

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Accolade Healthcare Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 801 North Logan Avenue Danville, IL 61832	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to timely notify the physician of newly developed, draining wounds for one (R1) of four resident reviewed for wounds in the sample list of six.</p> <p>Findings include:</p> <p>R1's ongoing census documents R1 readmitted from the hospital on 3/1/24. R1's Nurses Weekly Skin assessment dated [DATE] documents R1 had bruising to the groin and abdomen. There is no documentation that R1 had wounds to the abdomen when R1 readmitted on [DATE].</p> <p>R1's Nursing Note dated 3/3/24 at 1:41 PM documents, CNA (Certified Nursing Assistant) found 3 new open areas just above resident's penis. Green pus coming out of all 3 open areas. Cleaned and dressing placed. Wound nurse notified. R1's Nursing Note dated 03/04/2024 at 5:49 PM documents, Order received for Doxycycline (antibiotic) BID (twice daily) today r/t (related to) open areas on abdominal area.</p> <p>There is no documentation that R1's Physician (V11) was notified of R1's abdominal wounds found on 3/3/24 prior to 3/4/24 when antibiotics were ordered.</p> <p>On 4/25/24 at 1:20 PM V4 Registered Nurse/Wound Nurse stated the facility has standing orders to follow when new wounds are found, and the nurses should notify the physician and document in the progress notes. V4 stated V4 was off work for the first 10 days of March 2024. V4 reviewed R1's nursing notes and stated V4 did not see that the physician was notified of R1's wounds on 3/3/24. V4 confirmed green puslike drainage is a sign of infection.</p> <p>The facility's Physician Notification of Resident Change of Condition policy dated 8/1/18 documents the physician will be notified of changes in resident's condition including symptoms of infection and pressure sores.</p> <p>The facility's Skin and Wound Management Guidelines dated April 2023 documents to report wounds to the wound nurse and if the wound nurse is not in the facility, then the nurse is responsible for notifying the physician to obtain treatment orders.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Failures at this level requires more than one deficient practice statement:</p> <p>A. Based on observation, interview, and record review the facility failed to culture a residents' draining wound prior to initiating antibiotics, assess a residents' surgical incision upon admission to include measurements/description of the surgical wound, and accurately transcribe wound treatment orders for three (R1, R2, R6) of four residents reviewed for wounds in the sample list of six.</p> <p>Findings include:</p> <p>A1.) R1's ongoing census documents R1 readmitted from the hospital on 3/1/24. R1's Nursing Weekly Skin assessment dated [DATE] documents R1 had bruising to the groin and abdomen and this note does not document open abdominal wounds. There is no documentation in R1's electronic medical record that R1 had abdominal wounds when R1 readmitted on [DATE]. R1's Nursing Note dated 3/3/24 at 1:41 PM documents, CNA (Certified Nursing Assistant) found 3 new open areas just above resident's penis. Green pus coming out of all 3 open areas. Cleaned and dressing placed. Wound nurse notified. R1's Nursing Note dated 03/04/2024 at 5:49 PM documents, Order received for Doxycycline (antibiotic) BID (twice daily) today r/t (related to) open areas on abdominal area.</p> <p>There is no documentation that a wound culture was ordered/obtained prior to antibiotic treatment on 3/4/24 or that R1 was evaluated by V10 Wound Physician prior to 3/14/24. R1's March 2024 Medication Administration Record documents R1 received Doxycycline 100 milligrams (mg) by mouth twice daily from 3/4/24-3/13/24.</p> <p>There are no documented wound measurements/descriptions on 3/3/24 when R1's wounds were identified to be open and draining. R1's Wound Summary with date range 3/4/24-4/17/24 documents on 3/4/24 the wound had partial thickness with 100% loose slough, moderate serosanguineous drainage, and measured 6.1 centimeters (cm) by 10.2 cm by unknown depth. This summary documents on 3/15/24 the wound was full thickness, 100% bright pink/red tissue, had heavy purulent (pus) drainage, and measured 6.1 cm by 10.2 cm by 6 cm deep. This summary documents R1's wound was present on admission on 3/1/24 and infection was present 3/4/24-4/17/24.