Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: ______ B. WING ______	C 08/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.1010h)
300.1210b)
300.1210d)5
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. .

Section 300.1210 General Requirements for Nursing and Personal Care
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:
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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on observation, interview, and record review, the facility failed to prevent, identify, and treat a pressure ulcer for 1 of 3 residents (R1) all reviewed for pressure sore, and failed to implement interventions to prevent a pressure sore from developing for 1 of 3 residents (R5) all reviewed for pressure sores. This failure resulted in R1 being admitted to the hospital and being assessed and treated for an infected right lateral malleolar decubitus ulcer.

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S9999	Continued From page 2	S9999		

Findings include:

R1 was admitted 1-16-12 with diagnoses significant for Alzheimer's Disease, Major Depressive Disorder with Recurrent Episodes of Psychotic Behavior, Schizoaffective Disorder, Dementia with Behavioral Disturbances, and Cerebral Disease, per facility face sheet. R1's MDS (Minimum Data Set) dated 3-19-15 indicates a BIMS (Brief Interview for Mental Status) score of "06" of a possible high score of "15" related to cognitive functioning. This MDS also indicates R1 was always incontinent of bowel and bladder, and was totally dependent on two staff members to transfer. R1 required the extensive assistance of two staff members for bed mobility and to dress. R1 used a wheelchair for mobility, and a full body lift to transfer. "Functional Limitation in Range of Motion assessment" dated 3-19-15 indicates R1 had a right wrist contracture, for which she wore a hand splint.

E5 (Wound Nurse/Clinical Manager) stated 8-5-15 at 2:32pm R1 lived at the facility for two years. The only skin alterations R1 experienced were the MASD to her buttocks area discovered 2-14-15, as well as a fluid-filled blister to her left shoulder found 2-12-15, as a result of R1 scratching at her shoulder. This blister was treated with antibiotic/zinc ointment daily until healed 2-26-15. R1's Treament Administration Records (TARS) February through April 2015 indicate ointments were administered to both of these areas, as ordered. E5 stated she was unaware of any right malleolar ulcer.

E1 (Administrator) stated 8-6-15 at 10:30am she has been the administrator since May, 2014, and

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S9999	Continued From page 3	S9999		

attends daily "Stand Up" meetings on each nursing floor Monday through Friday, where significant events/changes in resident care are discussed. E1 was unaware of a pressure ulcer to R1's right lateral malleolus.

E2 (Director of Nursing) stated 8-6-15 at 10:30am she was not the DON at the time of R1's admission to the hospital 4-26-15, and was the facility's Restorative Nurse at that time. CNA's should be checking the condition of resident skin daily when they are dressing residents. Any new skin alterations should be reported to the nurse, who will then call the Wound Nurse (if present in the facility) or the Physician/Nurse Practitioner for wound treatment orders. In addition, CNA's document any skin alterations twice weekly on resident "Shower Sheets," and report any new findings to the nurse. Review of R1's "Shower Sheets" February through May 2015 do not indicate any skin alteration to the right malleolus area.

Z11 (Nurse Consultant) stated 8-5-15 at 3:17pm their is no mention in R1's entire medical record of a right malleolar ulcer.

Z7's (Former Nurse) note dated 4-26-15 at 1:49pm indicate R1 was sent to the hospital ER (Emergency Room) for evaluation of low blood pressure and change in consciousness. This note indicates, in part "head to toe assessment done small open area on right button (buttocks?) noted barrier cream and dry dressing applied to area no other lacerations, redness or bruises noted." Z7 could not be reached for comment despite several attempts.

Hospital records indicate R1 arrived in the ER 4-26-15 at 1:52pm. Upon admission to the ER,

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S9999	Continued From page 4	S9999		

R1 had a right lateral malleolar decubitus ulcer which was "foul smelling" with mild purulent drainage, which was subsequently diagnosed as a wound infection of MRSA (Methicillin-Resistant Staphlococcus Aureus). R1 was admitted to the Telemetry Unit of the hospital with Diagnoses of Sepsis Syndrome, Severe Dehydration, and Acute Kidney Injury Secondary to Volume Depletion.

R1's "Braden Scale" 3-17-15 indicated she was at "mild risk" for skin alterations. R1's nursing "Monthly Summary" dated 4-17-15 indicated she did not have and wounds or skin conditions. R1's care plan contains the focus "Actual impaired skin integrity related to MASD" but no mention of a right malleolar ulcer. This care plan includes the intervention "inspect skin with care daily."

Z5 (R1's Attending Physician) stated 8-6-15 at 3:01pm he was not aware of R1's right malleolar ulcer, stating he expects nursing to report any new ulcerations to him, so treatment can be ordered.

R5 has diagnoses significant for Vascular Dementia, Bipolar Disorder, Parkinson's Disease, and Difficulty Walking. R5's MDS dated 7-22-15 indicates she requires the extensive assistance of two staff members to transfer. R5 was identified by the facility 8-3-15 as having a facility acquired pressure ulcer. R5's "Braden Scale" dated 7-21-15 indicates a score of "17," placing her at "mild risk" for pressure ulcers. R5's care plan includes the focus "Alteration in skin integrity," and indicates she had a history of Deep Tissue Injury, dating back to October, 2012. R5's care plan includes the intervention "off load heels."

