

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2018
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF CANTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2081 NORTH MAIN STREET CANTON, IL 61520		
(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
S 000	Initial Comments Annual Certification Survey Statement of Licensure Violations:	S 000		
S9999	Final Observations Licensure Violation 1 of 2 : 300.1210b)d)5) 300.3240a) 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. 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.	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/13/18

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect 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) These requirements were NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to identify a pressure ulcer and have a physician ordered treatment that was clinically indicated for a unstageable necrotic pressure ulcer for one of two residents (R46) reviewed for pressure ulcers in the sample of 20. This failure resulted in R46's pressure ulcer worsening from a Stage two to unstageable. Findings include: The facility's Skin Practice Guide, dated 2013, documents, "Dressing selection is based upon: wound type, tissue type, need to contain exudate, need to protect wound bed, need to minimize pain, treatment goals, protection of peri-wound area, and manufacturer recommendations for product utilization and frequency of change." According to the National Pressure Ulcer Advisory Panel: Prevention and Treatment of Pressure Ulcers Quick Guide, dated 2014, "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. Category/Stage II: Partial Thickness Skin Loss: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also	S9999			

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S9999	Continued From page 2 present as an intact or open/ruptured serum filled blister. Unstageable: Depth Unknown: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Guide also documents, "Wound Dressings For Treatment Of Pressure Ulcers General Recommendations 1. Select a wound dressing based on the: Ability to keep the wound bed moist; Need to address bacterial bioburden; Nature and volume of wound exudate; Condition of the tissue in the ulcer bed; Condition of periwound skin; Ulcer size, depth and location; Presence of tunneling and/or undermining; Goals of the individual with the ulcer. According to Gentell Total Wound Care Solution (Gentell.com), "MASD (Moisture Associated Skin Damage) versus Pressure Ulcers," dated 7/13/2017, "Moisture Associated Skin Damage: LOCATION: Diffusely distributed; COLOR: Pink or red; DEPTH: Partial thickness, or blistering; TISSUE: NO slough or eschar. Pressure Ulcers: LOCATION: Usually over a bony prominence, or under a medical device/including brief; COLOR: Red or bluish/purple; DEPTH: Partial or full thickness; TISSUE: With or without slough or eschar." According to Merck Manual Professional Version, "Pressure Ulcers," dated 2018, "Direct ulcer care. Appropriate ulcer care involves cleaning, debridement, and dressings. Debridement is necessary to remove necrotic tissue. Necrotic tissue serves as a medium for bacterial growth and blocks normal wound healing. Dressings are helpful for protecting the wound and facilitating the healing process (Dressings should be used for stage I pressure ulcers that are subject to friction or incontinence and for all other pressure	S9999			

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S9999	Continued From page 3 ulcers." R46's Braden risk assessment, dated 5/1/18, documents a score of 15 putting R46 at risk for developing pressure ulcers. R46's Nurse's notes, dated 5/15/2018 at 3:29 p.m. documents, This nurse called to R46's room by CNAs who reported open area to buttocks. Right buttock skin fold red open area approximately 2.0 cm (centimeters) x 1.0 cm no drainage, no bleeding, peri wound area light red. On 05/22/18 at 01:55 PM, R46 was incontinent of urine. V22 (Certified Nursing Assistant-CNA) rolled R46 to his right side. Clear bloody drainage was on R46's bed sheets. R46 had an irregular shaped open area to R46's right ischial tuberosity area (buttock crease) with clear bloody drainage. R46's wound bed was dark red partial wound area then dark brown tissue (eschar) scattered throughout the wound. R46's wound was uncovered and remained uncovered following R46's incontinent care. On 05/23/18 at 08:50 AM, R46 was incontinent of a soft light brown feces. R46 had an irregular shaped open area to his right ischial tuberosity area (buttock crease). The wound had a dark red wound bed with small areas of dark brown tissue. V18 (Wound Nurse) stated that the area of the open area is a pressure point when R46 is sitting, and that R46 sits quite a bit for long periods. V18 also stated that they don't consider it a pressure ulcer, they are calling it MASD (Moisture Associated Skin Damage). (V18) also confirmed that the wound had necrotic areas in it, and needs a physician prescribed treatment because the treatment now is preventative barrier cream.	S9999			

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S9999	Continued From page 4 R46's Nurse's notes, dated 5/23/18 at 9:07 a.m., documents, "R46 has the following wound moisture related area below right buttock measuring 3.8 cm x 3 cm. No drainage noted. Area bright red with some darkened area." The facility's in house stock preventative cream product information sheet, dated 5/23/18, documents that the cream is indicated for the relief of discomfort associated with diaper rash caused by wetness, urine, and/or stool and other macerated skin conditions. R46's Physician's Orders, dated 5/18, have no documentation of a physician ordered treatment. R46's Current Electronic Care plan documents that R46 is at risk for alteration in skin integrity related to incontinence and dementia. The care plan has no documentation of revision to include R46's current area. On 05/23/18 at 02:45 PM, V16 (V46's physician) stated she was notified when the area developed and informed them to continue using the barrier cream. I was notified today (5/23/18) about the change in the wound, and I ordered to continue the barrier cream." 05/23/18 02:53 PM V2 (Director of Nursing) stated, "If the area has necrotic tissue, then it wouldn't be an MASD wound. Barrier cream would not be appropriate to treat an open area with necrotic tissue." (B)	S9999			

