

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6004758</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/11/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RIVER VIEW REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 NORTH JANE ELGIN, IL 60123</b>
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(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
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S 000	<p>Initial Comments</p> <p>Investigation of Complaints:</p> <p>1770163 - IL90962</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.1210a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</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</p>	S 000	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>01/26/17</b>
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S 000	<p>Continued From page 1</p> <p>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>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel,</p>	S 000		
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S 000	Continued From page 2  representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.  Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S 000		
S9999	Final Observations  These regulations are not met as evidenced by:  Based on observation, interview, and record review the facility failed to conduct a comprehensive assessment to identify the root cause for the development of R 11 and R 10 ' s facility acquired pressure injuries and failed to develop a person-centered plan of care to address the promotion of healing and the prevention of additional skin alteration. The facility failed to develop and implement a specific repositioning plan for R 11 and to follow R 11 ' s care plan intervention to provide pressure-relieving mattress. These failures resulted in R 11 acquiring Stage 3 pressure injury on the left ischium, Stage 2 on the anterior aspect of the right buttocks and a Deep Tissue Pressure Injury on the posterior aspect of R 11 ' s right buttocks that the facility was not aware of. R10 acquired a stage 2 pressure injury to the sacrum and a stage 3 pressure injury to the left thigh.	S9999		

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S9999	<p>Continued From page 3</p> <p>This applies to 2 of 3 residents (R 11 and R 10) reviewed for pressure injury in the sample of 11. The findings include: The facility pressure ulcers/wounds sheet for January 1, 2017 showed R 11 acquired a Stage 3 pressure injury on the left ischium initially noted on December 7, 2016. On January 10, 2017 at 1:00 PM, R 11 was in bed sleeping positioned on his left side. At 2:00 PM R 11 remains in the same position, no positioning device was noted. At 2:05 PM, E 15 (Nurse) stated that R 11 has a pressure ulcer on the left ischium/buttocks. E 15 and E 16 (Certified Nursing Assistant) showed R 11 has altered skin and noted with multiple open areas ( left ischium, sacrum and right buttocks ) and discoloration on the right buttocks. There was no dressing noted on these areas. R 11 ' s order summary report dated January 11, 2017 showed an order to apply wound dressing (hydrocol pad) to R 11 ' s sacrum and left ischium. On January 10, 2017 at 2:40 PM, E 14 (Treatment Nurse) and E 17 (Certified Nursing Assistant) were observed during skin assessment. E 14 identified, described, and provided measurement on the following areas of skin alteration: (1) Acquired Stage 3 pressure injury on the left ischium measured at 0.6 cm X 0.5 cm X 0.2 cm (initially noted on December 7, 2016). (2) Stage 2 pressure injury (admitted with) on the sacrum measuring 0.5 cm X 0.3 cm X 0.1 cm (3) New area of Stage 2 pressure injury on the right buttocks measuring 0.2 cm X 0.2 cm X 0.1 cm (4) New area of Deep Tissue Pressure Injury (Deep purple discoloration) on the posterior aspect of the right buttocks measured at 3.5 cm X 1.0 cm.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>E 14 stated, " I was not aware about these areas on his right buttocks (Stage 2 and Deep Tissue Pressure Injury). No one told me about these. I do not know why his wounds have no dressing (on the left ischium and the sacrum), probably it fell off. " E 14 also acknowledged that R 11 has no positioning device while in bed and on a regular bariatric mattress only. E 14 was unable to present a root cause analysis for the development of R 11 ' s Stage 3 pressure injury on the sacrum.</p> <p>R 11 ' s skin care plan dated October 24, 2016 (page 4 of 7) presented by E 14 on January 11, 2017 at 11:00 AM showed an interventions that were not followed/implemented:</p> <ol style="list-style-type: none"> <li>(1.) Administer treatments as ordered.</li> <li>(2.) Inform the resident/family/care givers of any new area of skin breakdown.</li> <li>(3.) Monitor dressing to ensure it is intact and adhering. Report loose dressings to treatment nurse.</li> <li>(4.) The resident requires pressure relieving mattress</li> </ol> <p>On January 11, 2016 at 3:20 PM, E 20 (3-11 shift Certified Nursing Assistant) explained, " He (R11) cannot reposition himself, he needs assistance with all of his activities of daily living ' s with at least 2 person. He usually gets up at around 8:00 or 9:00 AM then we (3-11 shift) put him back to bed around 4:30 or around 5:30 PM.</p> <p>On January12, 2017 at 12:20 PM via phone, Z3 (Nurse Practitioner) stated, " No I was not informed that he (R 11) has a new pressure ulcers (injuries), they usually inform me but not about this. I was even there yesterday. To avoid wounds from developing of course they cannot leave him in bed or in chair for too long and he needs to stay off of those areas. Absolutely he</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>needs a specialty mattress to relieve the pressure."</p> <p>R 10 ' s weekly skin alteration review for November 7, 2016, documents that R 10 acquired a Stage 3 pressure injury on the left thigh measured at 0.5 cm X 0.5 cm X 0.1 cm. This area worsened on December 5, 2016, increased in size to 2.0 cm X 3.0 cm X 0.1 cm documented with presence of black eschar at 20 % and stringy yellow slough at 30%.</p> <p>R 10 ' s pressure injury on the left thigh was not addressed on the care plan presented by E14 on January 10, 2017.</p> <p>In addition, R10 was noted on November 29, 2016 to acquire a Stage 2 pressure injury on the sacrum measured at 2.2 cm X 2.2 cm X 0.1 cm. E14 (Treatment Nurse) stated on January 10, 2017 at 12:00 PM that the facility has not analyzed R 10 ' s root cause for the development of these two areas of pressure injuries. E 14 also expressed that the interventions for R 10 ' s skin alteration care plan was not specific to R 10's identified needs, and E14 confirmed that the sacral and the left thigh pressure injuries were not care planned.</p> <p>(B)</p>	S9999		
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