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
	IL6006134	A. BUILDING: ______ B. WING ______	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPTOWN HEALTH CENTER	4920 NORTH KENMORE CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation 1883755/IL103271 - Licensure Violations 1885557/IL105232 - No Findings 1886483/IL106263 - Licensure Violations 1885837/IL105556 - No Findings 1883642/IL103151 - Licensure Violations 1883593/IL103102 - Licensure Violations 1885787/IL105499 - Licensure Violations 1885126/IL104759 - Licensure Violations 1886064/IL105813 - Licensure Violations 1884805/IL104439 - No Findings 1885314/IL104962 - No Findings 1885666/IL105363 - No Findings 1883633/IL103144 - No Findings	S 000		
S9999	Final Observations Statement of Licensure Violations Licensure 1 of 2 300.610a) 300.1210b) 300.1210c) 300.1210d)4)B)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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
11/23/18

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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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.

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

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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. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to document, monitor, and provide goods and services to three residents. This failure affects three residents (R9, R15, and R20) reviewed for ADL care in a sample of 23. The facility also failed to provide bathing resulting in maggots in and around the vaginal area for 1 of 3 residents (R20) reviewed for bathing and personal care and failed to ensure that incontinence checks were conducted at least every 2 hours and as needed for 2 of 3 residents R12/R13 reviewed for incontinence checks frequency. These failures caused physical harm resulting in a stage 4 pressure ulcer behind the ear (R9) and resulted in R20 being admitted to the local hospital and assessed with maggots found around R20's vaginal area.

Findings include:

Minimum data set dated 07/07/2018 documents that R20 has a BIMS (Brief Interview for Mental

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Status) of zero. R20 cannot make her needs known. R20 is an extensive assist for personal hygiene. R20 is always incontinent of bowel and bladder.

Report dated 08/30/2018 documents V27 (Certified Nursing Assistant) was interviewed by V2 (Director of Nursing). V27 reported that R20's abdominal binder was removed during a bed bath that she provided. The binder was visibly soaked. The binder was used regularly to prevent R20 from trying to dislodge her g-tube. V27 stated she regularly gave R20 extra full body baths, but did not document them on the bath records.

Discharge summary dated 08/31/2018, from a local hospital, documents that R20 has superficial wounds at the sacrum, below her breast and her groin area, likely secondary to abdominal binder that was not cleaned properly in the nursing facility. Per V26 (Social Worker) from a local hospital, maggots were found near and in R20's vagina area. R20 was admitted 08/28/2018 and discharged from a local hospital on 08/31/2018.

ADL monitoring sheet, undated, was reviewed for the week of 08/21/2018 to 08/27/2018. No baths are recorded for R20. R20 was admitted 08/28/2018 and discharged from a local hospital on 08/31/2018.

On 10/18/2018 at 2:12 PM, V27 stated, "I consistently work on the 5th floor. Other shifts did not notice R20's abdominal binder. When I took care of R20, I gave her a bed bath daily, but I did not document the baths."

On 10/18/2018 at 2:51PM, V2 stated, "Staff try to give baths once a day and personal care

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whenever it is needed. I did not review the other months for R20 showers. Staff need to document what they do."

Care plan dated 10/09/2018 documents that R20 has an ADL self-care performance deficit and R20 will be treated with respect, dignity, and reside in the facility free of mistreatment.

Facility policy dated 08/15/2018, titled Activities of Daily Living, documents that documentation will be provided in the residents medical record of the assistance and amount of staff required to complete the task. The frequency of documentation will be determined by the individual resident's care needs.

Facility policy dated 11/17, titled Abuse, Neglect and Exploitation, documents neglect as failure of the facility to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
R9 is an 81-year old male admitted on 2/23/2006 from acute care hospital with diagnoses include: vascular dementia, cognitive deficits, gastrostomy and retention of urine.

MDS (Minimum data Set) dated 4/24/18 reads ....Section G. Functional Status, G0110. Activities of Daily Living (ADL) Assistance: ....A. Bed mobility: 4 (Total dependence)/3 (Two+ persons assist), B. Transfer: 4 /3 ....Section H. Bladder and Bowel: ....H0300. Urinary Continence: 3 (Always incontinent), H400. Bowel Continence: 3 ....ar stage III

"Physician's Order" dated 5/3/18 reads, ...keep resident on 3 L (Liter) of O2 (Oxygen) nasal cannula ....

