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
	IL6005946	A. BUILDING: ______ B. WING ______	07/18/2019

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MCLEAN COUNTY NURSING HOME	901 NORTH MAIN NORMAL, IL 61761

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.3220f) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for

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further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These regulations are not met as evidence by:

Based on observation, interview and record review the facility failed to initiate a treatment for a pressure sore and failed to ensure pressure relieving interventions were implemented to prevent skin breakdown for six of seven residents (R52, R40, R63, R16, R59 and R83) reviewed for

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pressure sores in the sample list of 47 residents. These failures resulted in R52 developing a stage four pressure injury to R52's right heel and a stage three pressure injury to R52's left heel.

Findings include:

The undated Wound and Ulcer Guidelines policy states "The following prevention measures may be initiated to address pressure, moisture, friction, and/or shearing:" "Pressure reduction surface on bed/chair when indicated" "Turn and reposition at least every two hours" "Avoid positioning on an area of erythema or breakdown whenever possible" "Support heels on pillows or in splints" and "Limit time out of bed if needed."

The (seat cushion) Operations Manual dated July 2007 states "Precautions" "This product is designed to be used as a cushioning device to conform to a user's seated shape to protect skin tissue and aid in the preventions of tissue breakdown" and "Obstructions: DOT NOT place any obstructions between the user and the cushion because it will reduce product effectiveness."

The Mechanical Lift policy dated 5/1/19 states after transferring the resident "Remove the lifter."

The Wound and Ulcer Policy and Procedure policy dated 7/22/15 states "When a resident is found to have a wound or ulcer, either on admission of during their stay, the following will be completed by a licensed nurse" "Initiate the treatment protocol appropriate for the stage of ulcer or for the wound assessed" and "Notification of the physician, documenting, and initiating written and/or verbal orders of the physician."

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1. The Physician Order Sheet (POS) dated 4/18/19 through 7/16/19 documents R52 has diagnoses of Congestive Heart Failure, Diabetes, Chronic Kidney Disease and Peripheral Vascular disease. The Admission Minimum Data Set (MDS) dated 4/25/19 documents R52 is at risk for skin breakdown and that R52 has no pressure sores. The Admission MDS also documents R52 requires extensive assistance from staff for transfers and bed mobility. The Care Area Assessment dated 4/25/19 documents " (R52) requires staff assistance to move sufficiently to relieve pressure over any one site" "(R52) Confined to a bed or chair all or most of the time" and "(R52) Requires regular schedule of turning." R52's Care Plan updated 7/11/19 does not include a turning plan for R52.

The Progress Note dated 5/2/19 documents R52 has blisters to bilateral heels. The Physician Order Sheet (POS) dated 4/18/19 through 7/16/19 documents an order dated 5/2/19 which states "No Shoes." The 4/18/19 through 7/16/19 POS documents an order for staff to "float (R52's) heels when in bed." The Care Plan updated 7/11/19 documents an intervention for R52 of "BLE (bilateral lower extremity) heel protectors while in bed and in recliner" and "(R52) is not to wear (compression stockings) or shoes. (R52) may wear slipper socks and (pressure relieving) boots until blisters resolve on feet."

V27's (Wound Doctor) Progress Notes dated 5/9/19 documents "Suspect (R52) is getting pressure to heels when in bed and when in recliner so (R52) is going to use (pressure reducing boots) in both settings. V27's Progress Notes dated 5/23/19, 5/30/19, 6/6/19 and 6/13/19 document "(pressure reducing boots) boots to BLE when in bed. No closed heel shoes." V27's

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Progress Note dated 6/20/19 documents R52's right heel wound is a stage four pressure injury and R52's left heel wound is a stage three pressure injury.

The readmission Body Diagram dated 7/5/19 documents R52 was readmitted to the facility on 7/5/19 with an open areas to R52's medial buttocks measuring seven cm (centimeters) by two cm and six cm by two cm. The Treatment Administration Record dated 7/1/19 through 7/16/19 documents a treatment was not initiated for the wounds on R52's medial buttocks until 7/8/19. V27's Progress Note dated 7/11/19 documents R52's medial buttocks wound is a stage three pressure injury.

On 07/15/19 at 10:21 AM R52 was seated in the recliner chair with R52's feet on the foot rest and R52 was wearing closed back shoes.

On 07/16/19 at 08:47 AM, 10:56 AM, 11:40 AM R52 was seated in the wheelchair with the mechanical lift sling between R52 and the pressure relieving cushion and R52 was wearing closed back shoes.

On 7/16/19 at 11:40 V30 and V31 Certified Nurses Aides (CNA) used the mechanical lift to transfer R52 from the wheelchair to the bed. V30 and V31 removed R52's brief and completed perineal care. At that time R52's right hip and buttocks were red. After completing perineal care V30 and V31 left the room without placing R52's pressure relieving boots on R52's feet, with R52's heels resting on the bed.