</p> <p>R1's Nursing Note dated 3/13/2024 at 2:30 PM documents, Resident (R1) continues with abscess to R (right) groin and penial area. Copious amounts of greenish drainage noted. Per wound nurse assessment resident to be sent to ED (Emergency Department) for evaluation of abscess.</p> <p>R1's emergency room Notes dated 3/13/24 at 7:00 PM documents R1 presents with groin pain and abscess for two weeks and there are multiple abscesses to the pannus (excess abdominal skin) and groin that had thick and odorous drainage. R1's emergency room laboratory results dated [DATE] documents a white blood cell count of 13.1 (normal range 4-12), indicating infection. R1's emergency room Note dated 3/13/24 documents R1 was given intravenous Meropenem (antibiotic) and Vancomycin (antibiotic) for abdominal wall cellulitis and was discharged to the facility with orders for Bactrim DS (Double Strength) 800-160 mg twice daily for 10 days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Wound Assessment & Plan dated 3/14/24 recorded by V10 documents V10's initial evaluation of R1's suprapubic abscess and that this wound was treated with incision and drainage (I&D) in the ED.</p> <p>On 4/25/24 at 10:36 AM V1 Administrator provided copies of R1's wound cultures (dated 3/13/24, 4/13/24 and 4/18/24) that were requested for March and April 2024. V1 stated those are the only cultures that were done between the facility and the hospital.</p> <p>On 4/25/24 at 10:50 AM V10 stated V10 did not see R1 until after the I&D was done at the hospital, and there were four wounds to the suprapubic area. V10 stated V10 was not the physician who ordered the antibiotic on 3/4/24 and V10 would not have ordered Doxycycline as the antibiotic of choice unless the skin was red/inflamed. V10 stated the antibiotic ordered would be based on symptoms including fever and elevated white blood cell count, and a culture is ordered if there are additional signs of infection besides purulent drainage as they will often show growth of Escherichia Coli, Enterobacter, or Pseudomonas (bacteria).</p> <p>On 4/25/24 at 12:47 PM V11 Physician stated V11 was not treating R1's wound, V10 was. V11 stated V11 did not recall ordering antibiotics for R1's wound or if a wound culture was warranted. V11 stated generally if a wound is draining V11 refers to V10 and to determine the need for a culture.</p> <p>On 4/25/24 at 1:20 PM V4 Registered Nurse/Wound Nurse stated the facility has standing orders to follow when new wounds are found, and the nurses should notify the physician and document in the progress notes. V4 stated the nurses should assess and document in a progress note or assessment new identified wounds and upon admission and include measurements. V4 stated V4 was off work for the first 10 days of March 2024 and V4 is the one who usually refers a resident to V10. V4 stated V4 would have probably referred R1 to V10 or a general surgeon when R1's wounds were first identified. V4 stated V10 rounds weekly on Thursdays, and confirmed V10 could have evaluated R1's wounds on 3/7/24 (Thursday). V4 reviewed R1's nursing notes and stated V4 did not see documentation that the wound was assessed/measured prior to 3/4/24. V4 confirmed green puslike drainage is a sign of infection and the draining wound should be cultured.</p> <p>On 4/25/24 at 2:30 PM V3 Infection Preventionist stated wound cultures are left up to V10 to determine, and if the resident has not been seen by V10 then V3 leaves it up to V4 to follow up with the physician.</p> <p>A2.) On 4/25/24 at 8:50 AM V4 and V10 entered R2's room. V4 unwrapped and removed R2's left leg dressing where R2 had surgical above knee amputation. The incision line contained staples and some open blisters, and blood tinged drainage was on the dressing. V4 cleansed the wound and administered R2's wound treatment.