

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6019723</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/06/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKE COOK REHAB &amp; HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4101 LAKE COOK ROAD NORTHBROOK, IL 60062</b>
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S 000	Initial Comments  Complaint Investigation #2095946/IL125256	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.1210 b) 300.1210 d)2) 300.1210 d)5) 300.3240 a)  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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	<p>Continued From page 1</p> <p>pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a low pressure air loss mattress was in working order and failed to turn and reposition a resident per physician order. This failure contributed to one resident (R2) obtaining two facility-acquired pressure ulcers that became infected and necrotic (dead tissue).</p> <p>Findings include:</p> <p>R2 is an 87 year old originally admitted to the facility on 1/2/20 for long term nursing care and with diagnoses of stroke, dementia, hypertension and contractures.</p> <p>On 8/3/20 at 11:50 AM, R2 was observed in her bed fully dressed and lying on her back. R2 was lying atop beige crumpled bedsheets with a dark blue mattress that appeared to be deflated as her body sunk down the center of the bed down to the bed coils. An electronic pump mechanism was attached to the footboard and an indicator light to show the device was functioning was off (not lit) and a dial was set at 150 psi. At 1:15 PM, R2 remained in the same position on her backside atop the deflated mattress.</p> <p>On 8/3/20 at 1:20 PM, V14 (CNA.-Certified</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Nurses Aide) was walking past R2's room. V14 pointed to R2's room and stated, "Yes, she's mine" (referring to her resident she was assigned to). Asked if there was another aide working with her, V14 stated, "Yes, she's over there on that side" (pointing to the other wing); "This is my side."</p> <p>On 8/3/20 at 2:40 PM, surveyor entered the R2's room where she appeared to be in the same position on her backside and with the air pump indicator light was not lit.</p> <p>On 8/3/20 at 2:45 PM, V9 (Wound care nurse) provided surveyor a list of facility wounds as requested. V9 stated, "Did you want to see wound care because I already did them this morning." Surveyor asked who did wound care, V9 stated, "I do. I'm here Monday to Friday." Asked about her wound list provided the the surveyor, V9 stated, "I have all these that I do (pointing to her list) and these are the only two that are facility-acquired (pointing to R2)." Surveyor asked if nurses do wound care, V9 stated, "On the weekends they do."</p> <p>On 8/4/20 at 10:50 AM, V3 (Assistant Director of Nurses) was asked who did wound care in the facility. V3 stated, "We have a Wound care nurse (V9) who does it Monday to Friday, and our nurses do the treatments on the weekends." Surveyor asked V3 where nurses documented, V3 stated, "It's all in the charts, we don't have electronic records yet so its all on paper."</p> <p>On 8/4/20 at 11:00 AM, V9 showed surveyor her wound surveillance report and was asked about where nurses document what they did. V9 stated, "Well I chart on the TAR (Treatment Administration Record) and also in the nurses</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>notes." Surveyor asked if there was any other areas or forms used to document interventions such as turning and repositioning, V9 stated, "No just nurses notes and it should be signed off on the TAR." Surveyor asked V9 about the treatment order, V9 stated, "Well they are supposed to be turning and repositioning her but I guess they don't document it anywhere." Asked how staff know when to turn and reposition R2 if there is no flow-sheet or documentation showing which position R2 should be in after being turned, V9 stated, "I don't know but I will let my director of nurses know."</p> <p>Records in the nurses notes written by V9 (wound nurse) show: 4/23/20: "Noted with blanchable redness on left hip applied foam dressing after normal saline wash. MD aware. Skin monitored weekly." 4/24/20: "9A seen by wound doctor with N.O. (new order) noted and carried out." 5/5/20: "8A skin assessment done. Left hip with deteriorating wound, noted with 100% necrotic tissue, approximately 3 x 3.5 x 0. Right hip with blanchable redness. Resident high risk for further skin breakdown related to incontinence to both bowel and bladder, contracted to bilateral lower extremities, unable to shift weights.</p> <p>Nursing note records show no documented entries to show turning or repositioning of R2. TAR's presented to the surveyor show the order "Turning and Repositioning at frequent intervals" to be blank and with only an FYI to the nurses.</p> <p>On 8/4/20 at 12:30 PM, V9 (Wound Nurse) and V18 (CNA) showed R2's wound treatments to the surveyor. V9 approached R2 and explained to the resident the procedure. V9 observed that the bed was deflated and stated, "I did check this earlier</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>and it was working but I see it's still not inflating so perhaps it could be the tubing. I already called the company to replace it and they said it will be replaced sometime today." Surveyor asked V9 to explain the air mattress pump functions, V9 stated, "The dial has to be inflated to 125 psi setting suited for (R2's) weight and the green light should be lit showing normal pressure. Asked the importance of the correct pump setting, V9 stated, "Well it can't be over inflated or else it doesn't work properly but for some reason it's still not working anyway."