STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009310	A. BUILDING: _____ B. WING _____	C 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE MANOR	920 N SEMINARY AVE P O BOX 520 WOODSTOCK, IL 60098

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S9999	Final Observations	S9999		

Statement of Licensure Violations

One of two Licensure Violations:

330.720 (b)
330.4220 (f)

Section 330.720 Admission and Discharge Policies

b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.

This regulation was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure that residents in the sheltered care distinct part of the facility did not require nursing care and failed to ensure the safety of a resident on the sheltered care unit.

This applies to 2 of 3 residents (R1, R3) reviewed for appropriate placement and safety in a sheltered care unit in the sample of 3.

The findings include:

1. On July 3, 2019 at 11:45 AM, V1 (Administrator) said the facility determines whether or not a resident is appropriate for sheltered care by completing a resident assessment. The assessment indicates what level of care the resident is 1, 2, 3. The

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

determination if the resident is appropriate for the sheltered care unit is not based on the level indicated by the assessment. V1 said the facility primarily determines if a resident is appropriate for sheltered care by how the resident transfers for example a resident who required a mechanical lift would not be on the unit. V1 said the difference between the long term care unit and the sheltered care unit is that there is no nursing care done on the sheltered care unit. The nurse that covers sheltered care just passes medications to the residents. V1 said nursing care would include wound care, dressing changes, and IV's (intravenous medications). V1 said the nurse on the unit should be assessing and monitoring R1's circulation to her bilateral arms due to her having casts.

On July 3, 2019 at 12:00 PM, V3 RN (Registered Nurse/Supervisor) said there are residents living in sheltered care that require dressing changes. On July 3, 3019, at 1:20 PM, V3 said the residents on sheltered care should be more independent and not require skilled nursing care such as daily dressing changes. V3 said R1 should be assessed and monitored because she has the casts. V3 said the nurses should be assessing and monitoring R1 every shift and documenting their assessment in the interdisciplinary notes. V3 reviewed the interdisciplinary notes and said there were only a couple of assessments completed for R1 since her casts were placed.

On July 3, 2019 at 2:10 PM, V8 LPN (Licensed Practical Nurse) said we have been moving residents around to different areas now based on the level of care they need. We determine a resident's level of care through the resident assessment. We are going to start using that

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S9999	Continued From page 2	S9999		

now. We do not do care plans for residents on sheltered care we only do what we call a "service plan" to guide the residents' care.

R1's service plan was last updated on April 23, 2019 and showed R1 was a stand by assist for transfers, minimal assist for ambulation, minimal assist for eating, and requires rounds, redirection, and inclusion for safety needs with a goal to have no falls with injury.

R1's service plan had not been updated since her fall resulting in an increased need for assistance with transfers and feeding.

On July 3, 2019 at 11:30 AM, V4 CNA (Certified Nursing Assistant) said R1 has a tab alarm that is used on her wheelchair and bed. V4 said R1 now requires 2 staff for transfers and needs to be fed and given fluids by staff because she is unable to do this on her own.

According to R1's face sheet printed on July 3, 2019 showed R1 was originally admitted to the sheltered care unit on December 19, 2016 with diagnoses to include dementia, Alzheimer's Disease and hypertension.

On July 3, 2019 at 9:20 AM, R1 was on the sheltered care unit sitting in her wheelchair in the common area with her head down and eyes closed. R1 had casts on both of her arms and her arms were straight down resting on her lap. At 11:40 AM, R1 was in her wheelchair with her arms resting on her lap prior to being provided incontinence care and when she was transferred back into her wheelchair R1 did not have her arms elevated.

R1's Incident Report dated May 24, 2019 showed

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R1 had an unwitnessed fall. R1 was found laying face down in the dining room and the resident was crying when her left arm was moved or touched. R1's acute care hospital paperwork showed on May 24, 2019 R1 was diagnosed with both left and right wrist fractures resulting from the fall.

R1's incident report completed on June 24, 2019 showed, "Resident found on floor next to bed with casted arm stuck through bed rail. 911 called for help after staff attempted to gently free arm. [local fire department] had to cut the bed rail off to free resident... Continue to observe safety policy of facility and implement as best as possible facility protocols to keep both residents and staff safe."

R1's interdisciplinary note entered by the Nurse Practitioner on June 6, 2019 showed, "...continue to monitor circulation, movement, and sensation to both upper extremeties... maintain close observation and anticipate patients needs.." There is no documentation by nursing staff to show that R1's upper extremeties circulation, movement, and sensation were monitored.

