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GROVE AT THE LAKE LIVING AND REHABILIT.	2534 ELIM AVENUE ZION, IL 60099

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S9999	Final Observations Statement of Licensure violations 300.610a) 300.1210b) 300.1210d)6) 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 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: 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:	S9999		

Attachment A "Statement of Licensure Violations

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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.

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 requirements were not met as evidenced by:
Based on interview and record review the facility failed to protect a resident (R2) from sustaining a blister during transportation with liquid oxygen. The facility also failed to provide supervision and application of preventative devices to prevent injury from fall for R1 and R4.
This applies to three of three residents reviewed for falls and incidents (R1, R2, and R4) from a total sample of four.
As a result, R2 sustained two blisters (left interior thigh and right interior thigh) that became infected and required intravenous antibiotic therapy.

The findings include:

1. R2 has multiple medical diagnosis from the December 2014 physician order sheet, including encephalopathy, heart disease, chronic obstructive pulmonary disease (COPD) and history of anoxic encephalopathy. R2 also has a trachestomy and is non verbal and not able to make her needs known, as per section B of the November 5th 2014 Minimum Data Set (MDS) Assessment.

On 01/02/15 at 10:15 AM, Z1 (former CNA) stated he took R2 to the shower on 12/20/14 at

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approximately 9:00 AM and the portable oxygen tank R2 was using was on the side of R2's recliner chair. Z1 stated he put the portable liquid oxygen tank on the ground and then transferred R2 to the shower chair. Z1 stated he did a skin check at that time and found no issues, transferred back to the recliner chair after drying R2 off and placing her in a hospital type gown. Z1 stated he then placed the portable liquid oxygen tank on R2's lap, laying down flat. R2 was taken to her room and transferred to her bed. Z1 stated he noticed blistering on R2's left thigh at approximately 12:45 PM and notified E10 (Staff Nurse). E10 stated she examined the blisters at that time on R2's bilateral anterior thighs and notified Z5 (R1's spouse) and Z2 (Physician Assistant for R2's medical doctor). Z2 was in the facility at the time and wrote orders for treatment of tegaderm but was not asked to examine R2's blistered thighs.

On 01/02/14 at 11:50 AM, Z2 stated she was at the facility at the time of the incident. Z2 stated she was sitting at the nurses station when she noticed R2 being taken out of the shower room backwards in a recliner type chair and the portable liquid oxygen tank was on R1's lap. Z2 stated, "I saw steam rising from the tank and thought it was strange. Z2 stated, " I was notified by E10 approximately 2 hours later that R2 had a blister on each thigh but they didn't say I need to see it at that time so I wrote orders for cleaning the area and applying a tegaderm to keep the blister intact until seen by the wound nurse." Z2 stated she did not see the blister until 12/26/14 and stated she was "alarmed" by the look of the blisters and immediately thought it was from the oxygen "condenser". Z2 stated when the nurse initially mentioned that R2 had bullae she didn't think it was from her being immunocmpromised.

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Z2 stated, "There is nothing wrong with R2's immune system, bullae is just a fancy name for a large blister."

On 12/26/14 at 2:00 PM, E3 (Assistant Director of Nursing, ADON) stated E10 had told her about the blisters on the anterior aspect of both R2's thighs. E3 stated E10 (staff nurse) did not know how it happened. E3 stated she checked the video camera recording and saw that Z1 had placed the liquid oxygen tank on R2's lap and E3 stated she figured it was from friction from the oxygen tank. E3 stated she did an investigation of the incident and the analysis and cause of the incident at that time was determined to be liquid oxygen was placed on R2's lap after the shower.

On 01/02/15 at 9:55 AM, Z6 (Illinois Representative for Helgat Gas Product, sticker on facility portable oxygen tank), stated the liquid oxygen is 100 degrees below zero and if skin came in contact with the liquid oxygen it could cause second or third degree burns. Z6 also stated the portable oxygen tank should always be kept upright.