</p> <p>R2's ongoing census documents R2 was readmitted from the hospital on 4/15/24. R2's Nurses Weekly Skin assessment dated [DATE] documents R2 has a left AKA (above knee amputation) surgical incision. There are no description/characteristics of this wound or the number of staples present documented in R2's medical record until 4/16/24.</p> <p>R2's Wound Summary with date range 4/16/24-4/24/24 documents on 4/16/24 the wound was 40% non-granulating tissue, 50% slough, and 10% necrotic (dead tissue), had moderate serosanguineous drainage, and measured 18 cm by 0.5 cm.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 1:20 PM V4 stated there is an initial assessment of R2's wounds on 4/15/24, but it does not document measurements/description of the surgical wound. V4 stated V4 has told the nurses to measure wounds, even if they reference nickel size for example. V4 confirmed wounds should be assessed and measured upon admission.</p> <p>A3.) On 4/25/24 at 9:12 AM V4 and V10 entered R6's room. V4 removed R6's dressing to the right heel which contained a moderate amount of blood tinged/brown drainage. R6 had a red circular wound to the right outer heel. V10 measured the wound and stated it measured 1.9 cm by 1.7 cm by 0.2 cm. V10 stated the wound was almost 3 cm when V10 first started seeing R6. V4 cleansed the wound and administered R6's wound treatment.</p> <p>R6's Wound Summary with date range 3/4/24-4/24/24 documents Right Lateral Heel vascular wound measurements as follows:</p> <p>4.5 cm by 3.6 cm by 0.3 cm on 3/4/24.</p> <p>3 cm by 2.6 cm by 0.3 cm on 3/14/24.</p> <p>3 cm by 2.5 cm by 0.3 cm on 3/20/24</p> <p>2.8 cm by 2.5 cm by 0.3 cm on 3/27/24</p> <p>2.8 cm by 2.5 cm by 0.3 cm on 4/3/24</p> <p>R6's Wound Assessment and Plan dated 3/14/24 and recorded by V10 documents R6's right heel wound was 10% Epithelial/ 50% Granulation/40% Slough and includes a daily treatment order to cleanse the wound, apply alginate and cover with a clean/dry dressing. R6's Wound Assessment and Plan dated 3/21/24 and 3/28/24 document the same treatment order for R6's right heel wound as noted on 3/14/24. R6's Wound Assessment and Plan dated 4/4/24 documents to cleanse the wound, apply alginate with silver and cover with dry dressing three times weekly.</p> <p>R6's March and April 2024 Treatment Administration Records document R6's wound treatment was transcribed to be administer three times weekly (3/21/24-4/4/24), and not daily as ordered.</p> <p>On 4/25/24 at 1:30 PM V4 stated V4 goes by V10's written orders, and sometimes when the order is changed V4 forgets to uncheck the frequency of three times per week when updating the order in the electronic medical record. V4 confirmed R6's wound treatments were not transcribed correctly to administer daily as ordered on 3/21/24.</p> <p>The facility's Antibiotic Stewardship policy dated August 2023 documents, The Facility encourages licensed independent practitioners to use current Centers of Disease Control and Prevention's (CDC) guidelines and published recommendations regarding: 1. Appropriate and effective prescribing of antibiotics, including but not limited to: a. Availability of culture and sensitivity results prior to antibiotic administration, when medically appropriate and prudent. b. Limiting patient/resident exposures to empirically administered broad-spectrum antibiotics without cultures or medical necessity. 2. Consultation with pharmacy or epidemiology experts to determine most effective treatment regimens. 3. Prescription of antibiotics based on culture results, rather than symptomology alone- when prudent and medically appropriate.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Skin and Wound Management Guidelines dated April 2023 documents upon admission/readmission the nurse is responsible for documenting a complete admission assessment in the resident's electronic medical record, including thorough and descriptive documentation of altered skin integrity. This policy documents to report wounds to the wound nurse and if the wound nurse is not in the facility, then the nurse is responsible for notifying the physician to obtain treatment orders. This policy documents the wound nurse is responsible for obtaining and referring wound care consult with the facility's wound physician, and ensuring wound care orders are implemented and appropriate.