. A significant change in the resident's physical/emotional/metal condition; f. A need to alter the resident's medical treatment significantly; g. Refusal of treatment or medications h. A need to transfer the resident to a hospital/treatment center; i. A discharge without proper medical authority; j. Instructions to notify the physician of changes in the resident's condition; k. Onset of temperature of a temperature two degrees higher than baseline; l. Symptoms of any infectious process m. Abnormal lab findings n. 5% weigh gain or loss in 30 days, 7.5% weight gain or loss in 90 days, 10% weight gain or loss in 180 days o. Onset of pressure ulcers or stasis ulcers p. Abnormal complaints of pain 2 The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of kin or representative when the resident has any of the afore mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychological status; c. There is a need to change the resident's room assignment; d. A decision is made to discharge the resident from the facility and/or e. It is necessary to transfer the resident to a hospital/treatment center. 3 Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. 4 Regardless of the resident's current mental or physical condition, the nursing supervisor/charge nurse will inform the resident of any changes in his/her medical care or nursing treatments. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observation, and interview, the facility failed to prevent cross contamination during diabetic ulcer wound care for one (R5) of three residents reviewed for wound care on the sample list of 19. Findings include: R5's Physician order [REDACTED]. R5's Care Plan, dated 6/29/20, does not include any goal, focus area, or interventions for wound prevention or actual diabetic wound of R5's Left heel. R5's Wound Care Telemedicine Follow Up Evaluation, dated 8/6/20, documents a diabetic wound on R5's Left heel had deteriorated. This same Wound Care Telemedicine Follow Up Evaluation also documented an initial evaluation of a diabetic wound of R5's Left lateral heel. Minimum Data Set (MDS), dated [DATE], documents R5 as requiring extensive assistance of one staff for bed mobility, transfers, personal hygiene, dressing and toileting. This same MDS documents R5 as having a Multi Drug Resistant Organism (MDRO) (MRSA) infection. R5's Brief Interview for Mental Status, dated 8/11/20, documents a score of 15 out of a possible 15, rating R5 as cognitively intact. R5's Treatment Administration Record (TAR), dated 8/1/20-8/31/20, documents physician order [REDACTED]. On 8/14/20 at 9:10 AM, V21, Wound Nurse, completed a dressing change to the diabetic wound of R5's Left heel immediately after |

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

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| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>changing dressing to R5's Stage 4 pressure ulcer on Right lateral foot. R5 was laying on back in bed. R5's left foot was wrapped in previous dressing that was moderately saturated with pink/yellow drainage noted on bottom of dressing. Both of R5's feet, wrapped in saturated dressings, were laying on a white hand towel. V21 did not replace the soiled white hand towel with a clean one. R5's saturated dressing from the Left foot lay directly on the soiled towel. V21, Wound nurse, removed soiled dressing and placed R5's open diabetic Left heel wound directly on soiled towel. V21, Wound Nurse changed gloves and did not use Alcohol Based Hand Rub (ABHR) or wash hands. R5's open diabetic Left heel wound appeared 80% wet white/grey tissue with 20% wet pink tissue. V21 used same foam wound cleanser bottle with open nozzle directly touching R5's soiled pillowcase to apply to gauze and vigorously scrub R5's open diabetic wound on Left heel. V21, Wound Nurse, changed gloves again and did not use ABHR or wash hands. V21 used same cotton tipped applicator to apply ointment to entire wound using a back and forth motion. V21 cut Alginate larger than the size of the outer borderless foam and placed on R5's Left heel open diabetic wound. V21 replaced cap without sanitizing onto foam wound cleanser can and placed back in R5's dressing supply drawer. On 8/14/20 at 9:10 AM, V21, Licensed Practical Nurse (LPN)/Wound Nurse, stated, (V21) should have followed infection control guidelines during (R5's) open diabetic wound on Left heel. V21 stated, Contaminating wounds could cause spread of microorganisms and deterioration of wounds. On 8/14/20 at 11:35 AM, V2, Director of Nursing, stated, Nursing staff should maintain infection control policies while completing dressing changes. V2 further stated, Cross contamination of wounds during wound care could cause a wound to deteriorate. V2 stated, Staff need more education regarding infection control policies, wound care and dressing changes in order to prevent cross contamination to wounds. The facility Policy titled 'Preventative Skin Care' revised 1/18 documents the following: Policy: It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying and observation of the resident's skin condition to keep them clean, comfortable, well-groomed and free from pressure ulcers. 