On 12/31/14 at 2:00 PM, E9 (central supply / maintenance), stated he fills the portable liquid oxygen tanks daily and transports them to the nursing units. E9 stated he was trained by the supplier on how to fill the tanks and safety measures needed when handling. E9 stated the portable liquid oxygen tanks should be kept upright, not turned upside down or put on the side because they could leak.

On 01/02/15 at 9:00 AM, Z5 (R2's spouse) stated he was notified by E10 (Staff Nurse) of the blisters on R2's thighs but was told it was unknown how it happened. Z5 stated E2

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(Director of Nursing) notified him by telephone to let him know that the CNA involved had laid the portable liquid oxygen tank across R2's legs and was told the person involved was terminated.

On 12/31/14 at 12:05 PM, E12 (Wound Nurse), stated she was notified to see R2's blisters on 12/22/14. E12 stated her and Z3 (Wound Doctor) both examined the blisters. E12 stated she did not know what they were from and no one had told her the resident had an oxygen tank on her legs during a shower transport two days earlier.

On 12/31/14 at 12:45 PM, Z3 (Wound Doctor), stated she examined R2's blisters on 12/22/14 and was not aware how she obtained them. Z3 stated, no one ever told her that R2 was transported with a portable liquid oxygen tank on her lap two days earlier. Z3 Stated, "it would be unusual to just come out of a shower with blisters on her thighs."

The temporary care plan dated 12/20/14 tilted, "Potential for altered skin integrity" documents R2 to have a blister on the right anterior thigh that measured 4.5 cm x 1.3 cm and a blister on her left anterior thigh that measured 12.9 cm x 11 cm.

On 12/22/14, Z3 (Wound Doctor) documented the right anterior thigh measured
6 cm x 2 cm and the left anterior thigh measured 13 cm x 11 cm. The left blister is documented to be full-thickness with moderate exudate, serous fluid, mild odor, 26-50% slough, 1-25% granulation tissue. The right anterior thigh blister is documented to be intact, no drainage.

On 12/29/14, Z3 documented the left blister to measure 13 cm x 11 cm, all other assessments are the same. The note documents the left blister

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has denuded margins covered by slough. The fluid is becoming thickened, has an odor and surrounding redness. Cultures were done at that time and R2 was placed on oral antibiotics.

On 01/02/15 the left anterior thigh blister cultures were completed and shown to have E-Coli with ESBL (Extended Spectrum of Beta Lactamase) a bacteria that is resistant to many antibiotics. R2 needed to be placed on intravenous antibiotics.

The Facility's undated Policy and Procedure titled "Liquid Oxygen Policy and Procedure" documents "It is the facilities policy to ensure that liquid oxygen is stored and utilized appropriately." The procedure portion of the document states the supplier will remove all empty big liquid oxygen tankard replace with full tanks. The big and portable tanks are stores in the oxygen room and lastly, the filling of portable tanks will be done in the facility in the oxygen room by trained staff. On 12/31/14 at approximately 1:00 PM, E1 (Administrator), stated this was the only policy on liquid oxygen they facility has.

This policy does not cover any safety issues or hazards for staff that handles the portable oxygen tanks on the nursing units. There is no policy for transferring residents with portable liquid oxygen or how the tanks should be handled by staff.

R2 is unable to voice pain or move an object away if pain is felt due to upper extremity contractures in both arms and hands.

2. R1 ' s admission record shows she is an 83 year old female original admission date was 8/6/14, readmitted on 10/25/14. R1's most recent MDS (minimum data set) dated 11/20/14 shows cognitive status BIMS (brief interview for mental

