STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000939	A. BUILDING: _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANAGAN REHABILITATION & HCC	201 EAST FALCON HIGHWAY FLANAGAN, IL 61740

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S 000	Initial Comments Facility Reported Incident #IL134590 Complaint Investigation #2163893/IL134623	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210 d)5) 300.3240a) 1 of 2 300.1210 d)5) General Requirements for Nursing and Personal Care 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. 300.1210 b) General Requirements for Nursing and Personal Care 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 300.3240 a) Abuse and Neglect 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 findings are not met as evidenced by: Based on interview and record review the facility failed to complete wound assessment/treatment per facility policy for one resident (R4) of four residents reviewed for wounds in a sample list of six residents. This failure resulted in R4 developing an abscess and sepsis requiring surgical intervention, treatment and hospitalization. Finding Include: R4's Braden Scale skin risk assessment dated 4/26/21 documents R4 is at high risk for skin breakdown related to her skin being "constantly moist", "slightly limited sensory perception", "chair fast", "potential problems with friction and shear", and "very limited mobility." R4's Care Plan documents a problem dated 4/26/21 stating "Fragile Skin. Prone to bruising and/or skin tears. R4's High Skin Risk is not otherwise documented as addressed on R4's Care Plan. R4's Care Plan dated 4/26/21 documents "Weekly Skin Checks Document Results." The facility's policy "Pressure Sore Prevention Guidelines" dated January 2018 requires daily skin checks and documentation of skin condition for all residents assessed at high risk for skin	S9999		

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breakdown per the Braden scale. R4's Treatment Administration Record (TAR) for April and May 2021 document weekly skin checks, but R4's skin condition is not documented as per facility policy.

R4's "AIM For Wellness" document created by V7, Licensed Practical Nurse (LPN) on 4/30/21 at 12:00PM documents "CNA (Certified Nurse's Aide) notified nurse that (R4) had an abrasion to buttocks/Sacral area. (R4) has had this condition before a few times in past. Area assessed/cleaned. Duoderm with medihoney applied." R4's TAR for April 2021 includes this treatment order which is signed off as completed on 4/30/21 by V7. This same treatment is not documented on R4's TAR for May 2021 and there is no documentation to indicate the treatment was done after 4/30/21. R4's Skilled Progress Notes after 4/30/21 do not include a skin assessment.

On 6/8/21 at 1:20PM V8, Certified Nurse's Aide (CNA) stated "I took care of (R4) a few times the week she went to the hospital. She had a bruised hip. I've been doing this for almost 20 years (CNA work). (R4's) butt did get red at times because she was always wet. She dribbled urine almost constantly."

On 6/8/21 at 2:30PM V7 stated "I kind of remember 4/30/21. The CNA (can't remember which one) told me (R4) had an open area on her sacrum." V7 pointed to an area above her tail bone in the mid back. "I notified the doctor and got treatment orders. I started the treatment. I did not get measurements. It was probably the size of a quarter. It looked red and the top layer of skin was off. I'm not really sure what happened after that."

R4's "Shower/Abnormal Skin Report" dated

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5/6/21 by V13, Certified Nurse's Aide (CNA) documents "Findings Skin breakdown" An anatomical drawing documents the "area of abnormality" as the coccyx area of the buttocks. V10, Licensed Practical Nurse (LPN) signed off on this form dated 5/6/21. No skin assessment is documented. No treatment is documented as initiated.

On 6/9/21 at 10:58AM V13, Certified Nurse's Aide (CNA) stated "I did document on (R4's) shower sheet 5/6/21 she had an open area in the middle of her buttocks. It was open, very red, and raw. I gave the shower sheet to (V10) I didn't see the nurse check (R4's) buttocks."

R4's "AIM For Wellness" document created by V10, Licensed Practical Nurse (LPN) on 5/30/21 at 8:45PM documents "At 7:30PM (R4) noted to be confused and shaky. incomprehensible speech. Pupils dilated to three millimeters and do not react to light. Unable to follow simple commands."

