STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005748	A. BUILDING _____ B. WING _____	C 07/10/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations	S9999		

Statement of Licensure Violations:
1 of 2 Violations:

300.610a)
300.1210b)3)
300.1210d)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 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

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

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:

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 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

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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 are not met as evidenced by:

Based on observation, interview and record review, the Facility failed to timely assist a dependent resident off the bed pan and relieve pressure to her buttocks and coccyx for 1 of 2 residents (R2) reviewed for pressure ulcers in the sample of 9. This resulted in R2 acquiring two unstageable pressure ulcers to her coccyx and a deep tissue injury to her left buttock.

Findings include:

On 7/5/19 at 1:50 PM V7 and V8, Certified Nurse's Aides (CNAs) assisted R2 to stand, while V20, Licensed Practical Nurse (LPN) removed the dressing from an irregular shaped Stage II pressure ulcer with a dark red base on R2's coccyx. The pressure ulcer was located at the top of a horseshoe shaped bruise that went down both of R2's buttocks and connected at the top at her tailbone area. The bruises were purple in color, with the bruise to R2's right buttock darker than the one on her left buttock. R2 stated she got the pressure sore from being on the bedpan too long and stated that she could not remember who had put her on the bedpan that night. R2 stated, "My butt hurts where I sit on it." There was a plastic bedpan under R2's bedside table that

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matched the shape and size of her bruises. R2 stated that's the bedpan she uses at night.

On 7/9/19 at 1:00 PM, R2 was turned by V19, CNA, there was a dressing covering the pressure ulcer to her coccyx and a new dressing covering her left buttock. There was bruising noted the length of R2's right buttock, and a bruise extending above and below dressing to left buttock wound, but fading further down her left buttock. R2 stated, "It still hurts when I sit."

On 7/10/19 at 9:35 AM, V23, Family Nurse Practitioner from the Consultant Wound Management Company, completed R2's initial pressure ulcer assessment. V23 stated there were two unstageable wounds to R2's coccyx, one on each side of her butt crack. The unstageable ulcer on the right coccyx measured 0.5 cm by 1.6 cm by unstageable; the ulcer on the left coccyx measured 2.0 cm by 4.2 cm by unstageable. V23 stated these wounds are unstageable because the wound beds are obscured by slough (dead tissue usually cream or yellow in color). V23 stated the wound on the left buttock is a deep tissue injury (intact skin with localized area of persistent deep red, maroon, purple discoloration due to damage of underlying soft tissue). V2, Director of Nursing (DON) was present during V23's visit to R2 and V2 informed V23 that the wounds were pressure injuries from a bedpan.

R2's Minimum Data Set (MDS), dated 6/11/19, documents, in part, a Brief Interview for Mental Status (BIMS) score of 15, indicating she is alert and oriented. The same MDS also documents she is dependent on staff for transfers and toileting and bed mobility, including turning and repositioning while in bed, and is frequently

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incontinent of urine and occasionally incontinent of bowel. The MDS lists R2's diagnoses, which include deep venous thrombosis (blood clots), Diabetes, and Stroke. According to her MDS, R2's clinical skin risk assessment score documents she is at risk of developing pressure ulcers but did not have any pressure ulcers at the time of that assessment.

R2's Nurse's Note dated 6/28/19 at 10:00 AM documents, "Resident noted with purple discoloration from lower left buttocks, up and around top of right buttock and down to lower right buttocks. Skin intact. New orders to discontinue Flexiciol (wound dressing) and start Meplilex (wound dressing) to be changed every three days. This area noted by Power of Attorney when toileting done in AM. Bruised areas are noted to be approximately 1 centimeter (cm) in width."

R2's Incident Investigation dated 6/28/19 documents "Resident has linear purple bruising the shape of bedpan wall. Nurse reported after family member saw bruise this morning." The Incident Investigation documents, under, "What Corrective Actions Were Taken": "Staff educated to monitor all residents closely while on bedpan. Do not allow a resident to stay on a bedpan for a long period."

R2 was hospitalized for Urinary Tract Infection and Sepsis from 6/28/19 to 7/3/19. The hospital records include physician progress notes that documents, in part, "Skin: Bruising in a hemi-circle to right buttock. Skin intact." The hospital reports also include a Registered Dietician consultation report which documents, "Pt (patient) with a deep tissue injury on coccyx."

