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
	6016463	A. BUILDING: _____ B. WING _____	12/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE'S JOURNEY MATTOON	300 LERNA ROAD SOUTH MATTOON, IL 61938

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S 000	Initial Comments First Probationary Licensure Survey Statement of Licensure Violations 330.710a) 330.780a) 330.1110a)f) 330.1120a) 330.1930 330.2000 750.160a) 750.800e) 330.3970f)	S 000		
S9999	Final Observations 330.710a) 330.780a) 330.1110a)f) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 330.1110 Medical Care Policies a) The facility shall have a written program of	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition. These requirements were not met as evidenced by the following: 1-Based on interview and record review, the facility failed to have a pressure ulcer skin protocol in place, failed to prevent a pressure sore from developing and failed to identify and treat a pressure sore immediately for one of two residents (R101) reviewed for pressure ulcers in the sample of five. Findings include: The facility's undated "Guidelines Pressure Sore Prevention Chart" documents if a resident is identified as high risk for skin breakdown a pressure relieving mattress and cushion needs to be in place, a nutrition supplement should be in place and it should be added to the Care Plan. At the time this pressure sore developed for R101 the facility had no pressure ulcer skin protocol in place. On 12/17/15 at 9:57AM E1 Administrator stated that E2 Director of Nursing just implemented the "Newly Acquired Skin Conditions" form, they may not have one for R101. The Physician Order Sheet (POS) for R101 documents an admission date of 5/25/15 and documents diagnoses of Dementia, Hypertension	S9999		

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and Hypothyroidism. A " Braden Scale for Predicting Pressure Ulcer Risk " dated May, 2015 for R101 documents a total score of 16. This same document states, " If score of 16 or less, patient is at very high risk for skin breakdown. " The Service Plan dated 5/22/15 for R101 does not address skin integrity. On 12/17/15 at 10:57AM E2 Director of Nursing (DON) confirmed that skin integrity was not addressed on the Service Plan upon admission. R101 ' s Nutritional Assessment completed by E6 Registered Dietician dated 5/25/15 documents that R101 receives a multivitamin and skin is intact. E6 makes no recommendations on this assessment regarding R101 ' s high risk for skin breakdown. There is no other Nutritional Assessment available for R101. The POS dated December 2015 documents that R101 receives 80cc (cubic centimeters) of 2.0 calorie supplement with no diagnosis listed or documentation of the reason for starting the supplement.
The Monthly Skin Assessment for R101 dated 10/7/15 documents, " Stage 2 on left hip, change dressing to left hip daily, reposition every two hours." There is no documentation that R101's physician was notified of the pressure area. Convenient Care documentation for R101 dated 10/12/15 documents the reason for visit as redness/swelling on the left hip. This document also states that R101 will be taken to an appointment at a wound clinic for consultation on 10/16/15 which was five days later and an order for an air mattress was given. Wound center documentation for R101 dated 10/16/15 documents measurements of 2.9 centimeters(cm) X 4.2cm X 0.2cm and classification of unstageable and recommended a wheelchair cushion to assist with offloading and to increase protein in R101's diet. On 12/17/15 at

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S9999	Continued From page 3 12:30PM E2 stated that the wheelchair cushion was added 6/17/15 which was before R101 went to the wound clinic on 10/16/15. R101's Plan of Care documents to increase intake of protein per wound clinic with a start date of 12/7/15. The Laboratory result sheet dated 10/16/15 for R101 documents a wound culture was obtained with the result of the following bacteria, " Proteus Mirabilis, Enterococcus Faecalis, and Methicillin Resistant Staphylococcus Aureus (MRSA). " R101' s POS documents that oral antibiotics were started on 10/19/15. A Radiology report dated 10/26/15 for R101 documents that a PICC (peripherally inserted central catheter) line was inserted in the right upper extremity for " soft tissue infection. " R101 ' s Home Health Care visit note dated 10/27/15 documents that R101 is being admitted into home health on this day and wound care will be completed by the home health nurse and the facility nurses. This note also documents, " (R101) was recently diagnosed with osteomyelitis " and home health is to administer IV (intravenous) Vancomycin (antibiotic) via the PICC line for 14 days. In addition this note documents that the wound is draining and has a strong, foul odor. R101 has an Emergency Room (ER) Report dated 11/12/15 that documents R101 was having a debridement of the left hip wound at the wound center and it was noted that R101 ' s blood pressure became elevated and was brought to the ER. This ER note documents, " It does not appear that the patient (R101) was given any pain medicine ....patient (R101) was given 4 mg (milligrams) morphine IV push ...patient ' s (R101) blood pressure improved ...I think this may have been secondary to a pain response ... " Wound Clinic note dated 11/19/15 for R101 documents to arrange to start Negative Pressure Wound Therapy.	S9999		