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Hospital record reads, after visit summary: 5/29/18-6/1/18 ... pressure ulcer 5/30/18 right posterior ear stage IV, pressure ulcer left posterior ear ....

On 10/16/18 at 11:35am, V17 (Wound Care Coordinator) stated, the resident was on oxygen therapy with a nasal cannula. "Prior to his hospitalization on 5/29/18, I was not informed of pressure ulcer behind his ears. The nurses should be checking behind the resident's ears daily and use the cushions with the tubing all the time to protect the skin behind the ears when residents are on oxygen. For the residents tend to lean on one side, more skin breakdown may develop overtime. His hospitalization is preventable had I been notified early. Redness of the skin could be an indication of a stage 1 pressure ulcer."

R15 is an 88-year old male admitted on 7/29/16 from acute care hospital with diagnoses include: mild cognitive impairment, benign prostatic hyperplasia and heart failure.

"Physician's Orders" dated 2/23/18 reads, Oxygen at 3L/Min via Nasal Cannula Continuous ....

On 10/11/18 at 1:15pm, this writer noted skin is slightly red behind right ear where the oxygen tubing is placed. V6 (LPN-Licensed Practical Nurse) stated, a cushion should have been placed with the tubing.

On 10/16/18 at 12:10pm, V9 (LPN-Licensed Practical Nurse) confirmed there are no cushions with oxygen tubing for R15. V9 stated, the cushions should have been placed with the tubing to prevent irritation and skin breakdown.

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On 10/16/18 at 12:55pm, V2 (DON-Director of Nursing) stated, the nurses should be checking skin behinds residents ears to make sure there is no skin breakdown. If the residents are not able to remove their oxygen tubing, the cushions should be placed with the tubing to prevent pressure sores.

On 10/11/18 at 2:22pm, this writer noted R12's incontinence brief was saturated with dark color urine. R12 has a suprapubic catheter and a colostomy bag .Dark color stains inside of the empty catheter bag, colostomy bag is full. V13 (CNA-Certified Nursing Aide) stated, "On a good day, I am supposed to check incontinence brief and change it every two hour, the last time I checked was 11am. I am not aware that the resident has a catheter."

On 10/11/18 at 2:40pm, V6 (LPN-Licensed Practical Nurse) confirmed R12's colostomy bag is full and stated, his colostomy bag is full and should have been emptied as needed. I changed his colostomy bag at 7am today.

On 10/11/18 at 3:30pm, this writer noted strong odor of bowel movement from R13, observed large amount of bowel movement in R13's incontinence brief. V10 (Unit Manager) stated, "The resident's CNA has left for the day, I don't normally work on this floor but heard the commotion from the roommate and came. The CNA should be checking incontinence brief every two hours and as needed."

Incontinence care plan dated 9/10/18 reads, ...check for incontinence every 2 hours and as needed ....

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On 10/18/18 at 1;35pm, V2 (DON-Director of Nursing) stated, "Incontinence care should be provided according to resident's need. Everyone should be checked upon risen before and after meal and before bed time. The CNAs should be rounding every two hours and more frequently if the residents are unable to make their needs known. "

(A)

Licensure 2 of 2

300.1210b)
300.1210c)
300.1210d)6)
300.3240a)
300.3240d)

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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:
6) All necessary precautions shall be taken

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to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

These Requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow its use of mechanical lift policy by not ensuring the resident has the proper size sling before a transfer for 1 of 3 residents R11 reviewed for mechanical lift use. This failure resulted in R11 falling to the floor sustaining a right trochanteric fracture, and non-displaced C7 fracture. The facility also failed to develop a plan of care with interventions to reduce or prevent frequent falls for 1 of 3 residents R16 reviewed for fall prevention.

