

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006779	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/29/2023
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NAME OF PROVIDER OR SUPPLIER OAK LAWN RESPIRATORY & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 9525 SOUTH MAYFIELD OAK LAWN, IL 60453
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S 000	Initial Comments Complaint Survey: 2397932/IL164718, 2397948/IL164734 & 2397988/IL164784	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 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	S9999	Attachment A Statement of Licensure Violations	

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

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</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>These Requirements were not met as evidenced by:</p> <p>Based on interviews and records reviewed the facility failed to follow their policy to prevent or determine an injury of unknown origin. This affects one of three residents (R1) reviewed for injury of unknown origin. This failure resulted in (R1) being found with a change in skin pigmentation and sent to the hospital for an evaluation and admitted with a hip wound consistent with a second degree burn.</p> <p>The findings include:</p> <p>R1's diagnosis include but are not limited to Hemiplegia Affecting Right Dominant Side, Dementia, Contracture Left Hand, Hypertension, Cognitive Communication Deficit, Adult Failure to Thrive, and Need For Assistance with Personal Care. R1 is severely cognitively impaired. R1 is African American.</p> <p>On 9/27/23 at 9:47AM V11, Certified Nursing Assistant (CNA) said I worked night shift on</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>9/22/23. V11 said at 11:00PM I saw R1, she was dry and asleep. V11 said at around 12:00PM -12:30PM the nurse did rounds and came and told me R1 was wiggling and wet so I went to change her. V11 said when I pulled the covers I saw it on her hip, before I took off the diaper. V11 said It looked like a burn to me. V11 said it was puffed up, round, white, and around the diaper had blood on the side. V11 said I told the nurse to come look.</p> <p>On 9/27/23 at 5:03PM V3, Nurse, said stuff happens and no one had told me anything. V3 said I came in at 7:00PM on 9/22/23. V3 said I went in to see R1 and saw a circular area, no blood, a white patch, and no signs of distress. V3 said the area was about the size of a hand. V3 said I didn't call anyone on the night shift, because I didn't see her in distress and I didn't know if she already had it.</p> <p>On 9/27/23 at 9:11AM V5, CNA, said when I left at 11:00PM on Friday 9/22/23 R1 did not have a mark. V5 said when I came in on Saturday 9/23/23 morning the CNA asked me if I knew about the mark. I said no. V5 said I saw the spot, it looked like her skin turned white and I could see pigment spots of her skin on it.</p> <p>On 9/26/23 at 11:02AM V1, Wound Nurse, said the Director of Nursing (DON), told me to check R1 on 9/23/23. V1 said I saw a discoloration, white patch the size of a pear, no drainage, not puffy, and not open. V1 said R1 did not have a history of pressure ulcers. V1 said R1 was sent to the hospital for evaluation. V1 said we didn't understand what it was. V1 said "looked like they rubbed her with bleaching cream." V1 said I don't know what it was, I don't know what they were using on her.</p>	S9999		
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S9999	Continued From page 3 On 9/27/23 at 10:00am V12, Registered Nurse, said the DON called the facility and asked me to call the hospital and ask about R1. V12 said, I initially was told by the nurse she was admitted for burns. The nurse asked me to call back. V12 said I was confused when I checked the chart I saw she was very dependent on staff. V12 said I told the DON and she said call them back. V12 said then I was told by the nurse, the family did not want the hospital to disclose any information to us. On 9/27/23 at 10:13AM V9, DON, said the clerk spoke to me and said R1's daughter needed the wound nurse. V9 said this call happened around 11:00AM. V9 said the area appeared Saturday morning. V9 said the conclusion is that this is was a skin discoloration, not a wound. V9 said the nurse should have told me about it. V9 said no one mentioned a burn to me, I don't know what it was. V9 said an injury of unknown injury is when something happened that was not witnessed and we don't know what happened. V9 said we would document that on an incident report. V9 said from midnight until the wound nurse saw it, we don't know what it was. On 9/27/23 at 11:30AM V7, Administrator, said I was aware the wound nurse said it was not a wound on R1. V7 said the family insisted calling the police and going to the hospital. V7 said I have not looked at camera footage for the care of R1. R1's progress notes dated 9/24/23 6:30AM written by V3 states general report from CNA that R1 has a wound. "Not sure if it was an old wound." Endorsed to the next nurse that left hip "missing skin".	S9999		

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S9999	<p>Continued From page 4</p> <p>R1's progress notes dated 9/23/23 at 12:39PM written by V1 states writer made aware on 9/23/23 of intact, discolored skin patch on left hip. 15 x 8.5, size of large pear-shaped diamond, surrounding area small non raised reddish dots. Patch has small block of petechia.</p> <p>R1's functional States dated 8/12/23 notes R1 requires extensive assistance with bed mobility and dressing. R1 requires total dependence with transfer and toilet use.</p> <p>R1's care plan indicates R1 is has allegation of abuse. Goal sates R1 will be treated with respect, dignity, and reside in the facility free of mistreatment. R1 is at risk for alteration in skin integrity.</p> <p>R1's hospital records dated 9/23/23 states: left hip wound concerning for second degree burn 8x10cm area of white leathery discoloration consistent with a second degree burn located on the left lateral hip and extends posteriorly. Due to concerns for patient safety and elder abuse, plan to admit.</p> <p>The facility had no incident report or documented investigation to explain the left hip area observed on R1.</p> <p>The facility Abuse Prevention Program revised 1/2019 states For resident injuries not involving an allegation of abuse or neglect, the administrator will gather facts to decide whether the injury should be classified as an injury of unknown injury.</p> <p>Abuse Prevention Program states if the injury is classified injury of unknown origin the time</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>frames for reporting and investigating abuse will be followed. All incidents will be documented, whether or not abuse occurred, alleged or suspected. The charge nurse must complete an incident report. All staff must report any incident of resident abuse.</p> <p>The facility undated Incident/Accident/ Falls policy states The incident report will be completed as information is obtained. The occurrence will be documented. Some occurrences will require a more extensive investigation. Including skin tears and bruises.</p> <p>(B)</p>	S9999		
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