On 6/8/21 at 2:45PM V10 stated "Yes that is my signature on the (5/6/21) shower sheet. I honestly don't remember the CNA telling me about an open area or signing the shower sheet. I found (R4) to be unresponsive on 5/30/21. I immediately called the doctor and got her transferred to the hospital. I'm not sure what happened after that."

On 6/8/21 at 12:30PM V3, Care Plan Coordinator checked the records of the contracted wound doctor utilized by the facility. V3 stated "there is no record that (R4) was ever seen by the wound doctor."

On 6/8/21 at 1:00PM V1, Director of Nursing

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S9999	Continued From page 4 (DON) stated "I was aware that we had some failure of staff to follow through with skin documentation for (R4). This was addressed in morning meeting and I am in the process of determining where the breakdown occurred and taking steps to prevent it from happening again. It is being looked at by our Quality Assurance/Quality Assessment committee." R4's nurse's note by V16, Emergency Room Nurse dated 5/30/21 at 11:00PM documents "Black colored wound noted to Right buttocks. Erythema (redness) noted around wound." R4's hospital note by V7, MD (Facility medical Director) documents "The patient (R4) comes in with the high fever, acute mental state change and was found to have a Urinary Tract Infection, sepsis, and abscess in the right buttock. The patient is a resident of (the facility). She had acute mental state change, most likely metabolic encephalopathy. Was brought over to ER (Emergency room) where she was found to have a temperature 103.7. Urinary Tract Infection (e-coli positive). We later found she has positive blood cultures (staphylococcus hominus positive) and also an abscess in the right buttock (Methicillin Resistant Staphylococcus Aureus positive). On 6/9/21 at V14, Medical Doctor, the surgeon who incised and drained R4's Right buttock abscess stated "The wound on (R4's) buttocks was not new. It definitely had been there at least several days. I removed a lot of pus and dead tissue. The wound was definitely the cause of the sepsis. The Urinary Tract Infection complicated (R4's) condition too. I can't say for sure that this wound was pressure related, the buttocks are a pressure point and pressure would certainly have	S9999		

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aggravated it. The wound should have been apparent for some time as it would have caused pain, redness, and the area most likely would have been hard."

The facility's policy "Pressure Sore Prevention Guidelines" dated January 2019 includes a grid that documents daily skin checks for residents identified by a Braden Scale skin risk assessment as high risk. Under "Comments" this policy states "Follow Protocol for coding skin condition C-clear, R-red, O-other, P-pressure, S-skin tear. Any area that doesn't resolve after 30 minutes after pressure is relieved must be documented as Stage I." This policy also states "Any resident scoring High or Moderate for skin breakdown will have scheduled skin checks on the Treatment Record. Skin checks will be completed and documented by the nurse."

(A)

2 of 2

300.610a)
300.1210 b)5)
300.1210 d)6)

300.610 Resident Care Policies

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

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S9999	Continued From page 6 by this committee, documented by written, signed and dated minutes of the meeting. 300.1210 b)5) General Requirements for Nursing and Personal Care 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. 300.1210 d)6) General Requirements for Nursing and Personal Care 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 300.1210 d)5) General Requirements for Nursing and Personal Care 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.	S9999		

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S9999	Continued From page 7 These findingss are not met as evidenced by: Based on interview and record review the facility failed to assess for the use of an electromechanical lift chair and develop and implement targeted resident centered interventions for one resident (R1) of four residents reviewed for falls in a sample list of six residents. This failure resulted in R1 using the remote control to lift herself and fell to the floor sustaining a fracture of her right femur. Findings include: R1's Physician's Order sheet for May 2021 includes the following diagnoses: History of Falls, General Weakness, and Anxiety. R1's Minimum Data Set (MDS) dated 4/6/21 documents R1 is totally dependant for transfer with the need for the assistance of two or more staff and R1's balance in not steady without staff assistance. R1's Care Plan dated 4/6/21 documents R1 has "Potential for Falls. Risk factors include: Unsteady Balance, Increased Weakness, and (R1) has history of falls." R1's Care Plan Intervention dated 4/7/21 documents "Insure adaptive devices (Walker/Wheel Chair) are within reach and in good repair." An electric lift chair is not documented in R1's Care Plan. No assessment is documented for the safe use of an electric lift chair. R1's progress note dated 5/20/21 at 8:00AM	S9999		

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documents "Continues with confusion. Alert X (times) 1 (Alert to self only). Treated for Urinary Tract Infection." R1's progress note dated 5/21/21 at 9:00AM documents "Alert X1. Confusion continues." R1's Progress note dated 5/22/21 at 9:00AM documents "Alert and Oriented X1 confusion continues." R1's progress note dated 5/23/21 at 10:00PM documents "(remote audio) monitor remains in place related to increased confusion." There is no documentation to indicate a fall assessment was completed to address this change in R1's mental status.

