

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2016
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NAME OF PROVIDER OR SUPPLIER A MERKLE C KNIPPRATH N H	STREET ADDRESS, CITY, STATE, ZIP CODE 1190 E 2900 NORTH ROAD CLIFTON, IL 60927
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S 000	Initial Comments	S 000		
	Annual Licensure and Certification Survey			
S9999	Final Observations	S9999		
	<p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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</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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p>			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 07/08/16
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S9999	<p>Continued From page 1</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>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 are not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure supervision and use of assistive devices to prevent injury for one of 14 residents (R2) reviewed for accidents on the sample of 14. This failure resulted in a large laceration on the leg requiring hospital treatment with sutures.</p> <p>Findings include:</p> <p>According to the current Physician's Order Sheet (POS) for 6/2016, R2 has multiple diagnoses including Congestive Heart Failure, Ascorbic Acid Deficiency, Anxiety, and history of Fractured Femur. This POS also lists an order for Coumadin (anticoagulant) daily. R2's Minimum Data Set (MDS) dated 3/28/16 assesses R2 as moderately cognitively impaired, and requiring extensive assist of two staff for transfers. On 6/20/16 at 10:00am, R2 was identified by E3 (Assistant Director of Nursing) as interviewable. R2's careplan dated 4/6/16 states that R2 "does not ambulate... .transfer with mechanical lift for safety."</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>The Resident Incident Report dated 5/1/16 states the following: "CNA (Certified Nurse Aide) reported large laceration to resident's (R2) leg stated happened during transfer from wheelchair to bed. Laceration to right lower leg on outer aspect measuring 12 x 5.5 cm (centimeters) with unknown depth; noted fatty tissue attached to lacerated skin and muscle tissue visible. Site cleansed and covered with {non-stick} dressing . . . hospital transfer."</p> <p>Hospital discharge instructions dated 5/1/16 at 10:52pm note the repair of the laceration on the right lower leg. The POS documents continuing treatment with antibiotic ointment and dressing until suture removal on 5/14/16. The Final Report of the incident completed on 5/5/16 documents R2 returning from the hospital with 20 sutures.</p> <p>The dictated statement by Z2 (agency CNA) dated 5/1/16 states that Z2 had removed the footrests and heel boots prior to positioning R2's wheelchair next to the bed. "I (Z2) asked {R2} to give me a hug. Then I (Z2) stood {R2} and pivoted to the left on to the bed. I noticed leg was bleeding. I cleaned the blood on the floor. I lifted {R2's} legs into the bed so {R2} was in a laying position. I applied pressure to {R2's} legs with tissue and my hand to stop the bleeding then I (Z2) reported to the nurse {R2's} injury." No mention is in the statement regarding use of gait belt, mechanical lift, or assistance from another staff person.</p> <p>Dictated statements by E16, E17, E18 and E19 (CNAs) all stated that Z2 did not ask for assistance with transfers from any of them throughout the evening. The written Witness Statement signed by E15 (CNA) on 5/3/16 states,</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>"I have worked with {Z2} before and I have told her multiple times how {R2} transferred." On 6/23/16 at 3:15pm, E15 confirmed the written statement, and stated E15 told Z2 that R2 was to be a sit-to-stand lift with two assist. E15 stated there are to be two assist with all mechanical lifts.</p> <p>The statement by E7 (Licensed Practical Nurse/LPN) dated 5/1/16 stated that Z2 entered the charting room on 5/1/16 about 7:55pm and reported a laceration to R2's leg. Along with E14 (LPN), E7 assessed the large laceration to the right lower leg, noting fatty tissue and white muscle tissue visible with "no active bleeding present." E7 noted a blood smear on the floor. The statement documented that R2 stated at that time that the cut happened during the transfer but did not know what R2 cut her leg on. R2 also stated at that time that she had told Z2 to use a mechanical lift, but did not recall whether it was before or after the transfer and injury. E7's statement states that Z2 gave multiple versions of sequence of events, including when Z2 noticed the injury, cleaning up the blood, putting pressure on the wound, placement of bed rails, wheelchair, bedside table, etc. E7 also noted in the statement that the room had been re-arranged from the time of the transfer, including the wheelchair in the hallway, and the bedside table next to the bed. R2 complained of pain at that time. The wound was cleansed and covered, R2 was medicated for pain, and transferred per ambulance to the hospital as per physician's orders. This statement also stated that Z2 was asked to leave the facility, following completion of Z2's statement.</p> <p>The written statement by E14 LPN concurred with the assessment of the laceration, and that R2 had said "I told her (Z2) to use the machine,"</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>E14's statement also included that Z2 was told she should not have touched the wound or tried to clean up, "to come and get the nurse directly." E14's statement noted that the bed and wheelchair were inspected with no sharp edges and no blood noted. "{R2} does receive Coumadin. When entering room wound was not actively bleeding."</p> <p>On 6/21/16 at 9:45am, E12 and E13 (CNAs) transferred R2 for incontinence care, using a sit to stand lift. E12 and E13 stated at that time that R2 had always been either a mechanical or sit to stand lift for transfers.</p> <p>On 6/21/16 at 10:00am, E11 (Registered Nurse/Wound Nurse) cleansed and applied Skin Prep to the large, curved healing scar on R2's right lower leg. Upon completion of the treatment, R2 stated she "didn't see anything in her (Z2's) hand, but somehow she sliced me and there was blood. The nurse came in and said she couldn't do anything for me, that I would have to go to the hospital and get stitches." R2 did not recall anything else regarding the incident, i.e. with the transfer, when the cut occurred, or if she told Z2 to get a lift.