2. Staff on every shift and as necessary will provide skin care. 4. After thorough cleansing of the skin, lotion or other approved skin protectant is to be applied and observation of any reddened ares will be reported to the Charge Nurse. The facility policy 'Dressing Change' revised 7/07 documents the following: Policy: To avoid introducing organisms into a wound. Procedure: 7. Set up clean area for supplies. 8. Wash your hands. 10. Remove soiled dressing and place in plastic bag. 12. Remove and discard soiled gloves. 13. Wash your hands. The facility policy titled 'Hand Hygiene' reviewed 12/7/18 documents the following: Policy: All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions. If soap and water are not available use alcohol gel/rub to clean your hands. |
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observation, and interview, the facility failed to prevent cross contamination, during a dressing change of a Stage 4 Pressure Ulcer and also failed to complete Physician ordered skin assessments resulting in a new pressure ulcer to be undetected for one (R5) of three residents reviewed for pressure ulcers on the sample list of 19.<br>Findings include: 1. R5's Physician order [REDACTED]. R5's Wound Care Telemedicine Follow Up Evaluation, dated 8/6/20, documents a Stage 4 Pressure Ulcer to R5's Right Lateral Foot that had deteriorated. R5's Care Plan, dated 6/29/20, does not include any goal, focus area or interventions for pressure ulcer prevention or actual Stage 4 pressure ulcer of R5's Right lateral foot. R5's Minimum Data Set (MDS), dated [DATE], documents R5 as requiring extensive assistance of one staff for bed mobility, transfers, personal hygiene, dressing and toileting. This same MDS documents R5 as having a Multi Drug Resistant Organism (MDRO) (MRSA) infection. R5's Brief Interview for Mental Status, dated 8/11/20, documents a score of 15 out of a possible 15, rating R5 as cognitively intact. R5's Treatment Administration Record (TAR), dated 8/1/20-8/31/20, documents physician order [REDACTED]. On 8/14/20 at 9:10 AM, V21, Licensed Practical Nurse (LPN)/Wound nurse, completed a dressing change to R5's Stage 4 Pressure ulcer of Right lateral foot. A sign on R5's door documented R5 was on isolation precautions until To Be Determined (TBD) date. V21 verified that R5 has [MEDICAL CONDITION] (MRSA) in feet wounds before entering R5's room. R5 was laying in bed on her back. R5's right foot was wrapped in a previous dressing that was moderately saturated with pink/yellow drainage noted on 50 % of the bottom of the dressing. Both of R5's feet, wrapped in saturated dressings, were laying on a white hand towel. V21 did not replace the soiled white hand towel with a clean one. V21, Wound nurse, removed the soiled dressing and placed R5's open Stage 4 pressure ulcer on Right foot directly on the soiled towel. V21 obtained R5's dressing change supplies and placed them on the soiled bedside table. V21 moved dressing supplies from the contaminated bedside table to same the soiled white towel R5's feet were laying on. V21 placed ointment in clear plastic medicine cup and placed directly on R5's soiled fitted sheet. R5's Right lateral Stage 4 pressure ulcer was open with approximately 80% wet, grey tissue and 20% wet yellow tissue. V21 applied foam wound cleanser to gauze and vigorously scrubbed R5's entire right foot in circular motions, overlapping intact skin and R5's Right lateral Stage 4 pressure wound. V21, Wound Nurse, used the same cotton tipped applicator to apply ointment to entire wound using a back and forth motion. V21 placed foam a wound cleanser bottle directly on R5's soiled fitted sheet, leaning the open nozzle against R5's soiled pillow. Foam was slowly oozing from foam wound cleanser bottle onto soiled pillowcase. V21 placed the cap to the foam wound cleanser bottle with the open end down directly onto R5's soiled fitted sheet. V21 repeated this process to R5's entire foot with dry gauze. V21 did not disingect the scissors and placed them directly on the soiled bedside table. V21 used these same contaminated scissors to cut the new clean dressing to be placed over R5's Right lateral Stage 4 pressure ulcer. V21 completed the dressing change to R5's Stage 4 pressure ulcer and placed R5's gauze wrapped foot directly on same soiled white towel. 