</p> <p>V9 proceeded with the treatment demonstration and with V18 (CNA) turned R2 to her side. V9 first removed a layer of incontinence pad described to the surveyor as a "hip-hugger". V9 removed the hip hugger to reveal another incontinence pad, and then the bandage on her pressure sores. V9 removed the right hip dressing to show a tennis ball-sized wound. Surveyor asked V9 to describe the wound, V9 stated, "It was just blanchable redness at first probably around April and the next time I say it was already necrotic. Right now it appears to have a lot of slough and old necrotic tissue about 5 by 6 centimeters. It was just blanchable redness at first and she scratched it and it just like happened over night and was necrotic the next morning." V18 then turned R2 to her other side to show her left hip pressure ulcer that appeared to be a golf ball-sized hole. V9 stated, "The left hip wound is undermining at around 10:00 o'clock and 12:00 o'clock (describing the location of the undermining tissue of the wound). Surveyor asked how deep the wound was, V9 stated, "It's about 3 centimeters deep." Surveyor asked V9 to describe the undergarments R2 had on, V9 stated, "After we do the treatments, she has a wound dressing (bandage) on her wounds, she has a diaper because she's incontinent, then</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>there's a hip hugger (incontinence briefs with foam padding on each side of the hips)." V9 stated, "Those are the hip huggers we put on her to keep her from scratching herself." Surveyor asked if the facility tried other means to keep R2 from scratching, V9 stated, "No, it's just a behavior she has." Asked if they tried other methods to address R2's itching and V9 stated, "No." At the conclusion of the wound treatments, surveyor asked again about R2's wounds. V9 stated, "Both the wounds to her left and right hip is facility-acquired meaning she got them when she was here. Yes, they are considered avoidable and she should not have gotten them." Surveyor asked about turning and repositioning and to show how nurses document that it's being done, V9 stated, "Well the nurses are supposed to turn (R2) at least every two hours but we don't put it anywhere."</p> <p>Physician order sheet shows an order for low air loss mattress ordered on 5/5/20, four months after R2's admission of 1/2/20. Minimum Data Set (MDS), dated 1/8/20, considered high risk for pressure ulcers and was admitted with a stage 3 pressure ulcer on the right buttock. The same physician order sheet shows a doctor's order, dated 1/2/20, to "Turn and reposition at frequent intervals" but does not clarify actual frequency of turning and repositioning. TAR's(Treatment Administration Record) were transcribed from the doctor's order as "Turn and Reposition at frequent intervals" and with a hand-written FYI next to the order but had no initials or signatures by nurses to document that the frequent turning was accomplished.</p> <p>On 8/4/20 at 1:20 PM, V14 (CNA-Certified Nurses Aide) was asked about R2. V14 stated, "Yes she is my resident again. I usually have her and I took</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>care of her yesterday too." Surveyor asked when the last time she went in to see R2, V14 stated, "I saw her earlier when I changed her (referring to her incontinence briefs)." Asked the time she went in to change her, V14 stated, "I don't know maybe early in the morning." Asked when else she saw R2, V14 stated, "Well I peek in and watch her and she was okay why is there something wrong." Asked if she goes and turns R2, V14 stated, "Oh yes we do that too, I did that earlier when I changed her." Asked if anyone helped in turning R2, V14 stated, "No I did it myself but sometimes I ask someone to help but everyone's always busy so I just do it." Asked how often R2 needed to be repositioned while in bed, V14 stated, "I don't know, until they (nurses) tell me."</p> <p>All OBRA quarterly assessments (MDS-Minimum Data Set) dated 1/8/2020, 4/6/2020, 6/23/2020, and 7/10/2020 show R2 to be totally dependent of full staff performance for bed mobility requiring 2 staff to turn and reposition while in bed. . All four of R2's MDS quarterly assessments show R2" at risk for developing pressure ulcers" but do not include any turning and repositioning program in all the four MDS's.</p> <p>Interview with V15 (Wound Doctor) on 8/4/20 at 1:30 PM, states, "I've been seeing R2 since the beginning of the year. I see her every Friday when I do my wound rounds at the facility. She should be on a low air loss mattress because she came in with a stage 3 pressure ulcer. If you tell me that mattress was not functioning since yesterday, that should have been changed immediately. I hope they did. Surveyor asked V15 if he considered R2's wounds to be avoidable, V15 stated, "Her wound is avoidable. If she is capable of healing her other wounds I would have</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>to agree with you and say her wounds are avoidable." Surveyor asked whether he ordered turning and repositioning for R2, V15 stated, "Turning and repositioning at a minimum of 2 hours or less I always order for someone at risk for pressure injuries. I also agree that she should not have obtained these other two wounds if she was being turned and repositioned at least every two hours to off-load any pressure on her skin." Surveyor asked about microclimates of wounds, V15 stated, "Microclimates are contributing factors such as linens, covers, padding impact wound healing. Excessive-padding, linens, coverings can be a problem and there shouldn't be that much padding on her. There should be minimal coverings over her wounds. I wasn't aware that there was that many layers of padding because when I come in to see her wounds, the staff already have her wounds ready for me to see. I'll be there (facility) this Friday so I'll address this with the staff." Asked about about necrotic wounds, V15 stated, "Wound necrosis cannot happen over night. If she (R2) was scratching herself, she could not caused necrosis of her wound right away as the nurse told you. That would be incorrect. If she was scratching her wounds, the staff should have seen this before hand and also regularly off-loaded the pressure. Her skin doesn't just become necrotic. This is why it is important to turn and reposition a patient to take the pressure off otherwise the wound will die (necrosis) due to pressure not being relieved on the body part or bony prominence." Surveyor asked about his orders, V15 stated, " If I say turn and reposition every two hours at a minimum, that should not be written as a FYI as it is an order not a recommendation."</p> <p>(B)</p>	S9999		