

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>
--	---

(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
S 000	Initial Comments	S 000		
	Annual Licensure			
S9999	<p>Final Observations</p> <p>Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b)4) 300.1210 c) 300.1210 d)1)3) 300.1210 d)5)</p> <p>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.</p> <p>Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of</p>	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

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

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>
--	---

(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	<p>Continued From page 1 notification</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.</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>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>		
(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	<p>Continued From page 2</p> <p>determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to follow physician orders for 2 of 7 residents(R17, R41) and failed to follow care plan interventions for 1 resident (R7) to prevent a pressure ulcer for 3 of 7 residents (R7, R17, R41). The facility failed to ensure infection control practices were implemented during care for 1 of 7 residents (R7) reviewed for pressure ulcers in a sample of 21. This failure resulted in R41 acquiring multiple stage 2 pressure ulcers.</p> <p>Findings include:</p> <p>The facility's Decubitus Care/Pressure Areas policy, revised 1/18, documents that it is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. The pressure ulcer area will be assessed and documented on the TAR (Treatment Administration Record) or the Wound Documentation Record. Document size, stage,</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>
--	---

(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	<p>Continued From page 3</p> <p>site, depth, drainage, color, odor, and treatment (upon obtaining from the Physician). Notify the Physician for treatment orders. Documentation, of the pressure area must occur upon identification and at least once each week on the TAR or Wound Documentation Form.</p> <p>1. R41's TAR, dated 3/1/21 through 3/31/21, documents to cleanse R41's coccyx with normal saline, pat dry, apply duoderm (hydrocolloid dressing), and change every 3 days, as a preventative treatment.</p> <p>R41's Braden Scale for Predicting Pressure Ulcer Risk, dated 3/18/21, documents that R41 is high risk for pressure ulcers.</p> <p>On 3/30/21 at 11:40 am, R41 was assisted to the bathroom by V8 CNA (Certified Nursing Assistant) and V6 CNA. At this time, V6 and V8 verified that R41 did not have a dressing on his coccyx. R41's wound on his coccyx had an open area 2 cm (centimeters) by 1 cm. The center of the wound was yellowish in color and the surrounding tissue was red and inflamed. V6 stated that she was going to tell V5 LPN (Licensed Practical Nurse) that R41's dressing was off his coccyx.</p> <p>On 3/30/21 at 12:40 pm, V5 LPN stated that she was not told that R41 had an open area on his coccyx or needed a new dressing.</p> <p>On 3/30/21 at 1:00 pm, R41 stated that no one had been in to apply a dressing to his coccyx.</p> <p>On 3/31/21 at 10:00 am V1 Administrator stated that R41 does not have an open area to the coccyx, and the dressing is in place as preventative measure. V1 verified that she was not notified of R41's open area on 3/30/21.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>		
(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	Continued From page 4  03/31/21 10:30 am, V11 RN (Registered Nurse) stated that R41 does not have any measurement for a wound because the treatment was supposed to be preventive. V11 RN stated that the facility was not aware that R41's wound was open. V11 RN and V12 LPN assisted R41 back to bed. R41 did not have a preventative dressing on his coccyx at that time. R41 stated that he has not had a dressing on his coccyx for a few days. V11 RN verified that R41's dressing was not in place, and that R41 now had 6 separate pressure ulcers on his coccyx in a crescent shape. V11 RN measured the six areas, the top number one wound measured 2.1cm by 1.5cm, the second measured 0.8cm by 0.4cm, the third measured 1 cm by 1.2 cm, the fourth measured 1 cm by 1 cm, the fifth measured 0.9 cm by 0.5 cm and the sixth measured 1 cm by 0.8cm. V11 RN stated that the first and third wounds have slough in the center and the surrounding tissue is red and inflamed. V11 RN stated that R41's Physician had not been notified.  2. R7's current TAR documents to cleanse the coccyx with wound cleanser, pat dry, apply hydrogel (medicated cream) and cover with a dry dressing daily and as needed. R7's current care plan documents that R7 is to be turned and repositioned every hour.  R7's Braden Scale for Predicting Pressure Ulcer Risk documents that R7 is at high risk for pressure ulcers.  On 3/29/21 at 10:00 am, R7 was lying in bed on her right side facing the wall. At 10:30 am, R7 remained facing the wall, and at 11:00 am R7 remained in the same position on R7's right side. On 3/30/21 at 7:30 am, R7 was in bed lying on	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>
--	---

(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	<p>Continued From page 5</p> <p>her right side, facing the wall. From 7:30 am to 11:45 am, R7 remained in the same position. On 3/31/21 from 7:30 am to 11:00 am, R7 was in bed on her right side facing the wall.</p> <p>On 03/30/21 11:50 am, V9 CNA removed R7's soiled dressing from the coccyx. V9 CNA cleansed the wound with a clean washcloth then cleansed the feces and moved the contaminated washcloth with the feces into R7's open wound. R7's wound measured 2.0 cm by 2.2 cm round, center was yellowish and surrounding tissue was fiery red. V9 CNA verified that she should not have touched the open wound with the washcloth contaminated with feces. V9 CNA and V6 CNAs stated that R7 is turned and repositioned every two hours. Both V9 CNA and V6 CNA stated that they were not aware that R7 was supposed to be repositioned every hour.</p> <p>On 3/30/21, V5 LPN verified that V9 CNA should not have moved the washcloth containing feces into R7's wound during incontinence care.</p> <p>3. R17's Weekly Wound tracking, dated 3/2021, documents that R17 has a Stage II pressure ulcer to R17's left ischium that measures 1.5 cm (centimeters) x 0.1 cm x 0.3 cm, and a Stage II pressure ulcer on R17's coccyx that measures 0.1 cm x 0.1 cm x 0.2 cm.</p> <p>R17's Wound Care Provider Orders, dated 3/19/21, document the following orders: Lidocaine 2% topical gel applied to wound 10 minutes prior to procedure. Left ischium collagen double layered and covered with a mepilex (silicone border foam) dressing changed daily. Coccyx apply hydrogel and cover with a mepilex silicone border foam dressing daily.</p> <p>On 03/30/21 at 09:08 am, V4 LPN removed a silicone border foam dressing from R17's left</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2021</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KEWANEE CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>144 JUNIOR AVENUE KEWANEE, IL 61443</b>
--	---

(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	<p>Continued From page 6</p> <p>ischium and a border gauze dressing from R17's coccyx. R17's left ischium had round open area with depth. V4 LPN cleansed the area with normal saline, folded a piece of collagen and packed into wound. R17 said "Ouch" while V4 LPN was packing the wound. R17's coccyx had a small irregular shape open area covered in white tissue. V4 LPN cleansed R17's coccyx with normal saline, applied hydrogel to the wound bed, and covered both wounds with a silicone border foam dressing. Barrier cream applied to reddened peri wound areas. V4 LPN stated the reddened areas are irritation related to the use of regular gauze tape. No Lidocaine was applied to R17's wound prior to wound care.</p> <p>On 03/30/21 at 09:24 am, V4 LPN stated, "I removed a border gauze dressing from R17's coccyx, and it should have been a silicone border foam dressing. R17 is supposed to have Lidocaine applied to the areas prior to wound care and I did not do that."</p> <p>On 03/30/21 at 09:33 am, R17 stated, "Both of my wounds are in bad places, right on a bony spot. It's sore because of that and hard to heal. I'm supposed to get Lidocaine before they do the treatments. When I said ouch, it was a sharp stabbing pain when she packed it with that stuff. The treatment isn't comfortable."</p> <p>(B)</p>	S9999		
-------	---	-------	--	--