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R2's readmission Skin Assessment, dated 7/3/19, documents, "3 centimeter (cm) w (wide) by 1 cm (long) open area; marks from bedpan 54 cm." This description has a line drawn indicating the wound is in R2's coccyx region.

R2's readmission Nurse's Notes dated 7/3/19 at 8:00 PM documents, "(R2) has open areas to coccyx and to bedpan marks - marks measure 54 cm."

R2's Nurse's Notes dated 7/6/19 at 12:05 AM documents an open area to R2's buttock marks on left side that measures 1 1/2 cm by 3 1/2 cm. A Nurse's Note on 7/7/19 at 10:20 AM documents a new order was received from the Nurse Practitioner for the Facility's contracted Wound Specialist to evaluate and treat R2's wounds.

R2's Care Plan dated 6/13/19 documents a problem that R2 is at risk for skin impairment and includes an update on 6/28/19 to apply Mepilex to coccyx and change every three days, but it does not include current pressure ulcers to her coccyx and left buttock, or the bruising to her buttocks from the bedpan.

On 7/9/19 at 8:55 AM V2 stated she had the night nurse, V13, Registered Nurse (RN) question the CNAs on the night shift and none of them knew who had put R2 on the bedpan on 6/28/19, or who took her off it. V2 stated she would expect staff to keep checking on a resident who was on the bedpan every 4-5 minutes to see if they were finished. V2 stated her worry was that a CNA put R2 on the bedpan that night, and then got busy and R2 fell asleep and did not call to remind staff to take her off the bedpan. V2 stated R2's daughter had been in on the evening shift on 6/27/19 and toileted R2, cleaned her up and put

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her to bed around 7:30 PM per her usual routine. V2 stated R2's daughter informed her that R2's skin on her buttocks and coccyx were clear at that time. V2 stated she was appalled that R2 was left on the bedpan long enough to get the wounds she has.

On 7/9/19 at 1:45 PM V21, R2's Physician, stated if the family saw R2's coccyx and buttocks the evening before and her skin was clear, and then the next day she had bruising from the bedpan, and has since developed open areas on the bruise lines, it is most likely the wounds were caused by pressure from being left on the bedpan for an extended length of time.

On 7/9/19 at 2:00 PM V2 stated she classifies R2's coccyx wound as a Stage 2 Pressure Ulcer and the wound on her left buttock is an unstageable pressure ulcer. This is not documented in R2's medical record, nor is there a description of the wounds to the coccyx and left buttock.

The Facility's undated policy, "Decubitus Ulcer (Care and Prevention)" documents, in part, under "Purpose: To prevent and treat further breakdown of pressure sores." According to this policy, documentation should include: Preventative measures used; Condition of the resident's skin; Physician notification, if appropriate; Preventative equipment used; and if decubitus is present, the licensed nurse is responsible to record condition of the skin, including stage, size, depth, color, drainage, and odor as well as the treatment provided. Notification of the physician is required when a new decubitus is identified as well as when treatment is not effective."

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(B)

2 of 2 Violations:
300.610a)
300.1210a)
300.1210b)5)
300.1210d)6)
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 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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

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6) All necessary precautions shall be taken 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)

These Requirements are not met as evidenced by:

Based on observation, interview and record review the Facility failed to supervise a cognitively impaired resident, failed to ensure resident equipment was in place and in good working condition, and failed to provide progressive interventions after falls to prevent further falls for 4 of 4 residents (R1, R2, R3 and R4) reviewed for falls in the sample of 9. This failure resulted in R4 falling and receiving a laceration to her left eye that required 9 sutures.

Findings include:

1. R4's Face Sheet, dated 1/2/19 documents her diagnoses, in part, as Alzheimer's Disease and Fracture of left hip on 12/14/18.

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On 7/5/19 at 10:00 AM R4 was sitting in her wheelchair in the dining room. She was noted to have a laceration to her left forehead with steri-strips over it.

R4's Minimum Data Set (MDS) dated 6/12/19 documents Brief Interview for Mental Status (BIMS) score of 6, indicating she is severely cognitively impaired, and she requires extensive assist with bed mobility, transfers, dressing, eating, toileting and bathing. It documents R4 is dependent on staff for locomotion in and outside of the facility and uses a wheelchair.