Findings include:

On 10/11/18 at 12:00pm, this writer noted R11 in bed, alert and oriented to self, place and time. R11 stated, "I am still waiting for someone to put me in a chair. They have to put me on a lift to

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transfer me. On July 8, the CNAs (Certified Nursing Aides) put me on a smaller lift pad to transfer me instead of using my regular lift pad because my regular lift pad was soiled. One strap broke and my back landed on the wheelchair. Three CNAs tried to carry me, then the other strap broke and I landed on the floor. I broke my right femur and was hospitalized 4-5 days. Last week, one strap came off the hook when they were transferring me to the lift, luckily the CNA grabbed it before I fell. They were rushing and should have checked to make sure all the straps are secured before the transfer. "

On 10/13/18 at 1:32pm, during an observation of mechanical lift transfer, this writer noted R11 sitting on transfer sling leaning towards her left, staff did not reposition the resident prior to the transfer. This writer also noted staff did not physically check the straps prior to the transfer.

On 10/13/18 at 1:35pm, V20 (CNA) stated, "Prior to the transfer we should make sure all straps are in good condition and are connected to the hooks and to make sure the resident is repositioned so her weight is distributed evenly while sitting on the sling. We are not supposed to use the shower sling because she is a big lady and her back is wide. Prevention is important."

On 10/13/18 at 2:13pm, V2 (DON-Director of Nursing) stated, R11 normally uses is a full size mechanical transfer sling. On the day of the fall, a shower sling was used because there is no back up slings available. According to the investigation, there was also a nurse in the room where the transfer occurred, she should have asked for the appropriate equipment, The CNAs there should have called the supervisor to obtain a backup sling. The shower sling is used when resident

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S9999	Continued From page 10 takes a shower but there is no evidence that R11 uses the shower sling safely prior to the fall. The measurement of the shower sling at the waist line is 24" (inches) and is 37-3/4" of the regular sling. The strap broke on the left side of the shower sling during the transfer. R11's Hospital record dated 7/8/18 reads, ...length of stay: 3 ....Surgical procedure: Right Intermedullary Nail Femur ....History of present Illinois: ....The patient ....admitted for right trochanteric fracture, and non displaced C7 fracture due to fall from hoyer lift while transferring to wheelchair to bed, hoyer lift broke and patient fell. Patient underwent surgery for right trochanteric fracture ....Assessment and plan: ....Injuries: 1. Displaced comminuted fracture of the left neural arch at C7, 2. Right femur fx (fracture), left dislocation of head of left femur .... "Use of mechanical Lift" policy dated 8/18 reads, ...Procedure: ....2, Confirm the resident has the proper sling size available and appropriate o the task being assisted ....10.. Place the sling under the resident..Visually check the size to ensure it is not too large or too small......12....c. Before resident is lifted, double check the security of the sling attachment. d. Examine all hooks, clips or fasteners. e. Check the stability of the straps....13. Lift the resident 2 inches from the surface to check the stability of the attachment, the fit of the sling and the weight distribution... R16 fell a total of 27 times from 03/31/2018 to 10/05/2018. Two of those falls were witnessed by staff. The fall on 07/25/2018 resulted in hospitalization and injury. Physician documentation dated 08/06/2018 notes on 07/25/2018 R16 was at nursing facility when	S9999		

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staff stated R16 fell but, it was unclear if R16 hit her head. After that R16 had a tonic-clonic seizure. R16 was found lying in her bed and had a couple of staring episodes. These episodes lasted for less than a minute and it is unknown if she had any shaking or loss of sphincter control at that time. Review of R16's reporting records after the fall and injury found the facility did not report an initial or final report to the state.

Fall risk screen dated 04/06/2018 documents R16 is a high risk for falling. Care plan dated 08/07/2018 documents the following: need to attempt to anticipate R16's needs to go to the toilet before and after meals, at bedtime and as needed; ensure call light is within reach while R16 is in her room especially while in bed; frequent rounds while in bed to assure safety. Care plan dated 10/11/2018 documents that R16 potentially has mixed bladder function as evidenced by frequent falls related to toileting.

On 10/12/2018 at 12:25PM, R16 was in bed alert and orient to self. R16 stated, "I need to pee." R16 was asked to pull call light but the call light was behind R16's bed. R16 was unable to reach the call light.

On 10/18/2018 at 12:49PM, V14 (Certified Nursing Assistant) stated, "R16 is impulsive and you never know what she is going to do. R16 will jump up and pull the call light and go to the bathroom without assistance. R16's falls have to do with her going to the bathroom. CNA's have to really monitor her and check on her regularly. I have fourteen residents by myself and nine of them are total care. R16 needs to be monitored 24 hours a day, seven days a week. R16 should not be getting out of bed by herself. She is very unsteady."

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