

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/09/2023
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NAME OF PROVIDER OR SUPPLIER NEWMAN REHAB & HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942
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S 000	Initial Comments	S 000		
	<p>Complaint Investigation: 2361555/IL156790</p> <p>S9999 Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.1210b) 300.1210d)6)</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>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>These requirments are not met as evidenced by: Based on observation, interview and record</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>review the facility failed to ensure a severely cognitively impaired resident (R1) was positioned safely away from an electric baseboard heater that had been turned to the highest temperature setting, resulting in R1 suffering second and third degree burns, requiring hospitalization, antibiotics, and skin grafting, when staff positioned R1's bed directly next to the heater. This failure has the potential to affect all 43 residents residing in the facility all of whom have electric baseboard heaters in their rooms.</p> <p>Findings include:</p> <p>The facility Nurses' Midnight Census Report dated 2/24/23 documents 43 residents residing in the facility.</p> <p>On 3/9/23 between 2:00 PM and 2:20 PM the facility was toured with V1 Administrator. An electric baseboard heater was present in all resident rooms.</p> <p>R1's Physician Order Sheet (POS) dated February 1-28, 2023, documents medical diagnoses of Dementia, Parkinson's Disease, Myofascial Pain, Lumbar Radiculopathy, Insomnia, Cardiovascular Accident and Iron Deficiency Anemia.</p> <p>R1's Minimum Data Set (MDS) dated 1/27/23 documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring extensive assistance of one person for bed mobility, dressing, eating, toileting, and personal hygiene and total assistance of two people using a mechanical lift for transfers.</p> <p>R1's Care Plan dated 6/25/22 documents (R1) slides self out of low bed onto floor mat.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R1's Assess Intercommunicate Manage (AIM) Report dated 2/20/23 documents "This change in condition, symptoms, or signs observed and evaluated are injury which started on 2/20/23. Blood Pressure 150/99, Pulse 101 beats per minute, Respirations 26 per minute, Temperature 99.4 degrees Fahrenheit (F) and Pulse Oximetry was 95% on room air. (R1) not responding to questions correctly. Skin Evaluation: Burn"</p> <p>R1's Emergency Room Record dated 2/20/23 documents "Chief Complaint: Burn to left leg. (R1) was found by nursing home staff with right lower leg against a radiator heater. (R1) was sleeping near an old metal space heater and (R1's) leg was against it for the night causing burn to the right leg below the knee. Musculoskeletal: Burn of the lateral leg on the right from the knee to the ankle avoiding joint space of knee. Observational admit for wound care and pain control. Cephalexin (antibiotic) 250 milligrams (mg) every eight hours for seven days starting 2/20/23. Silvadene 1% topical cream Apply a 1/16 inch thick layer to entire burn area daily. Cleanse wound daily with saline dampened gauze, then apply thick layer of Silvadene Cream to each burn, cover with Adaptec, then apply saline soaked gauze over the Adaptec, then absorbent pad, then roll gauze, secure all with stockinet. Follow up with wound clinic."</p> <p>R1's Hospital Record dated 2/20/23 documents "(R1) presented to the emergency department this morning from facility after being found by staff lying up against a hot radiator for unknown length of time. (R1) has burns to right lower extremity, along with right toes and left great toe. Chief complaint: Burn. Inpatient diagnosis: Primary Burn and Anemia. Assessment and Plan:</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>Integumentary System: Thermal burn to right lower extremity and left great toe from radiator at Skilled Nursing Facility (SNF). Estimated 9% Total Body Surface Area (TBSA)."</p> <p>R1's Hospital Operative Notes dated 3/3/23 document "Preoperative Diagnoses: Full thickness third degree burn of right lower leg, right foot and left foot. Brief history and indication: (R1) suffered third degree burns to his right lower extremity, right foot and left foot after his bed was pushed against a radiant heater. Findings: Bilateral foot burns went down to bone with minimal bleeding noted. The right leg burn measured 27.0 centimeters (cm) by 9.0 cm with a thick fibrotic layer covering the wound base. The right lateral foot burn measured 5.0 cm by 3.0 cm with a thick fibrotic and necrotic covering. The left medial foot measured 6.0 cm by 3.0 cm with a thick fibrotic and necrotic covering. (V18) Wound Clinic Podiatrist then applied the meshed fish skin graft to the right lateral leg wound and stapled in place. (V18) then took the remaining meshed fish skin graft and applied over the (bilateral) foot wounds. (V18) then took the remaining meshed fish skin graft to add more fish skin to the Right lateral leg wound. (V18) then placed Adaptec, gauze, absorbent pads and roll gauze over the wounds."