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Home Health visit notes for R101 dated 11/25/15 documents wound measurements of 3cm X 4cm X 1.7cm with undermining at 9 o ' clock of 3.7cm, stage 3. Started negative pressure dressing (wound vac) as ordered by the wound clinic.
The Wound Care Center visit notes dated 12/7/15 for R101 document that the pressure sore on the left ilium is now classified as a stage 4 pressure sore.
On 12/16/15 at 11:30AM Z1 Home Health Registered Nurse stated that a nurse comes in every Monday, Wednesday and Friday to change the dressing and more often as needed.
R101's physician was unavailable for a statement.
2-Based on record review and interview the facility failed to record, document and identify the cause of an injuryfor one (R104) of two residents reviewed for falls/injuries in the sample of five.

3-Based on record review and interview the facility failed to notify a physician of an injury in one (R104) of two residents reviewed for falls/accidents in the sample of five.

Findings include:
The Physician Order Sheet dated December 2015 for R104 documents the diagnosis of Dementia. A facility Mini Mental State Examination dated 12/15 documents R104 could not keep focused during the exam.
A facility Skin Report dated 11/12/15 at 1:40 pm documents that R104 was found lying in bed with a laceration and hematoma to left brow area. No explanation on how the injury occurred is documented.
R104's Nursing Notes dated 11/12/15 at 2:00 pm documents "Resident (R104) sustained laceration and hematoma to left eye brow area., daughter notified..." There is no documentation of the

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physician being notified. The Nursing Notes continue to document the appearance of R104's left eye through 11/20/15 with no documentation of a cause for the injury. R104's Care Plan does not address R104's fall risk or any injury.
The Physician Progress Notes do not have any documentation of R104's injury.
On 12/16/15 at 11:15 am E2, Director of Nursing acknowledged that there had been no investigation into the injury of R104's left eye and brow. E2 stated she assumed R104 had fallen or rolled out of bed. E2 stated "I did not realize the injury needed to be investigated and documented."
On 12/16/15 at 11:55 am E1, Administrator stated that it had been assumed R104 had fallen or rolled out of bed. E1 stated "I should not have assumed that is what happened."
On 12/17/15 at 2:20 pm, E2 Director of Nursing confirmed R104's physician had not been notified of R104's injury.
(B)

330.1120a)
Section 330.1120 Personal Care
a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
This requirement is not met as evidenced by:
Based on observation and interview, the facility failed to maintain the dignity of one (R104) of five on the sample of five and one (R106) on the supplemental sample that were reviewed for dining.
Findings include:
On 12/15/15 at 12:05 pm R104 and R106 were seated in the dining room. Both R104 and R106 had blueberry cobbler on a plate, placed in front

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S9999	Continued From page 6 of them. R106 picked the plate up and was chewing on the plate while blueberries ran down both arms. R106 then began using her hands to eat and had blueberries down the front of her clothing and the placesetting. R104, sitting at the same table, used R104's hands and began eating the blueberry cobbler. R104 had the cobbler running down the front of R104's shirt. R104 and R106 received their other menu items of ham, broccoli and rice. R104 and R106 used their hands the entire meal, scooping up food into their mouths. There were no aides in the dining room at this time. An unidentified dietary aide was the only staff member present serving food. On 12/16/15 at 12:20 pm R104 and R106 were seated in the dining room. Both were being fed by staff. R104 and R106's Care Plan document that they are independent in eating. On 12/17/15 at 2:05 pm E8, Certified Nursing Assistant and E9, Resident Care Specialist stated that R104 can eat independently on someday's and on others R104 needs to be fed. E9 stated R104 had been seen before using his hands to eat. E8 stated "(R106) will usually follow the crowd and do what they are doing but is capable of eating independently on someday's." (AW) 330.1930 330.2000 750.160a) 750.800e) Section 330.1930 Hygiene of Dietary Staff Food Service personnel shall be in good health, shall practice hygienic food handling techniques, and good personal grooming. (Source: Amended at 13 Ill. Reg. 6562, effective April 17, 1989)	S9999		