R4's Care Plan, dated 6/13/19, documents the problem, "(R4) is at risk for falls related to: she requires assist with ADL's (Activities of Daily Living). (R4) has a history of falls and has had two falls since last assessment. (R4) will attempt to stand unassisted." The Care Plan Intervention dated 12/31/18 documents "Check on (R4) frequently." The Care Plan Intervention dated 4/17/19, documents " Instructed CNAs (Certified Nurse's Aides) to make sure call light in reach and chair pad alarm in wheelchair and turned on." The Care Plan Intervention dated 6/15/19, documents "Utilize wheelchair only for locomotion."

R4's Fall Risk Assessment dated 6/13/19 documents a fall risk score of 12, indicating R4 is at a high risk of falls.

A written summary, dated 6/19/19, of R4's fall incident on 6/15/19 at 9:30 AM documented, R4 fell in her bathroom on 6/15/19 and sustained a laceration to her right forehead (nurses notes document left forehead) and a skin tear to her left forearm. The Summary documented prior to her

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fall, V9, Certified Nurse's Aide (CNA) had assisted R4 into the geriatric reclining chair to take her to the shower, but instead went to assist another CNA on the hall, leaving R4 alone in the geriatric reclining chair in the hall. The summary of R4's fall included written statements from the staff who were working at the time of R4's fall on 6/15/19. V9 gave a written statement, dated 6/15/19, documenting that she was in the other resident's room for 3 minutes and when she came out of that resident's room, R4 was no longer in the hall. V9 documented she heard a "thud" and went to R4's room and found her lying on the floor with her pants and adult clothing protector around her knees. According to the summary, the geriatric chair was in the doorway of R4's bathroom, in semi-reclined position, and the wheels were not locked. Per the report, R4 was sent to the emergency room where she received stitches to the laceration to her right side of her forehead. The summary did not document if the chair pad alarm was in the reclining geriatric chair and sounded at the time of R4's fall.

An untimed Nurses Note dated 6/25/19 documents that 6 stitches above R4's left brow and 3 to left brow line removed with sterile technique. Steri-strips applied to secure wound.

On 7/10/19 at 2:30 PM, V2 stated, "(R4) should never have been in that (geriatric chair). She should have been in her wheelchair." V2 continued to state that R4 should not have been left in the hall.

2. On 7/5/19 at 9:27 AM R1 was transferred from his wheel chair to his bed by V8, CNA, and V9, CNA using the mechanical lift. The lift sling was under R1 in his chair and V8 and V9 fastened the sling straps to the lift. Without double checking

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that the straps were correctly applied to the lift and that the sling did not have any rips or tears, V8 raised R1 in the air with the lift, and he hung there while V9 pushed his wheel chair out of the room. R1 was hanging in the sling across the room from his bed, and then V9 came back into the room and assisted V8 to maneuver the lift over to the bed and lower R1 down onto the bed. V9 stated she did not double check the sling before lifting R1 because it was a new sling and they had been checked a lot lately. V9 stated, "We are supposed to double check them (slings) before we get a resident up with a mechanical lift."

R1's MDS dated 5/17/19 documents, in part, a BIMS score of 4, indicating he is severely cognitively impaired. The same MDS documents R1 is dependent on staff for transfers.

R1's Fall Risk Assessment dated 5/20/19 documents his risk score is 14. According to the Fall Risk Assessment, a score of 10 or more represents a high risk of falls.

3. According to the Facility's Resident Fall Log, dated May 2019, R2 fell on 5/23/19 at 8:10 AM.

On 7/9/19 at 1:00 PM, V19, CNA and V26, CNA transferred R2 from her wheelchair to her bed. During the transfer, R2 told the CNA's, "I hate this thing. I was up in the air and the strap broke and I fell. It was very bad. I still hurt from it."

The Facility's "Investigative Report Summary" dated 5/23/19 documents, in part, that while V24 and V25, CNAs, were transferring R2 from her bed to her bedside commode, the loop near R2's head/shoulder area gave way and R2 fell to the floor, striking the back of her head on the floor,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and landed with her legs over one leg of the lift, laying on her right buttock and back, tilted to right side. R2 was sent to the local hospital for evaluation. The Investigative Report Summary documents that the lift pad that tore during R2's transfer and another pad that had a tear in the handle was removed from use.

R2's MDS, dated 6/11/19, documents, in part, a BIMS score of 15, indicating she is alert and oriented. The same MDS also documents she is dependent on staff for transfers.