</p> <p>R1's Wound Clinic Encounters and Procedures Note dated 3/6/23 documents "Chief complaint: nurse visit, wound check. The right lateral and left medial foot were at least third degree, the right lateral foot was still blistered and could not tell the degree yet." The Wound Clinic Note documents (R1) was taken to operating room by (V18) Wound Clinic Podiatrist on 3/3/23 for surgical debridement and skin grafting over the debrided areas on R1's right lateral lower leg,</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>right lateral foot and left medial foot.</p> <p>On 2/24/23 at 9:20 AM V3 Licensed Practical Nurse (LPN) via phone stated "That night (evening of 2/19/23 and early morning of 2/20/23) was very busy (V7) Certified Nurse Aide (CNA) rounded on (R1) in between 12:00 AM-1:00 AM by herself. So then (V7) left at 2:00 AM and (V4) CNA came in at 2:00 AM. I am not certain if (V4) CNA did a round at 2:00 AM or not. (R1) is a frequent faller. (R1) also has a lot of behaviors. (R1) cusses, hits and yells at staff. (R1) calls staff derogatory names based on their skin color or weight. Normally, (R1) would be up all night banging on the wall or yelling out 'come in here' and as soon as staff enter to ask what is needed (R1) replies 'I just wanted to see you'. I know (R1) went to bed about 8:30 PM that night. (R1) was really tired because he slept a lot that night. Sometimes the girls (CNA's) will skip (R1) on rounds if he is sleeping just to let him sleep. They (staff) do not want to 'wake the bear' so to speak. I should have been more on top of that. I can't guarantee that (R1) was checked on at the 2:00 AM check which means the next time they (staff) would check him was the 4:00 AM check and that is when they (staff) found him with his legs laying on the radiator. (V4) CNA came to get me at about 4:25 AM to report 'something was wrong with (R1)' and that '(R1) had huge wounds on his legs'. When I walked into (R1's) room, (R1's) skin on face and body was beet red. (R1's) skin was burning hot to touch. (R1's) right lower leg from knee to top of ankle was hot to touch, blistered and beet red. I remember (R1's) temperature being 99.4 degrees Fahrenheit (F). (R1) was laying with his back flat on the bed and his legs bent up at the knees like in a fetal position from the waist down when I walked in the room. (R1's) Left Great Toe was gray and had</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>nasty discoloration, there was a huge blister with fluid in it from (R1's) right knee to right ankle, little burns on toes that were deep purple one of which had opened. The big blister on (R1's) outer right lower leg area popped when (R1) was moved from his bed at the facility to the gurney to be transported to the hospital. (R1) did not have any type of pants, sweatpants, lounge pants etc. on. (R1's) legs were bare. (R1's) bed was in the lowest position clear down to the floor. Sometimes the low beds get stuck to the heater, and we (staff) have to really tug at them to get them separated. The staff moved (R1's) bed so that it sat right in front of the wall with the window right up against the radiator. They (staff) did this because (R1) was sleeping and they (staff) wanted to keep an eye on him. The staff moved (R1's) bed and kept the door to his room open so they could monitor him without waking him up. There was no table or dresser between (R1's) bed and radiator/wall. (R1's) bed was directly up against (R1's) heater. You would have to move the entire bed to get between (R1's) bed and the wall. Those heaters get very hot. It is a little metal radiator. I worked here (facility) as a CNA, and I remember almost burning my own leg because some of the beds were so close to the radiators and I would have to help assist a resident with cares. I would lean my legs against the radiators and would have to move real quick because they (radiators) get so hot. It would have burned me if I left my legs there too long. I can't believe someone would turn the thermostat up so high. It was turned up past the 80 degree mark which is the highest mark on the thermostat."