

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012579	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2019
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NAME OF PROVIDER OR SUPPLIER IMBODEN CREEK LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 180 WEST IMBODEN DECATUR, IL 62521
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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d) 6) 300.3240 a) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/18/19

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S9999	<p>Continued From page 1</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>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 safely transfer two residents (R5, R7) of 39 residents reviewed for accident hazards in a sample list of 39. This failure resulted in R5 sustaining a 12 centimeter skin tear, which required emergency services and 13 sutures to close.</p> <p>1.) R5's Physician's Order Sheet (POS) for June 2019, includes the following diagnoses: Cellulitis of Left Lower Limb, Muscle Weakness, End Stage Renal Disease, Dependence on Renal Dialysis, and Cognitive Communication Deficit.</p> <p>R5's Care Plan, with a revision date of 6/13/19, documents, "(R5) transfers with one CNA/gait (Certified Nursing Assistants, belt) with a wheeled walker. Use two assist if needed related to</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>weakness." R5's Care Plan also documents, "(R5) is at risk for falls, related to poor safety awareness, mobility deficits, pain, Hypertension, Coronary Artery Disease, Chronic Kidney Disease, anemia. Do not leave alone in recliner in room without supervision of staff/family."</p> <p>On 6/23/19 at 10:00 AM, V26 (R5's family member) stated, "On (R5's) dialysis days (Monday, Wednesday, and Friday), (R5) is so weak that (R5) can barely stay awake."</p> <p>R5's "Progress Note" dated 3/14/2019 at 9:30 PM, documents, "(V20) CNA reported to writer that (R5) had a skin tear to R (right) lower leg. Writer entered room and (R5) noted to be sitting on side of bed. Large skin tear actively bleeding noted to right lower leg. Measures 11 cm (centimeters) X 6 cm X 0.3 cm. Pressure applied. Area is too large for writer to approximate. CNA states thinks resident's leg may have got caught in recliner while transferring. MD (medical doctor) called, spoke with (Nurse Practitioner) and gave orders to sent to ED (Emergency Department). POA (Power of Attorney) called and coming to facility."</p> <p>R5's progress note, dated 3/15/2019 at 3:54 PM, documents, "right lateral calf wound assessed. 13 sutures in place to cane shaped skin tear. No signs and symptoms of infection. Minimal serous exudate noted. No abnormal redness noted. Dark purple bruising noted on inner edge (more distal left lateral calf). Denies pain or discomfort."</p> <p>On 6/25/19 at 11:26 AM, V20 stated, "I was getting (R5) out of the recliner in (R5's) room. I was the only staff present in the room. Before that (R5) was alone in room sitting in the recliner. R5 had feet outside the foot rest. I did not use a</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>gait belt for (R5). I put (R5's) feet back on the foot rest and lowered the foot rest. I helped (R5) to stand. It was a Friday and (R5) had been to dialysis. (R5) gets weak and tired after dialysis. (R5) wasn't able to take a step or pivot, but I finally was able to get (R5) on the bed. As I was transferring (R5's) right leg twisted and got caught in either the recliner or the bed. I didn't even know (R5) was hurt until R5's roommate screamed for me after I had stepped into R5's bathroom. The roommate pointed out (R5) was bleeding quite a bit. I called another (CNA) to get the nurse. The nurse came in and we sent (R5) out to the hospital."</p> <p>On 6/25/19 at 3:30 PM, V31, Medical Doctor, stated "I can definitively say that if the facility did not follow their policy or the care plan that it could have contributed to the injury to (R5). I would agree that the description of the transfer of (R5) would be consistent with the injury (R5) was seen at the emergency room for."</p> <p>2.) R7's Physician's Order Sheet (POS) for June 2019 includes the following diagnoses: Cellulitis Right Lower Limb, Lymphedema, and Use of Anticoagulants Related to Chronic Atrial Fibrillation.</p> <p>On 6/23/19 at 9:30 AM, R7 was seated at the end of the hall in wheel chair with a bulky bandage covering R7's right hand, which was purple above the bandage. R7 stated, "I got a skin tear this morning when they were taking me to the bathroom. I told the CNAs (Certified Nurse's Aides) to be careful, but I was holding on to the handles on the lift and they got too close to that metal plate on the door and my skin got torn."</p> <p>R7's progress note, dated 06/23/2019 on 6:20</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>AM, documents "CNA came to get writer. Stated (R7) had skin tear to right hand being transferred to toilet on sit to stand. Cleaned area and applied steri strips (skin closure strips) with a non stick pad and wrapped with gauze. Passed information on to first shift to notify POA(Power of Attorney) and Continue to monitor area."</p> <p>On 6/26/19 at 4:00PM, R16, Licensed Practical Nurse (LPN)/Wound Nurse, stated, "The skin tear to (R7's) right hand happened 6/23/19 on night shift. The CNA's were transferring (R7) to the bathroom with a sit to stand lift and bumped (R7's) hand on the door."</p> <p>The facility's policy "Safe Resident Handling Policy", revised June 2017, documents, "Residents who require limited assistance (contact, guard/stand-by) will be transferred with a gait belt." This policy also states "The specific method for transferring, repositioning, and mobilizing individual residents will be communicated to the nursing and care staff by ensuring this information is included in the residents care plan as well as on the (electronic) care tool that guides the resident care."</p> <p>(B)</p>	S9999		
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