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S9999	Continued From page 5 ----- Licensure Violation 2 Of 2 300.610a) 300.1210b)d)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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999			

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S9999	Continued From page 6 seven-day-a-week basis: 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. (A, B) (Section 2-107 of the Act) These Requirements were NOT met as evidenced by: Based on observation, record review, and interview the facility failed to maintain R26's bed in a low position and failed to re-evaluate R26's fall risks and interventions after removing a planned fall reduction assistive mattress for one of two residents (R26) reviewed for falls in the sample of 20. These failures resulted in R26 falling out of bed at a higher plane and sustaining a right hip fracture. Findings include: A. The facility's Falls Practice Guide dated 12/2011 documents, "Fall interventions are clear, specific, and individualized for a patient's needs. Regardless of the interventions that are put in place, a key factor to success is the timely review of the interventions as the patient's conditions and needs change. Environmental risk factors which may be associated with falls may need to be reviewed and considered as ongoing fall preventions strategies. These factors may	S9999			

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S9999	Continued From page 7 include the bed height and assistive devices." On 05/22/18 at 2:00 PM, R26 was lying in bed. R26's right leg was approximately two inches shorter than R26's left leg and R26 had an approximate 4 inch diameter faded purple bruise to the right knee. R26's current Diagnosis Listing documents R26 has diagnoses of Dementia, Anxiety, History of Falls, Osteoporosis, and Muscle Weakness. R26's Incident Report dated 12-2-17 at 9:00 PM, documents R26 was found on the floor on R26's buttocks parallel to the bed. This same report documents a scoop mattress (mattress with raised sides) will be applied to R26's bed as a fall intervention. R26's Incident Reports and Progress Notes do not include R26 having any further falls out of bed since the incident on 12-2-17, until 5-13-18. R26's Incident Investigation Report dated 5-13-18 at 2:33 AM and signed by V8 (Licensed Practical Nurse) documents R26 was found on the floor beside the bed on R26's bottom, with no complaints of pain. This same report documents R26 later complained of pain to the right leg on 5-14-18 and an order was given to obtain an x-ray. R26's current Fall Care Plan documents a scoop mattress was re-applied to R26's bed on 5-15-18. R26's X-Ray report dated 5-15-18 documents R26 sustained an acute displaced fracture to the right hip. R26's Clinical Record does not include	S9999		

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S9999	Continued From page 8 documentation of R26's scoop mattress ever being removed off of R26's bed between the fall on 12-2-17 and 5-13-18. This same record also does not include a re-evaluation of R26's risks of falls and fall interventions once the scoop mattress was removed. The Manufacturer's Description of a scoop mattress (undated), documents, "The Defined Perimeter Mattress creates a raised fall, defined perimeter for enhanced fall prevention, without using patient restraints." On 05/22/18 at 3:41 PM, V7 (CNA/Certified Nursing Assistant) stated, " (R26) just got a scoop mattress back last week when (R26) rolled out of bed and got the right hip fracture. (R26) use to have a scoop mattress but they (the facility) took it off and put a regular air mattress on that did not have raised sides like the old scoop mattress. " On 05/22/18 at 3:24 PM, V8 (Licensed Practical Nurse/LPN) stated, " I worked the night (5-13-18) when (R26) rolled out of bed. The CNA (V9) got me and said (R26) landed on the floor around 2:30 am." On 05/22/18 at 3:27 PM, V9 (CNA) stated, " I worked 5-13-18. I heard (R26) yelling for help. I went in (R26's) room and (R26) was on the floor on the left side of the bed with her back against the bed and both legs out. I could see that (R26's) right leg was injured and was twisted. (R26) did not want her right knee touched because she had pain. Not excruciating. I thought her leg was fractured. Before the fall, the head and the feet of (R26's) bed were raised up and (R26's) bed was not in the lowest position. Sometimes (R26) gets restless at night. (R26)	S9999			

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S9999	Continued From page 9 needs a mattress with raised sides. The air mattress (R26) has at the time of the fall is thicker than a regular mattress and would have made her fall from a higher level." On 05/23/18 at 8:46 AM, V2 (Director of Nursing/DON) stated, " On 12-2-17 we (the facility) applied a scoop mattress because (R26) rolled out of bed. On 4-10-18 (R26) developed an area on the heel and needed an air mattress. We (the facility) discontinued (R26's) scoop mattress at that time (4-10-18). We (the facility) did not re-evaluate (R26's) fall interventions at that time when (R26's) fall intervention of a scoop mattress was removed. We should have re-evaluated (R26's) fall interventions at that time. (R26) rolled out of bed and that is when (R26) sustained the fracture. (R26) did not have any falls out of the bed when (R26) had the scoop mattress. The scoop mattress would most likely have prevented (R26) from rolling out of bed. The first thing I said when (R26) rolled out of the bed was that we (the facility) need to get a scoop mattress back on (R26's) bed to prevent further falls. (R26's) bed should have been in the lowest position when (R26) fell." On 05/23/18 at 3:00 PM, V8 (LPN) stated, "When (R26) fell out of bed on 5-13-18, (R26's) bed was not in the lowest position. It should have been." (B)	S9999			