</p> <p>On 2/24/23 at 10:05 AM V4 Certified Nurse Aide (CNA) stated "I worked 2:00 AM-10:00 AM on 2/20/23. I started the bed check around 3:00 AM</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>and got to (R1) around 4:30 AM. (R1's) bed was up against the wall with the heater. (R1) was laying on his right side facing the wall with his right lower leg and left foot all laying directly on the radiator. (R1's) right calf was blistered, the outside of his right foot was super red, and the left great toe had skin peeling off and was very red too. (R1) had on a sheet and blanket. (R1) had moved his legs out from underneath the blankets and rested them directly on the radiator. It was so hot in (R1's) room. The thermostat was set over 80 degrees Fahrenheit (F). (R1) was wearing a gown and incontinence brief. I turned the heat down. (R1's) bed was in the lowest position which makes it set right on the floor. (R1's) bed was directly up against the radiator. (R1) had pillows placed behind his back for positioning but that made it so he couldn't roll over to his left side also. Normally (R1) can roll around in bed on his own. Sometimes the low beds get hooked on the radiators. (R1's) low bed was not caught up on the radiator but it was shoved up against it so tight it was right on the bed."</p> <p>On 2/24/23 at 10:20 AM V5 Certified Nurse Aide (CNA) stated "I came into work at 4:00 AM that morning (2/20/23). We started helping (V4) CNA with the rounds. I saw (R1) laying on his right side with his bed completely up against the wall. (R1's) right lower leg felt very warm. I could feel (R1's) right lower leg skin move underneath my fingers. (R1's) room smelled like hot burning flesh. (R1) had blisters on his toes."</p> <p>On 2/24/23 at 11:00 AM V10 Regional Maintenance Director stated "The heat for the resident rooms comes solely from the electric baseboard heaters which are controlled from thermostats located in each resident room. Each</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>resident room can have a different temperature setting. If someone turns up the heat setting on the thermostat to 70 degrees or 80 degrees, the internal heating element in the electric baseboard heater will run at full speed until it satisfies the thermostats demand for heat. There is no gradual elevation of heat from the electric baseboard heaters. It is either on or off. The heating element can get up to 450 degrees (F)."</p> <p>On 2/24/23 at 11:10 AM V13 Certified Nurse Aide (CNA) stated "You would think it would be common sense not to put a Dementia resident's bed right up against the radiator and turn the heat up. But not everyone has common sense anymore."</p> <p>On 2/24/23 at 1:00 PM V10 Regional Maintenance Director stated the electric baseboard heaters were installed in 1973. V10 stated "We (facility) have looked all over for the manual for those baseboard heaters. We (facility) do not have the manuals for them. I have already asked Corporate for the manuals, and they (corporate) told me there are none to be found. I (Internet searched) the make and it said to provide at least 6 inches from the element to any other furniture and 10 inches from the element to the curtains. The facility has audited these baseboard heaters since that incident and found that the metal can get to 175 degrees (F) on the front side."</p> <p>On 2/24/23 at 1:45 PM V16 Maintenance Director stated, "The staff apparently turned up the heat on the thermostat and then pushed (R1's) bed directly up next to the baseboard heater."</p> <p>On 2/7/23 at 10:55 AM V8 Physician stated "All I can say really is that there should have been</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>some preventative measure in place so that (R1) was not able to get burned. The facility called me, and I told them to send (R1) to the hospital. I was not there so I cannot say what happened. But the preventative measure should have been in place prior to moving (R1's) bed so close to the heater."</p> <p>On 2/7/23 at 12:45 PM V2 Director of Nurses (DON) stated "We (facility) were not aware that staff were pushing beds up against the electric baseboards. They (staff) should not do that. That is dangerous. We (facility) educate and educate but it is hard to find staff with common sense."</p> <p>On 2/8/23 at 11:30 AM V16 Maintenance Director stated all resident rooms in this facility have the same type of electric baseboard heaters. V16 stated all of the heaters in resident rooms function the same way as (R1's) baseboard heater. V16 stated "Anyone could just come up and change the thermostat. Anyone could control the heat level in any one of the rooms."</p> <p>On 2/8/23 at 12:00 PM V18 Wound Clinic Podiatrist stated "What happened to (R1) was very preventable and caused him unnecessary wound care, hospitalizations and surgery. (R1's) right lateral leg did have some bleeding which means there is perfusion to the tissues but still certainly that burn has severely damaged (R1's) right lateral leg. (R1's) right lateral foot and left medial foot were burned to the bone. There was no bleeding when I debrided those areas on (R1's) feet. That means there is likely going to be more problems due to lack of circulation to the wound bed. (R1) will most likely be a long term wound patient and will certainly require more debridement, possibly more grafts. (R1) is at risk</p>	S9999		

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S9999	Continued From page 9 of infection and certainly at risk of losing at least part of both of his feet. This was all preventable. (R1) was not previously a wound patient at our clinic." (A)	S9999		