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status) score as 3 which indicates severe cognitive impairment. In addition, the MDS codes R1 as needing one person physical assistance with ambulation. The section for balance during transitions and walking shows that R1 is not steady, only able to stabilize with staff assistance when walking (with assistive device if used), and when turning around and facing the opposite direction while walking. The functional limitations in range of motion are coded for limitations that interfered with daily functions or placed resident at risk of injury. The Upper extremities (shoulders, elbow, wrist, hand), and the lower extremities (hip, knee, ankle, foot) are impaired on both sides for R1.
R1 ' s care plan dated 9/1/14 and revised on 10/26/14 focus for activities of daily living self care performance deficit related to dementia and shortness of breath, with a goal to remain free of fall related injury through 2/15/15. The interventions include for walking R1 used assistive device walker for ambulation, and R1 is able to walk with one person assistance. The focus area for osteoporosis has a goal that R1 will remain free of injuries or complications related to osteoporosis through 2/15/15. Interventions include wear padded hip protectors to prevent hip fractures.
Incident report dated 12/22/14 at 3:00 PM documenets that R1 was observed walking in the hallway with a walker and an unsteady gait when she lost her balance and fell with right side of the head hitting the wall. R1 complained of pain and numbness on right leg after the incident. R1' s Doctor and family were notified. R1 was admitted to the hospital with a fracture of the right hip.
During an interview on 12/31/14 at 1:35 PM with E14 LPN said that she was the only witness. E14 said she was at the nursing station towards the end of her shift when she saw R1 walking by

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herself with a walker when she lost her balance and fell down and grazed her head and landed on the floor.
During a telephone interview on 1/2/15 Z4 who was R1's physician said R1 was evaluated at the hospital for orthopedic surgery, however due to extensive lung disease and brain lesions it was determined that it would be too high risk of a procedure. Z4 said he never saw R1 have padded hip protectors.
On 12/30/14 at 1:23 PM E3 the assistant director of nursing said she completed the incident report involving R1 on 12/22/14 that was reported to the department and the post incident investigation dated 12/23/14. E3 said that R1 did walk by herself, she was not aware of care plan for hip protectors and never saw them. E3 said R1 was at high risk for falls and had previous fractures according to family.
The facility fall risk assessment dated 10/25/14 indicate R1 is at high risk for falls. The nursing monthly summary for November 2014 shows R1 needs 1 person assist with ambulation.
Physical therapy progress notes dated 12/6/14 indicate start of care was 11/7/14, treatment for muscle weakness and abnormality of gait. The current level of function for gait tasks with assistive devices shows R1 requires rolling walker and stand by assistance (close enough to reach patient if assist needed) for safe ambulation
3. On 11/15/2014 R4 experienced an unwitnessed fall with injury and a subsequent hospital admission resulting in a diagnosis of left hip fracture (left upper femoral fracture). R4 was readmitted to the nursing facility 11/19/13. On 12/8/2014, R4 ' s nursing notes show R4 " was found lying half and half out of bed, top half was lying on floor mat .... "
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S9999	Continued From page 8 Assessment dated 11/26/2014 shows R4 requires extensive assist for bed mobility, total assist for transfers, and total assist/non-ambulator for ambulation. On 11/19/2014 and 11/26/2014 facility Falls Assessment Tool shows R4 is assessed to be at high risk for falls. R4 's Fall prevention care plan interventions (updated 2/21/2014) include " Be sure the resident ' s call light is within reach and encourage the resident to use it for assistance as needed. " On 1/7/2015 at 2:30PM, when asked if R4 knew how to utilize the call light for assistance, R4 stated " Nobody ever showed me or told me. " The call light was observed to be clipped to the bed linen lying to the right side of R4 ' s head and the button of the call light rested approximately six inches to the right of R4 ' s right ear. When asked to demonstrate her ability to push the button R4 was unable to locate her call button. When the location of the call light was pointed out to R4, R4 attempted to reach for the call light by reaching across her body with her left hand, however was unable to reach her call light. At 2:40PM, E17 stated the resident is able to use the call light independently and " the call light must be within reach " which she stated would be " at the side of her arms clipped to the bed " . E17 stated resident will use call light when resident wants to get up or when she needs anything. When E17 was shown the call light was clipped out of R4 ' s reach, E17 repositioned the call light across R4 ' s torso toward R4 ' s left hand with the call light button resting on R4 ' s torso. After the call light was repositioned, R4 demonstrated she was able to locate and grab the call light. (B)	S9999		