On 7/16/19 11:50 am V30 CNA stated V30 and V25 CNA got R52 up in the wheelchair between 7:15 AM and 7:25 AM and R52 has been in the

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wheel chair since that time until R52 was transferred to the bed (11:40 am). V25 stated R52 had been in activities and therapy.

On 7/16/19 at 1:55 PM R52 was seated in the wheelchair with the mechanical lift sling between R52 and the pressure reliving cushion and R52 was wearing closed back shoes.

On 7/17/19 at 11:45 am V25 stated when R52 was admitted to the facility R52 wore pressure relieving boots. V25 stated V25 does not know why R52 stopped wearing the boots. V25 stated most days V25 puts shoes on R52. V25 stated V25 was not told R52 should not wear shoes.

On 7/17/19 at 1:00 PM V30 CNA stated V30 did not know R52 was not suppose to wear shoes.

ON 7/17/19 at 12:10 PM V2 Director of Nurses stated V2 would expect staff to follow the manufacturers guidelines for R52's seat cushion and would expect staff to have a plan in place to ensure R52 is repositioned every two hours around therapy and activities. V2 also stated V2 would have expected staff to contact the doctor for a treatment order for R52's medial buttocks wound when R52 returned from the hospital (7/5/19).

On 7/18/19 at 10:00 am V 22 Wound Nurse confirmed R52 was identified as at risk for skin breakdown when R52 was admitted to the facility (4/18/19). V22 stated V22 could not provide documentation that R52 had been on a repositioning program since R52 was admitted to the facility (on 4/18/19). V22 stated V22 usually adds a repositioning program to the care plan and then triggers the task to appear in the point of care (POC) computer system for the CNA staff so

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they know what to do and can sign off the tasks. V22 stated V22 missed adding the repositioning program program to R52's Care Plan. V22 stated V22 did not trigger the tasks of repositioning, pressure relieving boots and instructions that R52 should not wear shoes on the POC computer system so the tasks did not appear in POC for the CNA staff to complete.

On 7/17/19 at 12:30 PM V27 Wound Doctor stated that if the facility had carried out a plan to prevent R52's pressure sores when R52 was identified to be at risk for skin breakdown and R52 still developed the sores you could say they were unavoidable. If the plan was not carried out then they failed to prevent the development of the wounds or maybe the (right heel) wound would not have been as severe if the plan had been implemented. V27 stated that if interventions had been in place at the time R52 was identified as at risk for skin breakdown the wounds could possibly have been avoided. V27 stated the source of the right heel wound was pressure from the bed. V27 stated the outside of the heel is a common pressure area if residents are flat on their back. V27 also stated R52 should not be wearing closed back shoes.

2. R16's Physician's Order Report dated 7/17/19 documents R16's diagnoses including Pressure Ulcer of the Right Buttock.

R16's Care Plans dated 6/26/19 document R16 is at risk for impaired skin integrity and is to use a pressure relieving cushion to the wheelchair and an air mattress on R16's bed.

On 07/15/19 at 10:22 AM R16 was up in the wheelchair with R16's mechanical lift sling under R16 over top of R16's pressure relieving cushion

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in R16's wheelchair.

On 07/15/19 at 12:08 PM R16 was sitting up in R16's wheelchair in the dining room with the mechanical lift sling under R16 over top of the pressure relieving cushion.

On 07/16/19 at 12:00 PM R16 was sitting up in the wheelchair with the mechanical lift sling under R16 on top of the pressure relieving cushion.

On 07/16/19 at 02:57 PM R16 was laying in bed with a thick fabric incontinence pad under R16 over top of R16's air mattress.

On 7/17/19 at 01:00 PM V32, Licensed Practical Nurse (LPN) performed cares for R16. R16 was in bed in R16's room with a fabric incontinence pad under R16 over top of R16's pressure relieving alternating air mattress as well as on top of R16's bedding. V32 did not remove any of the extra bedding/linen after providing cares.

3. R40's Minimum Data Set (MDS) dated 4/11/19 documents R40 is at risk of developing pressure ulcers.

R40's Care Plans document R40 is at risk for impaired skin integrity due to incontinence, limited mobility and diagnosis of Diabetes. These Care Plans document R40 is to have a gel/foam cushion to wheelchair to relieve pressure.

On 07/15/19 at 09:06 AM there was a sign in R40's room, documenting R40 is to have pressure reducing boots to bilateral lower extremities at all times located on the wall across from R40's bed. At this time, R40 was sitting at the nurses station with the mechanical lift sling under R40 over top of the pressure relieving

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cushion. R40 did not have boots on at this time.

On 07/15/19 at 09:38 AM R40 was in bed and did not have pressure reducing boots in place.

On 07/15/19 at 11:37 AM No pressure reducing boots to R40's bilateral lower feet.

