| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6005649 | A. BUILDING: _____ B. WING _____ | 09/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACOMB POST ACUTE CARE CENTER | 8 DOCTORS LANE MACOMB, IL 61455 |

| (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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| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)5)<br>300.1210d)6)<br><br>Section 300.1210 General Requirement for Nursing and Personal Care<br><br>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:<br><br>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.<br><br>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:<br><br>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.<br><br>These regulations are not met as evidenced by: | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>Based on observation, interview and record review, the facility failed to ensure fall prevention interventions were implemented and adequate supervision was provided to prevent an intravenous line from being dislodged for one (R1) of four resident reviewed for accidents and incidents in a sample of seven.<br><br>Findings Include:<br><br>The facility's "Comprehensive Care Plan" policy dated 6/25/20, documents "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 3. Each resident Care Plan has been designed to: b. Incorporate risk factors associated with identified problems."<br><br>On 9/14/21, 9/15/21 and 9/16/21, multiple observation throughout the day of R1's room. R1's door remained closed during these frequent observations.<br><br>R1's medical record dated 8/18/21 document "Noted to have pulled PICC (peripherally inserted central catheter) in left upper arm out. Pressure dressing applied. Denies pain or discomfort at this time. Patient alert to self, unaware of surroundings, pleasant, fidgeting. Short term memory deficit noted when ask several questions concerning her and her situation; most answers are simple with happy and confused responses. Physician made aware of patient condition and said he would contact physician that placed PICC."<br><br>R1's medical record dated 8/27/21 documents | S9999 | | |

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| S9999 | Continued From page 2 | S9999 | | |

"(R1)'s IV (intravenous) Vancomycin was administering, and she pulled on tubing dislodging PICC line from arm. 25 cm (centimeter) catheter with tip intact noted on floor. Applied pressure dressing to right upper extremity for protection to site. Notified medical doctor and awaiting return call."

On 9/16/21 at 10:40 AM, V6, Care Plan Coordinator (CPC) stated, "(R1) was not admitted to us with PICC line. She had it placed on 8/17/21 but wound up pulling it out on 8/18/21. Then she had a second PICC line placed but wound up pulling that one out which did not get replaced. We didn't have any interventions in place to address (R1) pulling out her PICC line when the second PICC line was placed after she pulled it out the first time. Yes, she pulled the PICC line out twice. We should have addressed it more clearly on her Care Plan."

R1's CNA (Certified Nursing Assistant) point of care (POC) documentation dated September 2021, documents R1 to be on monitor checks every two hours. R1's POC documents R1 was checked on 9/9/21 at 9:48 AM with the next check being at 3:32 PM.

R1's medical record dated 9/9/21 at 3:45 PM, documents "Family notified nurse of this resident lying between bed and wheelchair."

R1's Fall investigation dated 9/9/21 documents R1's family member finding R1 on the floor and notifying the nurse of the fall at 3:32 PM with no injuries noted.

On 9/16/21 at 9: 30 AM, V6 (CPC) verified R1 was moved closer to the nurses' station for easier monitoring due to R1's restlessness, confusion

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| S9999 | Continued From page 3<br>and previous falls. V6 stated, "(R1) has a lot of confusion. She fidgets with her lines, clothing, climbs out of bed and when I was a CNA taking care of her one day, she was messing with her bowel movement thinking it was someone else's."<br><br>On 9/16/21 at 10:20 AM, V6 verified R1 is a two-hour check with no documentation confirming R1 was checked every two hours and stated, "I spoke to the activities director about 9/9/21, even though she documented she did a one on one activity with (R1) at 2:59 PM, she said she was actually in the room earlier that day before lunch and just charts everyone at the same time before shift change. So, I don't have documentation confirming she (R1) was checked after therapy left her room around 1:00 PM and before the family found her at 3:32 PM."<br><br>On 9/16/21 at 11:34 AM, V1 (Administrator) verified R1's door remained closed throughout the day and stated, "We were told by regional that anyone in isolation should have their door closed. The door being closed is in our COVID-19 policy, but (R1) is in contact isolation for her C-Diff (Clostridium Difficile). However, we were still directed to have all isolation doors closed. We don't have a policy that addresses the two-hour resident checks. It's a standard of practice and it's part of the CNA charting."<br>(C) | S9999 | | |