</p> <p>B. Based on interview and record review the facility failed to monitor and record fluid intake for one (R1) of three residents reviewed for nutrition in the sample list of six.</p> <p>B1.) R1's ongoing census documents R1 readmitted to the facility on [DATE] and discharged on [DATE]. R1's Care Plan revised 4/16/24 documents R1's diagnoses include Type 2 Diabetes Mellitus, Diabetic Chronic Kidney Disease Stage 4, Chronic Obstructive Pulmonary Disease, and Peripheral Vascular Disease.</p> <p>R1's Dietitian assessment dated [DATE] documents 2100 milliliters (ml) as R1's total fluid needs per day. There is no documentation that R1's fluid intake is routinely recorded, besides the HS (hour of sleep) snack intake. R1's March and April 2024 HS Snack intakes document R1's fluid intake varies from 120 ml- 980 ml, R1 refused fluids for three entries, and Not Applicable for five entries.</p> <p>R1's Nursing Note dated 04/09/2024 at 10:39 AM documents a care conference was held with V18 (R1's Family) and R1's poor oral intakes were reviewed during this meeting.</p> <p>On 4/25/24 at 1:44 PM V2 Director of Nursing stated V2 thinks fluid intake is recorded as part of the meal intake. V2 reviewed R1's meal intakes and confirmed they document percentage consumed and does not document fluid intake amounts. V2 reviewed R1's HS intake and stated that is recording the evening snack intake.</p> <p>The facility's Hydration and Prevention of Dehydration policy dated August 2017 documents: 5. Nurse's Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Intake will be document in the medical records. 6. If potential inadequate intake and or signs and symptoms of dehydration are observed the Physician will be informed and individual preferences, habits, and cognitive and medical status will be considered for possible interventions. 7. Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significant dehydration. 8. If laboratory results are consistent with actual dehydration, the physician may initiate IV hydration. hospitalization will be recommended as necessary. 9. Nursing will monitor, and document fluid intake and the Dietitian will be kept informed of status. Interdisciplinary Team will update care plan and document resident response to interventions until team agrees that fluid intake and relating factors are resolved.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record the facility failed to assess and measure a pressure ulcer upon admission for one (R2) of four residents reviewed for wounds in the sample list of six.</p> <p>Findings include:</p> <p>R2's ongoing Census documents R2 readmitted from the hospital on 4/15/24. R2's Nurses Weekly Skin assessment dated [DATE] documents R2 has an unstageable coccyx wound. There are no measurements or description/characteristics of this wound documented in R2's medical record until 4/16/24.</p> <p>R2's Wound Summary with date range 4/16/24-4/24/24 documents on 4/16/24 R2's unstageable pressure ulcer was 75% non-granulating tissue and 25% deep maroon, had moderate drainage, and measured 6 centimeters (cm) by 4 cm with unknown depth.</p> <p>On 4/25/24 at 8:50 AM V4 Wound Nurse and V10 Wound Physician entered R2's room. V4 removed R2's coccyx wound dressing. The wound was pink with some dark tissue in the center of the wound. V10 measured the wound and stated it measured 4.8 cm by 2.1 cm. V4 cleansed the wound and administered the wound treatment as ordered.</p> <p>On 4/25/24 at 1:20 PM V4 stated there is an initial assessment of R2's wounds on 4/15/24, but it does not document measurements/description of the coccyx wound. V4 stated V4 has told the nurses to measure wounds, even if they reference nickel size for example. V4 confirmed wounds should be assessed and measured upon admission.</p> <p>The facility's Skin and Wound Management Guidelines dated April 2023 documents upon admission/readmission the nurse is responsible for documenting a complete admission assessment in the resident's electronic medical record, including thorough and descriptive documentation of altered skin integrity.</p>