On 07/15/19 at 12:15 PM R40 was up in the hall in R40's wheelchair with the mechanical lift sling under R40 over top of the pressure relieving cushion in the seat of R40's wheelchair. R40 did not have pressure reducing boots in place.

On 07/16/19 at 11:03 AM R40 was in bed and did not have pressure reducing boots on.

On 07/16/19 at 11:40 AM R40 was up in the wheelchair in the hall without R40's pressure relieving boots on R40's feet. R40's mechanical lift sling was under R40 on top of R40's pressure relieving cushion.

On 07/17/19 11:00 AM R40 in bed, pressure relieving boots are on at this time. Per V29, Certified Nursing Assistant (CNA), R40 requires these boots for pressure ulcer prevention.

4. R59's Minimum Data Set (MDS) dated 5/29/19 documents R59 is at risk for pressure ulcers and uses a pressure reducing device for R59's chair and bed.

On 7/17/19 at 10:27am, R59 was in bed with a thick fabric incontinence pad under R59's buttocks over R59's pressure reducing air mattress. V36, Registered Nurse (RN) turned R59 to R59's side to observe R59's coccyx/buttocks area per request. V36 stated R59's coccyx area was reddened at this time and

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S9999	Continued From page 10 R59's coccyx was observed to be reddened at this time. 5. R63's Physician's Order Sheet (POS) for July 2019 includes the following diagnoses: Chronic Kidney Disease, Urinary Tract Infection, Other Iron Deficiency Anemias, Other Hemoglobinopathies, Chronic Obstructive Pulmonary Disease, unspecified,Pressure Ulcer of Left Lower Back, Unstageable, Nasal congestion, Hypertension, Type 2 Diabetes Mellitus, R63's "Resident Face Sheet printed 7/17/19 documents R63 was admitted to the facility 2/6/19. R63's Braden Scale dated 3/7/19 scored R63 as "at risk" R63's "Skin Wound Report" dated 2/17/19 by V22, Wound Nurse documents R63 had a deep tissue pressure injury to Left upper buttock/lower back. The wound is documented as measuring 1.0 centimeters by 1.0 centimeters by 0.1 centimeters. Interventions documented on R63's wound report include pressure reducing device for chair, pressure reducing device for bed, reposition every 2 hours and as needed, and moisture barrier. R3's Care Plan documents an entry dated 2/8/19 "(R3) has a stage IV pressure ulcer to left lower back related to limited mobility, weakness, and pain. Use gel/foam pad in wheel chair for pressure reduction, comfort, and positioning. Roho cushion." V27, Wound Physician's wound evaluation dated 7/22/29 documents "Stage IV pressure wound of greater than 135 days duration on R63's Left lower back measuring 0.8 centimeters by 0.5 centimeters by 1.7 centimeters with 2.5 centimeters of undermining and moderate serous exudate (drainage)." V27 recommends a "Roho" cushion.	S9999		

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On 7/15/19 at 9:30AM R63 is in room sitting in wheelchair. There is a Roho cushion in the wheelchair, but it is almost completely deflated. on 7/18/19 at 9:18AM R63 was transferred from wheel chair to bed. The roho cushion was in the wheel chair but was almost completely deflated. The manufacturer's "Precautions" provided by the facility for the Roho cushion state "Check your product every day and frequently while using. Under-inflation Do not use an under-inflated cushion. Using a cushion that is under-inflated reduces or eliminates the cushion's benefits increasing risk to skin and soft tissue."

On 7/18/19 at 10:00 V22 Wound Nurse states I check the Roho cushions every few days for inflation. I just do it when I get a chance. There isn't a schedule of documentation, I just do it when I get a chance. (R63's) cushion wasn't completely flat."

6. R83's face sheet printed 7/17/19 includes the following diagnoses: History of Cellulitis of the Left Leg, Muscle Wasting and Atrophy, Cerebral Infarction, and Bipolar Disorder.

R83's Care Plan dated 2/20/29 documents "(R83) is at risk for impaired skin integrity related to limited mobility, incontinence, and pain. R83's care plan entry dated 7/17/19 documents "Bilateral left extremity heel protectors on at all times except during cares."

On 7/15/19 at 9:45AM R83 is sitting in room in wheel chair alone. Heel protectors are lying on the unused bed in R83's room. There was a mechanical lift sling left between R83 and the cushion in R83's chair.

On 7/16/19 at 4:00 PM V13, Licensed Practical

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S9999	Continued From page 12 Nurse (LPN) checked R83's heels. There was a callous approximately one inch in diameter. R83's left heel had a calloused area with a pin point black spot to the center. V13 stated "The black spot is new." R83's heel protectors were in a chair in R83's room. On 7/16/19 at 4:10 PM V2, Director of Nursing stated "There is a small dark area on R83's heel. We are getting an order to start skin prep." On 7/16/19 at 4:15PM V22, Wound Nurse stated "I think the area on (R83's) left heel is just a callous." (B)	S9999		