</p> <p>On 6/21/16 at 3:20pm, E7 LPN confirmed information in the written statement. E7 stated what caused E7 and E14 to be "suspicious" right away was, with the seriousness of the laceration, there was no active bleeding, and that Z2 had cleaned up, put pressure on the wound and rearranged the room prior to getting the nurse. E7 stated Z2 "had to have been putting pressure on it for a while - {R2} is on Coumadin." E7 stated she saw a large blood smear on the floor where Z2 had apparently tried to clean it up, but did not see blood on anything else. E7 stated R2</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>said that R2 had told Z2 to get a lift and another person, but did not know when the cut occurred. E7 confirmed that Z2 transferred R2 by herself, without a lift or another person. E7 also stated that at that time the CNA worksheet had R2 down as a mechanical lift. E7 also confirmed that Z2 had worked at the facility multiple times.</p> <p>On 6/22/16 at 2:30pm, E14 LPN also confirmed information in the written statement. E14 stated Z2 was "very sketchy" as to how the laceration happened and versions of the reports "didn't jive." E14 also stated that R2 said she had told Z2 that Z2 needed to use a lift. E14 stated that R2 was a mechanical or sit to stand lift at that time and the two people are used even with a lift. E14 stated agency staff are given sheets as what kind of transfer or lifts are to be used. E14 also stated that Z2 had worked at the facility and assumed had cared for R2 prior to the incident.</p> <p>On 6/22/16 at 11:15am, E2 (Director of Nursing) stated that agency staff read and sign the abuse policy, are paired up with facility staff, and given worksheets for the halls they are assigned to that gives resident information, including transfers and special instructions. E2 provided examples of same. E2 stated that Z2 had worked at the facility a lot prior to 5/1/16. E2 stated that Z2 will not be returning to the facility.</p> <p>On 6/23/16 at 11:40am, Z2 confirmed information in the written statement, that footrests were off, Z2 asked R2 to "give her a hug" and transferred R2. Z2 stated she noticed the blood after placing R2's legs on the bed. Z2 stated she did not use a gait belt because R2 "didn't need it," and that Z2 had transferred R2 the same way that week prior to the incident. Z2 stated she did not know that R2 was to be a mechanical lift, nor did R2 say</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>anything about using a lift. Z2 also stated she did not have a worksheet with instructions for residents. Z2 stated they do a walk-through on the halls at the beginning of the shift. Z2 stated she wanted to stop the bleeding and clean up the blood before getting the nurse, and Z2 "couldn't reach the call light" to get help.</p> <p>The facility policy for Safe Patient/Resident Handling and Movement dated 1/7/13 "provides a process for all caregiver assisting inpatient movement to be protected for patient handling injuries while caring for patients/residents safely within an environment of dignity and respect. . . Staff should utilize the proper techniques, lifting devices, etc., to match the identified task. . . Avoid manual lifting unless identified as a qualifying manual lift in Section 3b. . . Use mechanical lifts, devices and other approved aids in accordance with instructions and training. . ."</p> <p>(B)</p> <p>300.1230 b) 300.1230d)1)2) 300.1230j)5) 300.1230l)1-6) Section 300.1230 Direct Care Staffing b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day. d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; and 2) Meeting the minimum direct care staffing ratios set forth in this Section.</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>j) Skilled Nursing and Intermediate Care For the purpose of this subsection, "nursing care" and "personal care" mean direct care provided by staff listed in subsection (f).</p> <p>5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act)</p> <p>l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used:</p> <p>1) The facility shall determine the number of residents needing skilled or intermediate care.</p> <p>2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category.</p> <p>3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility.</p> <p>4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period.</p> <p>5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act.</p> <p>6) The amount of time determined in subsections</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>(l)(4) and (5) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually 7.5 or 8 hours) will give the number of persons needed to staff each shift. Calculations shall not include time for scheduled breaks or scheduled in-service training. The number of residents used to calculate staff ratios shall be based on the facility's midnight census.</p> <p>This REQUIREMENT was not met as evidenced by the following: Based on record review and interview, the facility failed to meet staffing requirements for nursing and personal care for two of 14 consecutive days reviewed. This failure has the potential to affect all 53 residents who reside in the facility. Findings include: The two-week staffing spreadsheet dated 5/29/16 through 6/11/16 provided by E1, Administrator on 6/21/16 documents staffing for 14 consecutive days. This spreadsheet documents an average Skilled Resident Census of 8.43 and an average Intermediate Care Resident Census of 44.79 for this two week time period. Calculations determine a total minimum of 144.01 hours are needed for direct care staff in a 24 hour period. The staffing spreadsheet, including hours for all direct care staff, document the following staffing failures: 5/29/16 - 128 total hours worked, this is a shortage of 16.01 hours. 5/30/16 - 143.2 total hours worked, this is a shortage of 0.81 hours.</p> <p>The facility Resident Council Minutes document the following: 2/5/16 - residents are concerned that there are only three CNA's (Certified Nursing Assistant's) for four halls on night shift. 4/1/16 -residents are concerned that there are not</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>enough CNA's on the evening shift.</p> <p>On 6/21/16 at 3:05 pm during a group interview with R8, R22 and R23, these residents stated, all residents are supposed to be up before breakfast but unfortunately because of lower staffing, they don't get up until late therefore they are late getting out to breakfast. These resident's also stated, staffing problems started mid to end of winter and have been a regular issue since then.</p> <p>On 6/22/16 at 2:05 pm, E3 ADON (Assistant Director of Nursing) stated, E3 is in charge of scheduling the CNA's. E3 stated, "the minimum number of CNA's we have on second shift is 4. That is what is scheduled, so if there is a call in, someone from first shift covers it or we call in agency. We have to have 4 CNA's."</p> <p>The Resident Census and Conditions of Resident Report dated 6/20/16 documents 53 residents reside at the facility.</p> <p>(B)</p>	S9999		
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