On 8-3-15 at 1:43pm, R5 was seated in a

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S9999	Continued From page 5	S9999		

specialty char near the third floor nurses' station. This chair was in the reclining position. R5 had her knees bent, and heels placed directly against the footrest of this chair, occasionally pushing on her feet, her heels rubbing against the footrest. R5 did not have any shoes on, only socks. A dressing could be seen applied to her left foot, sticking out from under her left sock. E5 was present, and stated R5 had a Deep Tissue Injury to her left heel, and had been known to rub her heels against the footrest of the specialty chair. E5 stated R5 should be wearing shoes. E5 then looked at the computer, and saw E10's (Wound Nurse) WASA (Weekly Assessment of Skin Alteration) note dated 7-30-15. This note described R5 left heel as having a Deep Tissue injury measuring 7cm (centimeters) x 3.5cm, unstageable. This note also indicated "per family, they bought to resident one pair of shoes bigger than her size which the resident was using. Educated the family on the importance of having the right size of shoes. Dressing applied, no complain of pain. Off load heels and turning schedule placed. Family and MD (Medical Doctor) aware. Will continue to monitor."

On 8-3-15 at 2:10pm, R5 was taken to her room by E5 in the specialty chair (which has wheels) for a dressing change to her left heel. R5 continued to bend her knees and apply pressure to both heels. R5's left heel had a dark purple deep tissue injury area, as yet unopened, measuring approximately 7cm x 3.5cm. E5 cleansed the area with normal saline, then applied providine iodine, as ordered by her physician. Surveyor requested E5 remove R5's right sock. R5's right heel had a pronounced deep indentation in the place she was pressing it against the specialty chair footrest. E5 saw this, and picked up a pair of white athletic shoes placed by R5's bed.

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S9999	Continued From page 6	S9999		

Surveyor questioned E5 if she knew these were the shoes E10 indicated in his WASA note as being too big, or where these a new pair? E5 did not know, and put the shoes back on the floor.

E10 stated 8-5-15 at 11:25am he was first notified by a floor nurses' call 7-30-15 R5 had a suspected deep tissue injury to her left heel. E10 assessed R5 and suspected R5's shoes were too large. This, along with R5's behavior of rubbing her heels against the specialty chair's footrest caused the deep tissue injury. E10 called to notify the family of this, but did not remove the shoes from R5's room, or label them "do not use." Surveyor then went with E10 to R5's room, and found the white athletic shoes on R5's windowsill. E10 identified these were the same shoes he felt were too large for R5, causing the problem.

E2 (Director of Nursing) stated 8-5-15 at 3:24pm R5 was assessed for the specialty chair in April, as a comfort measure for when she became tired. The facility does not require a physician's order for this type of speciality chair, but an assessment needs to be done. This assessment was done 4-24-15. If a resident is seen to be putting pressure or rubbing his/her heels on the footrest of a chair, staff should first try to get the resident to straighten his/her legs; if not successful, the resident should have his/her heels off-loaded with pillows. If a nurse suspects shoes may be causing or contributing to the formation of a pressure ulcer, those shoes should be removed from the resident's care area, bagged, and labeled "do not use" so staff who are unaware of the problem do not inadvertently place the shoes on the resident.

Z9 (R5's Attending Physician) stated 8-6-15 at

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S9999	Continued From page 7 3:36pm he was noted of R5's left heel deep tissue injury 7-30-15, and gave orders for the providine iodine dressings daily. To protect residents from skin damage, they should wear comfortable, proper-fitting shoes. Resident's feet should be elevated to off-load pressure on heels. Facility policy titled "Prevention and Treatment of Skin Breakdown Guidelines" indicates, in part "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers; to implement preventative measures, and to provide appropriate treatment modalities for ulcers according to industry standards of care." (C)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN TOWN MANOR REHAB & HCC COMPLAINT #: 0076895
LIC. ID #: 0038000
DATE COMPLAINT RECEIVED: 05/01/15 10:02:00

IDPH Code	Allegation Summary	Determination
406	ADMINISTRATION	2

___ The facility has committed violations as indicated in the attached*
_✓_ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN TOWN MANOR REHAB & HCC COMPLAINT #: 0077786
LIC. ID #: 0038000
DATE COMPLAINT RECEIVED: 06/09/15 12:29:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	2
118	RESIDENT RIGHTS	2

___ The facility has committed violations as indicated in the attached*
_✓_ No Violation

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LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN TOWN MANOR REHAB & HCC COMPLAINT #: 0078925
LIC. ID #: 0038000
DATE COMPLAINT RECEIVED: 07/27/15 02:00:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1
131	RESIDENT INJURY	1
409	POLICY AND PROCEDURES	1

___ The facility has committed violations as indicated in the attached*
___ No Violation

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