

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/19/2017
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NAME OF PROVIDER OR SUPPLIER ALL AMERICAN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5448 NORTH BROADWAY STREET CHICAGO, IL 60640
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</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</p>	S9999	<p>Attachment A</p> <p>Statement of Licensure Violations</p>	
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 02/01/17
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S9999	<p>Continued From page 1</p> <p>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. 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>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, 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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>Based on observation, interview and record review the facility failed to implement interventions to prevent a pressure sore from developing. The facility failed to implement a treatment plan to prevent further decline of the wound and prevent infection. As a result, R12 developed a pressure ulcer that became infected and necrotic.</p> <p>This applies to 1 resident out of 3 (R12) reviewed for pressure ulcers from a total sample of 20.</p> <p>Findings include:</p> <p>R12's Physician Order Sheet (POS) shows an order for use of a wandering device since 7/23/15 related to elopement concerns and resident safety. The order was renewed 9/20/16 upon R12's return from a hospital stay. Weekly wandering device check logs listing R12 were documented prior to 1/1/16. R12's POS also includes an order starting 9/20/16 for "Vitamin A and D topical ointment, apply by topical route two times per day as needed. Apply to both feet and legs." The ointment was ordered as needed for the diagnosis of Dermatitis.</p> <p>R12's MDS assessments (Minimum Data Set) done 9/10/16 show R12 scored 8 out of 15 on the BIMS (Brief Interview for Mental Status), indicating moderate cognitive impairment. This compares to R12's most recent MDS of 12/10/16 which shows a BIMS score of 12 out of 15, indicating mild cognitive impairment and an improvement from the prior assessment. Both MDS note R12 has fluctuating inattention and disorganized thinking, has hallucinations and delusions, no pattern of rejecting care, and needs extensive assist for dressing, toileting and</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>hygiene.</p> <p>On 1/18/17 at 2:50 PM, E9 (Certified Nurse Aide - C.N.A.) removed R12's left sock. A healed, scarred area greater than four centimeters (cm) long was noted horizontally across the point at which the foot and ankle bend occurs.</p> <p>An Accident/Incident report for R12 dated 10/23/16 notes "a minor skin tear of about 1.5 cm (centimeter) long on top of left foot around the ankle area." The report indicated R12 had pain at level 2 out of 10 and was given Tylenol 650 milligrams (mg). The incident report lists "Contributing Factors: Ankle elopement monitoring bracelet got tight on the leg. Corrective Actions Taken: Loosen ankle monitoring bracelet and wrap it with tape to prevent pressure against the skin. Measures to Prevent Reoccurrence: Ensure ankle bracelet is fitting properly." The Investigation report lists "Other risk factors: Diagnosis of Vitamin Deficiency, Dermatitis, Paranoid Schizo-affective Disorder." E2 (Director of Nursing) signed the incident report on 10/24/16 noting "Wander [device] site changed to right ankle." The report does not indicate the presence of signs and symptoms of dermatitis at the time of the incident.</p> <p>R12's Treatment Administration Record (TAR) for September note that R12's order for Vitamin A and D Ointment started 12/31/15. September 2016 and October 2016 TAR do not include initials indicating PRN (as needed) ointment was needed and applied. R12's nurse progress noted do not include mention of lower leg edema or notable dermatitis or skin irritation.</p> <p>Nursing notes by E8 (Wound Nurse) dated 10/23/16 at 4:12 PM read "Noted limping by staff</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>member - writer and C.N.A. assessed resident. Noted with open area to top of left foot. c/o (complained of) pain to area. PRN (Tylenol) given as ordered. Wound care specialist to see next visit 10/25/16. Tx (treatment) done. Will continue to monitor." No mention is made regarding edema or abnormal condition of the surrounding skin.</p> <p>R12's Skin Check Assessment Tool dated 10/24/16 done by E8 reads "Noted with necrotic area to top of left foot. Small amount of bleeding noted. Tx done. Wound care specialist to see on 10/25/16." No mention is made regarding edema or abnormal condition of the surrounding skin.</p> <p>R12's Wound Care Specialist Initial Evaluation, dated 10/25/16 by Z2 (Wound Care Physician) notes " [R12] presents with an unstageable (due to necrosis) of the left, dorsal foot of at least one days duration. There is moderate serous exudate." The wound etiology lists "Pressure, Stage: Unstageable Necrosis. Wound Size: 1.6 x 6.8 cm (centimeters), Thick Adherent Devitalized Necrotic Tissue: 100%. Additional Information: Wound etiology associated with ankle bracelet and recent use of ted (T.E.D. - Thrombo-Embolic Deterrent) hose per wound nurse." Treatment included "Wound debrided via surgical excision and subcutaneous tissue removed along with necrotic tissue." No mention is made regarding edema or abnormal condition of the surrounding skin.</p> <p>On 11/1/16, Z2's assessment read "Wound Progress - Epithelialized and Resolved." Plan: Continue present skin care and breakdown prevention."</p> <p>R12's POS notes an order starting 11/4/16 for</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>"Daily skin checks - every day at 7:00 AM - 3:00 PM, for pressure ulcer of unspecified site, unstageable."