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S9999	Continued From page 7 Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 700). (Source: Amended at 13 Ill. Reg. 6562, effective April 17, 1989) Section 750.160 General - Food Preparation In an effort to prevent the transmission of pathogenic organisms from humans, food shall be prepared with the least possible manual contact, with suitable utensils and on surfaces that prior to use have been cleaned, rinsed and sanitized to prevent cross-contamination. a) Food employees shall avoid direct contact (i.e., using bare hands) with ready-to-eat food whenever possible and, to the extent possible, shall handle ready-to-eat food only with suitable utensils such as deli tissue, spatulas, tongs, or single-use gloves. Handling of ready-to-eat food with suitable utensils is not a substitute for proper hand washing. Use of utensils, including deli tissue, spatulas, tongs or single-use gloves, shall be preceded by thorough hand-washing. (Source: Amended at 20 Ill. Reg. 2171, effective January 20, 1996) Section 750.800 Cleaning Frequency e) Non-food-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. These requirements were not met as evidenced by the following: Based on observation, interview and record review, dietary staff failed to use hair nets while in the kitchen preparing food. This has the potential to affect all 21 resident residing in the facility. Findings include: On 12/15/15 at 11:15 am, E4 Kitchen Manager/Cook and E5, Dietary Aide were in the facility kitchen without hair nets. E5 was brushing	S9999		

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the hair from her face that was hanging down along the side. E5 was applying butter/margarine across the top of the lunch menu rolls. When asked about a hairnet, E5 replied "My hair wont stay in the hair nets." E4 was standing by the sink washing her hands and stated "I just took my hair net off."
A facility document undated and titled "Kitchen Daily Checklist" directs the facility staff as follows: "Anyone that steps into the kitchen needs to have a hair net on."
On 12/15/15 at 11:40 am E1, Administrator stated "they should have had hair nets on."
On 12/15/15 at 9:30 am E1 stated there were 21 residents residing in the facility.

Based on observation and interview, the facility failed to ensure that kitchen staff wear gloves during food handling. This has the potential to affect all 21 residents residing in the facility.

Findings include:

On 12/15/15 at 11:15 am E5, Kitchen Aid was applying butter/margarine to the top of rolls that were placed in a pan on the food prep surface. E5, using a bare hand, touched the rolls, moving them as the butter/margarine was brushed on. E5 stated, "I just forgot to put my gloves on."

E1, Administrator stated on 12/17/15 at 11:00 am that the facility did not have a written policy on proper food preparation or handling. E1 stated "They are trained to use gloves during food preparation in the kitchen."

On 12/15/15 at 9:30 am E1 stated there were 21 residents residing in the facility.

Based on observation, record review and

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S9999	Continued From page 9 interview the facility failed to ensure cleaning of the exhaust hood above the stove to prevent built-up debris and dust falling, causing possible contamination of food on the stovetop. This has the potential to affect all 21 residents in the facility. Findings include: On 12/15/15 at 11:15 am, during the sanitation check of the facility kitchen, it was identified that the exhaust hood above the stove had a built-up of grease and dust clusters. The dust clusters were approximately one-quarter of an inch around. An accumulation of dust clusters were also observed on the top of the stove. On 12/15/15 at 11:25 am E4, Cook and Kitchen Manager stated she did not know when the last time the exhaust hood had been cleaned. E4 stated E4 had no knowledge of any scheduled cleaning from an outside source. A facility document undated and titled "Cleaning List" for the kitchen was provided by E1, Administrator on 12/15/15. There were no directions or instructions to staff that the exhaust hood above the stove was to be checked or cleaned. On 12/15/15 at 11:40 am, E1 acknowledged the exhaust hood over the stove was not clean and there was no schedule for the cleaning of the exhaust hood. E1 had no knowledge of when the hood was last cleaned. On 12/15/15 at 9:30 am E1 stated there were 21 residents residing in the facility. (AW)	S9999		

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S9999	Continued From page 10 330.3970f) Section 330.3970 Hazardous Areas and Combustible Storage Every existing facility shall meet the following requirements: f) Floor type heaters or furnaces are not permitted. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one resident (R107) on the supplemental sample was not using an independent heat source (space heater) in a bedroom of building A. This has the potential to affect all 21 residents residing in the facility. Findings include: On 12/15/15 at 9:40 am, during tour of the facility, a space heater was plugged in using an extension cord in the bedroom of R107. The space heater was in the "on" position and running. On 12/16/15 at 9:05 am, the space heater was plugged in and in use. E7, Maintenance Director stated "I don't know anything about the heater and I did not realize there was an extension cord in use." On 12/16/15 at 10:00 am, E1 Administrator stated the facility thought R107 could have the space heater in R107's room, but did not realize an extension cord was being used for it. On 12/15/15 at 9:30 am E1 stated there were 21 residents residing in the facility. (B)	S9999		