

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/08/2015
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NAME OF PROVIDER OR SUPPLIER BALLARD RESPIRATORY AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 9300 BALLARD ROAD DES PLAINES, IL 60016
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610 300.1210b) 300.1210d)2) 300.1210d)5) 300.3220f) 300.3240a)</p> <p>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.</p> <p>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.</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>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/29/15

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S9999	<p>Continued From page 1</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</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. Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect</p> <p>a) 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)</p> <p>These requirements were not met as evidenced by: Based upon observation, interview and record review the facility failed to apply pressure relief devices, keep a resident's skin clean and dry as much as possible, rotate a resident for relief of pressure on bony prominences, track and monitor a resident for pressure ulcer development, asses the reason why a resident developed a pressure ulcer and implement interventions to prevent further development, follow physician's orders for wound treatment of a pressure ulcer and conducted the facility's pressure ulcer risk assessment for residents.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>This applies to three of three residents (R1, R2, R3) reviewed for the care and treatment for pressure ulcer, in a sample of three. As a result, R1 and R3 had acquired pressure ulcer development. R1 developed multiple deep tissue injuries and pressure sores to the feet. R3 acquired five pressure sores while at the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. According to a face sheet R1 was admitted to the facility on 8/13/2015. Also, had listed the diagnoses which include but not limited to; history of traumatic brain injury, encephalopathy, left hemiparesis, chronic respiratory failure and generalized muscle weakness. As a result of R1's physical condition, R1 requires extensive assistance with all ADLs (Activities of Daily Living). <p>An assessment for determining pressure sore risk dated 8/13/15 denoted R1 was at high risk for development of a pressure ulcer. R1's nursing admission assessment conducted on 8/13/15 did not denote any skin abnormalities on the feet.</p> <p>R1's wound documentation dated 8/23/15 had the following documented pressure ulcers : Left foot plantar (ball of foot) intact blister measuring 3.0 cm (centimeters) width x 6.4 cm. Right foot 4th MTH (Metatarsal Head) intact blister 2.6 cm x 1.8 cm. Right foot 5th MTH intact blister 2.0 cm x 1.3 cm. According to nursing progress notes dated 8/23/15, R1's wounds were identified by the family on that same date.</p> <p>-On 8/27/15 at 1:37pm, R1 was lying in bed his heels were elevated with a pillow. R1's head of bed and knees were noted to be elevated.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>Surveyor requested that E5 (Treatment Nurse) reposition the foot of bed to be flat, as E5 proceeded to lower the bed R1's left great toe touched the foot board (the bed was nowhere near flat). E5 stopped lowering the bed, with assistance from another staff member, repositioned R1 then proceeded to raise (not lower) the foot of bed as requested. E5 stated "I think he needs an extender on his bed. I mentioned it to environmental services. The surveyor inquired when the request for an extender transpired, E5 responded this morning.</p> <p>During this time, R1 had a dressing on both feet, some parts of R1's feet were visible. R1's left foot had a reddened area (Deep Tissue Injury/ DTI) on the 1st, 3rd and 5th toe. R1's right foot had dried blood beneath the skin (reddish black in color) on the 4th and 5th toes.</p> <p>The surveyor inquired about the aforementioned observations. E5 responded, "He has blisters on both feet, they're intact now. He's got the DTI." The surveyor asked how did R1's DTI happened? E5 stated, They're speculation so I can't really say. He has boots though we are not using them right now. At the time, R1's pressure relief boots were noted lying in the chair at the foot of the bed.</p> <p>Next, E5 removed the dressings from R1's feet, the right foot had a large broken blister noted on the plantar/lateral surface covering roughly 20% of the foot, the blistered area was reddish black in color and appeared to be dried blood pooled beneath the skin. R1's left foot had a large fluid filled blister on the plantar/lateral surface covering roughly 20% of the foot.</p> <p>R1's emergency department documentation</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>progress notes dated 8/24/15 included the following information: History of Present Illness: 2 weeks ago was sent into ED (emergency department) by family request for bil (bilateral foot pressure ulcers. Per family, patient is approximately 6 foot 7 inches and feet were pressed up against the bed. Patient subsequently developed pressure sores on the bottom of his feet. Chief complaint: Discolored toes. Physical Examination: Skin: Blistering along the plantar surface and lateral edges of feet bilaterally, right appears to have slight hemorrhage of the blister, left is without. No overlying erythema, no surrounding erythema, no induration, no exudates. Emergency Department Course: Patient with what appears to be pressure ulcers on bilateral feet. Patient with poor pulses particularly on right foot which raises concern for possible arterial insufficiency as etiology. Exam: Bilateral vascular lower extremity ABI (Ankle-Brachial Index). Normal ABI on both legs, no evidence of peripheral vascular disease. Discharged Diagnosis: Pressure ulcers.