R2's Fall Risk Assessment dated 7/3/19 documents her fall risk score is 13, indicating she is at a high risk for falls.

R2's Care Plan dated 6/13/19 documents "(R2) is at risk for falls related to she requires assist with her ADL's (Activities of Daily Living), incontinent of bowel and bladder, takes routine meds that have a black box warning and has a history of falls." The care plan also documents R2 has a diagnosis of stroke with left sided paralysis. The interventions for R2's Fall Care Plan documents an intervention dated 3/13/19 "May use (mechanical) lift for transfers. An additional intervention was added, "5/23/19 Fall-(mechanical lift) pad removed from floor-all (mechanical lift) pads inspected. If frayed or worn- remove from floor."

On 7/5/19 at 1:10 PM V2 stated, "I would absolutely expect staff to double check straps to ensure they are correctly hooked to the mechanical lift before lifting a resident. We have double checked all our slings and gotten rid of a couple that had loose threads."

On 7/9/19 at 2:39 PM, V22, Maintenance

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	IL6005748	A. BUILDING: _____ B. WING _____	C 07/10/2019

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Supervisor, stated he did not have a manual for the mechanical lifts in the building because the lifts are so old. He stated he did use the serial number from the lift and looked up some information on the internet regarding the mechanical lifts. The incomplete user, manual provided by V22 identifies the mechanical lifts by their model numbers and documents, on the cover page of this manual, " This manual must be given to the user of the product. Before using this product, this manual must be read and saved for future reference." According to this manual, under "Maintenance", it documents, "Slings and Hardware- Check all sling attachments each time it is used to ensure proper connection and patient safety. Inspect sling material for wear. Inspect straps for wear."

The Facility's undated policy, "Transfers and Lifts" documents, in part, "The facility will ensure that all staff members are instructed in safe transfer and lifting techniques and how to report suspected injuries." This policy includes a hand-written direction, dated 5/23/19, which documents, "Prior to use, staff will check for fraying or holes on sling and remove from use."

4. According to the Facility's Fall Logs dated May 2019, June 2019 and July 2019, R3 has had multiple falls:

On 5/17/19 R3 had an unwitnessed fall to the floor in his room. According to the Incident Investigation dated 5/17/19 the corrective action taken, "Instructed to use call light." After this fall R3 was sent to the hospital for evaluation and was diagnosed with a slight sprain of his right ankle. Upon return from hospital, according to the Incident Investigation, R3 was "instructed again not to get up unassisted" and documented,

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"Resident confused." R3's care plan was not updated with progressive interventions after this fall.

On 5/28/19 R3 fell when attempting to take self to the bathroom. According to the Incident Investigation dated 5/28/19, R3's wheelchair was outside his room in the hallway. His chair alarm did not sound to alert the staff he was getting up. V27, Physical Therapist, stated the chair alarm was not working the previous day either, when R3 was in therapy. V27 stated there was a towel on top of the alarm pad, and when she removed it the alarm worked correctly. The Incident Investigation documents that staff has been instructed to keep pad next to patient/do not cover pad with towel or blanket; instructed Therapy Department to communicate these situations to nursing staff; administrator has ordered new chair and bed alarm. The corrective action taken, "Resident should be taken to dining room after toileting- continue to remind to summon help if needed-check on resident every two hours or less-offer toileting every two hours-ensure chair and bed alarms are on at all times." R3's care plan was updated on 5/28/19 "chair alarm to be in place and on while up in chair", but chair alarm was already being utilized when R3 fell on 5/15/19. No progressive intervention was initiated after this fall.

On 6/17/19 R3 fell out of bed. According to the Incident Investigation dated 6/17/19 resident was crying for help and was found on a mat on the floor next to his bed. The report documents, "There was no bed alarm." According to R3's Care Plan intervention dated 5/16/19, R3 was to have a bed alarm in place at all times.

R3's MDS dated 5/29/19 documents, in part, a

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S9999	Continued From page 16 BIMS score of 6 indicating he is severely cognitively impaired, and also documents he is dependent on staff for transfers and toileting. The Facility's undated policy, "Fall Protocol and Procedure" does not document that falls need to be investigated to determine root cause of falls and to update the resident's plan of care with progressive interventions to prevent additional falls. (B)	S9999		