R1's progress note dated 5/24/21 at 3:15PM documents "Heard shuffle on monitor. Resident raised chair to up position. Resident observed on floor in front of chair. No apparent distress. Resident had no initial complaints. Assessed per staff. (Mechanical lift) assisted to bed. External rotation and shortening noted." The progress note goes on to document doctor was notified and an X-ray was performed.

R1's X-Ray of right hip dated 5/24/21 at 5:28PM documents "Impressions: Displaced Oblique Right Femoral Fracture."

R1's progress note dated 5/24/21 at 6:00PM documents "Orders received and (R1) sent to (local hospital)."

A hand written note dated 5/28/21 is documented on R1's care plan stating "Observed on floor. Sent to Emergency Room for evaluation. Hip Fracture. Upon return the following will be implemented: 15-minute checks, Removal of Lift Chair."

On 6/7/21 at 10:20AM V3, Registered Nurse (RN) Care Plan Coordinator (CPC) stated. "I was the

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nurse on duty the afternoon (R1) fell. R1 had been experiencing a recent decline. (R1) had been confused for a few days prior to the fall, but (R1) was having a good day that day. (V4,)Certified Nurse's Aide (CNA) and I put (R1) in her electric recliner. We gave (R1) the remote to the chair and her call light. Since (R1) had been having some confusion we even had a baby monitor in (R1's) room. (R1) had been having some respiratory signs and symptoms so she was on the "yellow" unit for precautions. We went back the room we use to chart and put on personal protective equipment. We heard a shuffling sound on the baby monitor and went in (R1's) room. The lift chair was in the high position and (R1) was lying in front of her chair. She was kind of tangled up in her over the bed tray. We used a (mechanical lift) to get her up. She didn't seem to be in much pain, but her leg was slightly shortened and rotated out. I got an order for an X-Ray and her femur was fractured. (R1) went to the hospital and was seen by the Orthopedic group. The family has decided not to have (R1) return here."

On 6/7/21 at 10:30AM V2, Director of Nursing (DON) stated "(R1) had been having some issues with respiratory problems recently and had been somewhat more confused than her baseline, but we thought she was improving the day the fall occurred (5/24/21). (R1) had the electric lift chair since she was admitted. It was hers. We do not have an assessment for electric lift chairs. (V3 and V4) are the only witnesses to the fall. "

On 6/7/21 at 11:40AM V4, CNA verbalized the same chain of events as V3. V4 stated We thought (R1) was better and we gave her the remote to the automatic chair. Then the next thing we knew we were in the charting room and

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S9999	Continued From page 10 we heard a commotion on the baby monitor and when we went in we found (R1) kind of tangled up in her tray table. We got her up with the lift and (V3) noticed her leg didn't look right and I hear she broke her hip." V5, Orthopedic Surgeon who treated R1 following fall supplied an electronic message to V15, Physician's Assistant (PAC) on 6/9/21 at 11:37AM stating "History provided was that (R1) had a mechanical lift chair and lifted to reach a remote and may also have reached forward to reach; This is documented in Emergency Room Intake Notes/History and Physical and Orthopedic Consult Notes. The resultant fall resulted in a femur fracture and Orthopedics was consulted as a result." The facility's policy "Fall Prevention" dated December 2009 states "1. Conduct fall assessments on the day of admission, quarterly, and with a change of condition. 2. Identify, on admission, the residents risk for falls. A visual prompt may be placed on the plaque by the entrance to the resident's room. If used any assistive device such as a walker or cane will be identified with the same visual prompt to match the prompt at the entrance to the room." (A)	S9999		