R1's interdisciplinary note entered by the Nurse Practitioner on June 27, 2019 showed, "... still waiting on whether or not [the orthopedic surgeon] would like to see patient prior to scheduled appointment on 7/23/19 follow up after placement of BUE (bilateral upper extremities) casts. Mild swelling to left fingers with tenderness to LUE (left upper extremity) with movement evident...advised to elevate BUE.... BUE elevated on pillow."

On July 3, 2019 at 3:15 PM, V2 DON (Director of Nursing) said the nurses should be assessing and documenting on R1. The assessment should

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S9999	Continued From page 4	S9999		

include sensations, capillary refill, and the ability to move fingers, redness around edges of cast, edges rubbing on her. This should be documented every shift and as needed.

The facility's policy for fall prevention dated December 2009 showed, "ensure that the resident' environment remains as free of accident/fall hazards as possible and that each resident receives appropriate supervision and assist to prevent accidents/falls by implementation of a comprehensive Accident/Falls Prevention Program.

The facility's policy for their sheltered care unit updated June 2017 showed under Care Program, "...this program is for individuals with dementia who require supervision but not skilled nursing care." The same policy showed under Statement of Philosophy, "...we provide a loving, supportive environment for those who cannot function independently but who do not need continuous nursing care." The same policy showed under Resident Assessment and Service Plan, "...the service plan is a problem-oriented guide to providing services to residents and is based on the Resident Functional Assessment.... the service plan will be modified as resident needs change..."

2. On 7/3/19 at 9:10 AM, R3 was observed walking in her room. R3 had a skin tear to her right forearm that was open to air and bleeding. R3's arm was red and swollen around the skin tear and dried blood was noted on R3's shirt sleeve.

R3's face sheet dated 7/3/19 showed she was admitted to the sheltered care unit on 6/17/19 with diagnoses of dementia, hypertension and

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S9999	Continued From page 5	S9999		

anxiety disorder. R3's treatment administration record (TAR) showed on 6/30/19 an order was initiated to change right arm dressing every 3 days with optifoam until healed for skin tear and an order was initiated on 10/26/18 for a skin assessment with shower/bath every Tuesday and Friday on evening shift.

On 7/3/19 at 3:15 PM, V2 Director of Nursing stated wound care documentation should include: assessment for redness, warmth and approximation of wound edges.

(B)

Two of Two Licensure Violations

330.4220 f)

Section 330.4220 Medical Care

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)

This regulation was not met as evidenced by:

Based on observation, interview and record review the facility failed to follow physician's treatment orders for a resident (R3).

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S9999	Continued From page 6	S9999		

This applies to 1 of 3 residents (R3) that were reviewed for physician's orders in the sample of 3.

The findings include:

On 7/3/19 at 9:10 AM, R3 was observed walking in her room. R3 had a skin tear to her right forearm that was open to air and bleeding. R3's arm was red and swollen around the skin tear and dried blood was noted on R3's shirt sleeve.

On 7/3/19 at 11:30 AM, R3 was observed walking into the dining room with the skin tear open to air. There was dried blood around the open wound.

R3's face sheet dated 7/3/19 showed she was admitted to the sheltered care unit on 6/17/19 with diagnoses of dementia, hypertension and anxiety disorder. R3's treatment administration record (TAR) showed on 6/30/19 an order was initiated to change right arm dressing every 3 days with optifoam until healed for skin tear and an order was initiated on 10/26/18 for a skin assessment with shower/bath every Tuesday and Friday on evening shift.

On 7/3/19 at 1:05 PM, R3 was observed in her room with a dressing to her right forearm skin tear that consisted of a non-adherent dressing wrapped with gauze.

On 7/3/19 at 1:20 PM, V3 Registered Nurse stated she performed dressing change on R3. V3 stated she did not use the dressing ordered by the physician. V3 stated she placed a call to (R3's) physician because "her arm looks really red, swollen and might be infected." V3 stated she knew she used a dressing that was not ordered by a physician. V3 stated skin

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S9999	Continued From page 7 assessments should be performed as ordered by a physician and on residents shower days. V3 confirmed R3's medical record had no documentation of a skin assessment since 1/8/19. V3 stated a nursing note with a wound assessment should be completed each time (R3's) wound care is completed. V3 confirmed R3's medical record had no documentation on (R3's) wound care or wound assessment. On 7/3/19 at 3:15 PM, V2 Director of Nursing stated wound care documentation should include: assessment for redness, warmth and approximation of wound edges. (B)	S9999		