</p> <p>On 9/3/15 at 10:35am, inquired about R1's feet, E8 (Registered Nurse) responded "It was my second day working there but my first day working with him. After (8/23/15 observation), I checked with the CNA (Certified Nursing Assistant) regarding repositioning every two hours. There was pressure applying to bed they removed the footboard." Inquired if the CNA reported R1's skin integrity impairments, E8 stated "No one else but the family told me anything about that."</p> <p>The facility's Etiology of the Wound policy and procedure (7/30/14) includes but not limited to; Policy: It is the policy of this facility to provide an</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>aggressive skin care program following guidelines of current standards of practice. Management will be based upon the etiology of the wound. Procedure: Pressure Ulcers; A pressure ulcer is a lesion caused by unrelieved pressure that results in damage to the underlying tissues. Treatment of the ulcer, management of tissue loads and interventions to improve tissue tolerance to pressure, friction, and shearing forces are critical components in the management of pressure ulcers.</p> <p>2. According to a face sheet, R2 was admitted to the facility on 2/5/15. Also, R2 had listed on the sheet, diagnoses which include but not limited to; chronic respiratory failure, hemiplegia, encephalopathy and pressure ulcer. R2 requires extensive assistance with ADL's as a result of her physical condition. R2's pressure sore risk assessment dated 6/20/15 indicated R2 was at high risk for developing a pressure ulcer. R2 has physician orders for August 2015 to reposition every 2 hours and as needed. Also, apply boots to BLE (Bilateral Lower Extremity) on 8am-off 12 (noon). On 8/20/15 a concern forms were filed on behalf of R2 which include the following; I've been here over 2 hours and (R2) hasn't been turned or put in the chair. They left the wound cover patch on (R2) full of stool. (7/22/15) R2's foot was noted against the foot board of the bed. (4/16/15) Family arrived and checked R2's diaper there was stool residue on her abdomen and back. R2's vagina was full of stool. Resolution: Staff was in-serviced on proper peri-care, ensuring the vaginal area is properly cleaned. On 8/27/15 at 1:13pm, R2 was sitting in a specialty wheelchair covered by a top of a sheet. The sheet from R2's knees to her feet was noted to be wet. R2's was wearing a gown that was</p>	S9999		

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S9999	Continued From page 6 also wet from her abdominal area to the bottom of the gown. Z3 (family) was present at the time of the observation. Z3 stated "She (nurse) was giving medicine and the (gastrostomy) tube popped loose." The surveyor inquired about care provided to R2 by the facility. Z3 responded, "They supposed to turn her, they don't turn her." Next, Z3 played a recording on his phone which states on 8/25/15, R2 was "not changed, turned or nothing" (3:00pm through 6:15pm). Z3 was advised by the party on the phone to request staff assistance, because he cannot care for R2 himself. On 9/3/15 at 11:15am, the surveyor observed a wound treatment provided by E4 (Wound Care Coordinator) R2 had a sacral wound and redness was noted to R2's right heel. E4 advised the surveyor, it was healed on 9/1/15. R2 was not wearing bilateral lower extremity boots as ordered. The facility's pressure ulcer prevention policy and procedure (7/30/15) includes but not limited to; Policy: It is the policy of this facility to implement measures to protect the resident's skin integrity and prevent skin breakdown whenever possible. Procedure: Residents who are unable to turn and reposition independently will be assisted to turn and reposition every two hours or as appropriate. Heels may be elevated off the bed to totally relieve pressure; boots, pillows, etc may be used for this purpose. R2's wound documentation includes the following; (2/5/15) Sacrum: 2.0 cm x 0.6 cm x 1.3 cm depth/stage III. (4/29/15) Sacrum: 2.0cm x 2.0cm x 2.5cm depth/stage IV. (8/19/15) Sacrum: 2.2 cm x 1.0 cm x 2.4 cm depth/ stage IV. R2's Physician assessment was conducted on 8/27/15 which denotes the following; stage IV pressure wound of the sacrum- no change.	S9999		