</p> <p>R12's TAR notes an order and indication of treatment to the left leg 11/4/16 - 11/11/17: "Cleanse area to left dorsal foot with normal saline and apply betadine daily - leave open to air until healed."</p> <p>On 11/9/16, nurses notes by E7 (Floor Nurse) read: "Noted a foul smell while changing resident's wound to the left foot. No drainage or swollen noted. [Physician] notified and an order for Keflex 500 mg (milligrams) QID x 10 day (four times daily for 10 days). Orders noted and carried out."</p> <p>R12's POS confirmed an order starting 11/10/16 for Keflex (Cephalexin) 500 mg four times daily and Mupirocin (Bactroban) 2% ointment to left leg wound daily starting 11/12/16.</p> <p>On 11/11/16, a wound culture was obtained from R12's left leg wound. Results reported 11/14/16 note the growth as Enterobacter cloacae, light growth, Gram negative rods - few, Gram Positive cocci in chains - many, Gram positive rods - many."</p> <p>On 11/15/16, Z2's assessment read: "Reopened Ankle. Pressure, Stage: Unstageable Necrosis. Wound Size: 1 x 2 cm (centimeters), Thick Adherent Devitalized Necrotic Tissue: 50%. Yellow Necrotic: 50%." The report indicates R12's wound was again debrided and wound treatment was ordered.</p> <p>On 1/19/17 at 11:30 AM, E8 (Wound Nurse) stated R12's leg wound when first seen on 10/23/16 was granulation tissue, with a black,</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>necrotic area. E8 stated R12 did not have support hose on, but had on mis-matched socks and dresses himself. E8 stated the wandering device was "really secure/snug". E8 stated "It doesn't take long, 24-48 hours, being tight to injure the skin - depends on the skin condition." E8 did not chart and did not state that R12's skin was in poor condition surrounding the injured area.</p> <p>On 1/19/17 at 11:15 AM, E2 (Director of Nursing) stated R12's hospital discharge records did not indicate leg edema. R12's Admission Assessment done 9/20/16 does not indicate R12 had lower leg edema and noted foot pulses were present bilaterally and no problems were noted with the condition of R12's skin. At 1:25 PM, E2 stated wandering devices are checked every shift to confirm the resident is wearing the wandering device. E2 stated the wander guard should allow at least two fingers space under the belt. E2 stated the belt cannot be removed or adjusted by the resident, so the fit remains the responsibility of the staff. E2 stated that R12 may have possibly been trying to remove the wandering device from R12's ankle. No such attempts were noted as a new or pattern of behavior in R12's progress notes or care plan. When questioned further, E2 acknowledged that R12 may have been trying to move the wandering device because it was causing discomfort. E2 stated R12 has difficulty communicating due to confusion. E2 stated R12 has behavior of digging and gouging and touching his feces. E2 stated R12 may have picked at the scab on the leg. E2 stated staff should "keep the wound dressed and closely monitored to prevent the resident from picking and contaminating it."</p> <p>R12's care plan dated 6/16/16 for Wandering</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>Device notes one intervention: "Staff will check wander [device] per facility policy." R12's care plan dated 10/23/16 for Skin Integrity - Abrasion lists the goal of "Resident will be free from infection to area involved." Interventions include: "Assess risk factors on a regular basis. Monitor healing process and regularly check efficacy of treatment." The care plan did not address R12's behaviors of picking at feces as a possible contamination concern. R12's care plan for wound care related to R12's leg wound was dated "Effective 10/19/16". That date predated the existence of R12's wound. E14 (MDS Nurse) clarified the wound care plan was first created 11/16/16, after the wound infection was noted.</p> <p>On 1/18/17 at 2:35 PM, E15 (Restorative Aide) stated weekly wandering device checks are done to assure the alarm is working and do not include device placement or skin checks.</p> <p>On 1/19/17 at 1:30 PM, E14 stated nurses check wandering devices every shift. "Checks should cover the fact that it's present and not irritating skin -- both. We just didn't write it that way." Logs presented from 10/18/16 to 11/3/16 for R12 include columns to note: Name, Room, [Device] On - Shift, Check (check mark placed in column), Nurse's Signature, and Date. No instruction is recorded on the form to indicate the elements monitored during the "check".</p> <p>The facility policy, Wandering Device Policy, dated 01/14, reads in part: "3. Apply wandering device to resident's ankle., 4. Document in medical record: - 1. Reason the wandering device is applied. - 2. Date and time applied. 5. The Care Plan must incorporate the resident's use of the wandering device. 6. Residents with</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>potential to wander that have wandering devices applied to the ankle will have the freedom to move about the facility. 7. Wandering device to be checked every shift." No policy text further defines the purpose or extent of the "check."</p> <p>On 1/19/17 at 12:31 PM, Z2 (Wound Physician) stated the timeframe for a pressure wound to develop and become necrotic depends on many factors, including any edema, vascular issues and diabetes. To become necrotic, it may or may not take more than a day.</p> <p>On 1/19/17 at 1:00 PM, Z3 (Microbiologist) from facility's contract laboratory stated wound cultures are described in terms of light, moderate or heavy growth, not by colony counts. Z3 stated any abnormal flora growth is reported and R12's growth of Gram negative rods/Few and Gram positive cocci/Many would indicate an infection.</p> <p>(B)</p>	S9999		