2. R5's Physician order [REDACTED]. This same POS documents a physician order [REDACTED]. This same MDS documents R5 as having a Multi Drug Resistant Organism (MDRO) (MRSA) infection and R5 is at risk of developing pressure ulcers. R5's Brief Interview for Mental Status, dated 8/11/20, documents a score of 15 out of a possible 15, rating R5 as cognitively intact. R5's Treatment Administration Record (TAR), dated 7/1/20-7/31/20, documents an order for [REDACTED]. This same TAR documents a physician order [REDACTED]. A sign on R5's door documented R5 was on isolation precautions until To Be Determined (TBD) date. V21 verified that R5 has [MEDICAL CONDITION] (MRSA) in feet wounds before entering R5's room. R5 was not wearing heel protectors when V21 entered R5's room. R5 was assisted to bed in supine laying position. While V21 completing R5's Stage 4 Pressure Ulcer dressing change to Right foot; R5 had an intact quarter sized very dark purple/brown area to bottom of Right heel. V21 did not measure this area during this observation. V21 did not apply any dressing to R5's right heel. 8/14/20 at 11:35 AM, V2, Director of Nursing stated, I was unaware of (R5's) right heel pressure area. V2 stated, Daily/weekly skin assessments should reveal any new areas. V2, Director of Nurses, stated, If Treatment Administration Record (TAR) was not signed off by the nurse, the treatment was not completed. V2 stated, Not completing physician ordered skin assessments could have caused (R5's) new pressure ulcer on Right heel to go unnoticed and possibly gotten worse without treatment. V2 stated, When a new area is noted, the physician, wound nurse, and Power of Attorney should be notified. On 8/14/20 at 2:30 PM, V21, Licensed Practical Nurse (LPN)/Wound Nurse, stated, I was unaware of (R5's) Right heel pressure wound until 8/14/20. V21, Wound Nurse, described R5's unaddressed wound on Right heel as quarter to half dollar sized dark brown pressure area. V21 stated, I had not been told of any further pressure wounds for (R5) other than the ones the Wound Physician was following. V21 stated, (R5) was last seen by the Wound Physician on 8/6/20 and had not been seen by the Wound Physician this week yet. On 8/18/20 at 9:10 AM, V9, Licensed Practical Nurse, stated, Skin assessments should be documented according to physician order. V9 stated, If the physician order [REDACTED]. The facility policy titled Decubitus Care/Pressure Areas revised 1/18 documents the following: Policy: It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. Procedure: 2. The pressure area will be assessed and documented on the Treatment Administration Record or the Wound Documentation Record. 3. Complete all areas of the Treatment Administration Record or Wound Documentation Record. 8. When a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers. The facility Policy titled 'Preventative Skin Care' revised 1/18 documents the following: Policy: It is the facility's policy to provide preventative skin care through repostionig and careful washing, rinsing, drying and observation of the resident's skin condition to keep them clean, comfortable, well groomed and free from pressure ulcers. 2. Staff on every shift and as necessary will provide skin care. 3. After thorough cleansing of the skin, lotion or other approved skin protectant is to be applied and observation of any reddened ares will be reported to the Charge Nurse. The facility policy 'Dressing Change' revised 7/07 documents the following: Policy: To avoid introducing organisms into a wound. Procedure: 7. Set up clean area for supplies. 8. Wash your hands. 10. Remove soiled dressing and place in plastic bag. 12. Remove and discard soiled gloves. 13. Wash |

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| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>your hands. The facility policy titled 'Hand Hygiene' reviewed 12/7/18 documents the following: Policy: All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions. If soap and water are not available use alcohol gel/rub to clean your hands. |