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S9999	<p>Continued From page 7</p> <p>Recommendation: off-load wound, reposition per facility protocol and place order for wound vac.</p> <p>3. R3 is a 43 year old with diagnoses which include but not limited to; acute respiratory failure, hemiplegia, and subdural hemorrhage. R3 requires extensive assistance with ADL's. R3 was admitted to the facility on 7/14/15. On 8/11/15 a pressure ulcer risk assessment indicated R3 was at high risk. R3's admission assessment (7/14/15) includes the following skin integrity impairments; unstageable wound to right antecubital forearm, and right heel necrosis. The facility tracking log dated 8/14/15 through 8/20/15 includes the following wounds for R3; Sacrum: 1cm (centimeter) width x 3 cm length x 0.1cm depth (stage 3), Left distal dorsal calf: 3cm x 1.5cm : unstageable (US), Left ear: 1.4cm x 0.4cm x 0.1cm (stage 3), Right heel : 5.5cm x 7cm :US, Left heel: 4cm x 4cm :US .</p> <p>R3's (August 2015) physician orders include the following; Boots while in bed. Turn and reposition every 2 hours. (7/15/15) Betadine to right heel, apply with dry dressing daily. (7/22/15) Betadine to left heel, apply daily. Bilateral shins; apply skin prep and cover with foam dressing. (8/12/15) Skin prep and foam to right calf and left upper back every 3 days. (8/17/15) Santyll ointment to right buttock daily and as needed. Left ear; apply hydrocolloid every 2 days and as needed. (8/27/15) Medihoney and dry dressing to left upper back wound every 3 days.</p> <p>On 8/27/15 at 12:12pm, during R3's full body assessment the following was noted; E2 (Director of Nursing) opened R3's incontinence brief the external catheter was noted to be falling off. R3 had a washcloth (saturated with urine) lying atop of his groin area. The surveyor inquired about</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>the observation. E2 did not respond. Next, R3 was turned to his left side there was a large opened dressing package on top of the sheet which he was lying on. There was a large foam dressing noted to R3's left upper back, the dressing was removed. The surveyor inquired about the left upper back wound. E2 responded "Looks like a healing wound." Requested a description of the wound, E2 described the wound as a stage healing III which is now a stage II. The surveyor asked, Why this wound was not listed on the tracking log? E2 responded "Let me check with my wound care team." R3's sacral wound had a foam dressing on top of Medihoney instead of the Santyll ointment as ordered. R3's shins were covered with ABD (abdominal dressing) pads instead of the foam dressings as ordered. Finally, R3 was turned to his right side there was a distinct non-blanchable indentation noted to his left flank from lying on the gastrostomy tube clamp.</p> <p>On 8/27/15 at 1:00pm, the surveyor questioned E5(Treatment Nurse) regarding the care and treatment of R3's wound. The surveyor inquired about R3's left upper back wound E5 alleged that R3 did not have a wound on his back. The surveyor inquired about the lack of a dressing for R3's left ear. E5 responded "I know we were putting a hydrocolloid on it but it may have come off." E5 noted a hydrocolloid dressing in R3's bed picked it up and stated "He sweats a lot, they should be replacing it." Afterward, E5 and E6 (Treatment Nurses) assessed R3's left upper back wound. E6 stated "It's like stage II but that's what I say." The surveyor asked why ABD pads were on R3's shins. E6 responded "For the foam we can just put the ABD pad for a protector." Surveyor responded so you did not follow physician orders? E6 responded "That's correct."</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>The facility's wound cleansing and dressing policy/procedure (7/30/14) includes but not limited to; Policy: It is the policy of this facility to perform wound dressing changes as ordered by the physician.</p> <p>R3's skin care assessment performed 8/12/15 includes a left upper back and right calf wounds, there are no measurements and/or description of either wound. Physician progress notes include the following; On 8/28/15 an addendum physician progress notes was documented for 8/26/15 as follows: Patient was last seen on 8/26/15, failed to document on abrasion at left mid back. Wound dimensions are 1.0 cm width x 1.0 cm length x 1.0 cm depth. Physician assessments were also conducted on 8/17/15 and 8/12/15, there is no mention of R3's left upper back wound (acquired on 8/12/15).</p> <p>4. The facility's risk and skin assessment (7/30/15) includes but not limited to; Policy: It is the policy of this facility to asses all residents for factors that place them at risk for developing pressure ulcers. It is also the policy of this facility to monitor the skin integrity of our residents for development of wounds or other skin conditions. These assessments will begin upon admission and continue throughout the resident's stay in our facility. Procedure: The standardized risk assessment will be completed using the braden scale for predicting pressure ulcer risk and is completed by the licensed nurse. The braden scale is completed: Upon admission/readmission, weekly for the first four weeks, quarterly and change in condition, cognition or functional ability.</p> <p>R2 was admitted to the facility on 2/5/15, braden scale assessments (for predicting pressure sore</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>risk) were conducted on 2/5/15, 3/5/15 and 6/20/15. All of which denote they were done on admission, there were no additional assessments.</p> <p>R3 was admitted to the facility on 7/14/15, braden scale assessments were conducted on 7/14/15, 7/21/15 and 8/11/15, there were no additional assessments.</p> <p>On 9/3/15 at 1:47pm, inquired about the requirements for braden scale assessments E3 (Assistant Director of Nursing) responded "We do upon admission, then weekly times four. Then quarterly unless change of condition of the wound then we do change in condition." (B)</p>	S9999		
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