

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/18/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MORTON TERRACE H &amp; R CENTRE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>191 EAST QUEENWOOD ROAD MORTON, IL 61550</b>
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1010h) 300.1210b) 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 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such</p>	S9999	<p><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

05/08/17

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>accident, injury or change in condition at the time of notification.</p> <p><b>Section 300.1210 General Requirements for Nursing and Personal Care</b></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><b>Section 300.3240 Abuse and Neglect</b></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><b>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</b></p> <p>Based on record review and interview the facility neglected to provide prompt medical care to prevent worsening of a right lower extremity obstruction for one of three residents (R1) reviewed for provision of nursing care in the sample of three. This neglect resulted in R1 failing to immediately receive treatment to relieve R1's right leg from worsening ischemia (lack of blood flow) which contributed to R1's death.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Findings include:</p> <p>The facility's Abuse Prevention Program policy dated 2-7-17 documents, "The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, or mental anguish. Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident.</p> <p>R1's Nurse's Notes dated 4-6-17 at 2:45 p.m. and signed by E7 (Licensed Practical Nurse/LPN) documents, "At 2:30 pm a CNA (Certified Nursing Assistant) alerted this nurse to the resident's (R1's) room. Upon observation the resident's right foot was purple in color, cold to touch, and had no pedal pulses present. The right lower extremity becomes colder to touch approximately one centimeter below the knee."</p> <p>R1's Nurse's Notes dated 4-6-17 at 2:50 p.m. and signed by E7 documents: N.O. (New Order) venous and arterial doppler to right lower extremity. Order called to mobile imaging provider. According to the Doppler Ultrasonography Scan the dopplers were not obtained until 4-7-17 at approximately 3:03 P.M.</p> <p>R1's Right Duplex Ultrasonography Scan dated 4-7-17 of the right lower extremity documents: Mild arthersclerotic disease plaque identified. Dampened waveforms and velocities may</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>indicate a proximal obstruction. Obstruction of the right proximal superficial femoral artery and distal superficial femoral/deep femoral bifurcation (two branches). The surrounding soft tissues are normal.</p> <p>R1's Nurse's Notes do not include any other nursing assessments or documentation of the condition of R1's leg between 4-6-17 at 2:50 p.m. to 4-7-17 at 10:00 p.m.</p> <p>R1's Nurse's Notes dated 4-7-17 at 10:00 p.m. and signed by E5 (LPN) indicate that E5 received R1's doppler results indicating that R1 had a blockage to the right lower extremity sometime earlier that day; however, the physician was not notified. R1's Nurse's Notes indicate that the physician was not notified of the doppler results until 4-8-17 at 10:15 a.m., and at this same time an order was given to send R1 to the emergency room for evaluation and treatment.</p> <p>R1's Hospital Vascular and Interventional Radiology History and Physical dated 4-8-17 documents: R1 has had a painful and discolored right foot since 4-6-17. The right foot is nonviable. R1's right foot has been cool and mottled since 4-6-17. Recommend amputation of the right lower extremity; however, the family wants to focus on comfort. Start Zosyn (Antibiotic) by I.V. (Intravenous) due to infection starting to set into the right leg. Palliative Care consulted for comfort care. Resident was at a (long term care facility) and family wants to discharge R1 to a different (long term care facility).</p> <p>R1's Hospice Admission Assessment dated 4-12-17, documents R1 was admitted to hospice for the diagnosis of Ischemia Right Foot.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>R1's Clinical Note Entry (from the alternative long term care facility) dated 4-17-17 at 5:09 a.m. documents that R1 passed away at 4:00 a.m. due to medical reasons.</p> <p>On 4-13-17 at 11:20 a.m., Z2 (Nurse Practitioner) stated, "I was notified that (R1) had a cold lower extremity with no pulse. I gave an order for dopplers to be done. I thought the dopplers would be done the same day. I did not realized the facility had the doppler results earlier than 4-8-17. I should have been notified as soon as they (the facility) received the results. I was notified of the results on 4-8-17 and gave an order to send (R1) directly to the emergency room. The quicker the treatment of this obstruction, the better it would have been for (R1)."</p> <p>On 4-13-17 at 11:45 a.m., E2 (Director Of Nursing/DON) stated, "I would have expected the nurses to follow up with the physician or nurse practitioner before 5 or 6 pm that day (4-6-17) that the doppler had not been done yet. The doppler was not obtained until 4-7-17 at 3:03 p.m."</p> <p>On 4-17-17 at 11:55 a.m., E2 (DON) stated, "When (R1's) doppler results were back they should have been called to the nurse practitioner or physician immediately. According to (R1's) chart, E5 (LPN) received the doppler results on 4-7-17 around 10:00 p.m. and did not call the physician. A blockage to the right leg should be treated immediately."</p> <p>On 4-18-17 at 1:30 p.m., Z5 (Family Member) stated, "We (the family) were given the option to amputate (R1's) leg or get hospice to let (R1) pass away. The physician at the hospital said</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>(R1) should have been treated sooner to save the leg. The nursing home neglected her."</p> <p>On 4-18-17 at 9:30 a.m. Z1 (R1's Surgeon) stated, "With (R1) being 81 years old she could have had poor circulation, however when the staff noticed the cold extremity with no pedal pulse the dopplers should have been done within two hours. The dopplers indicated (R1) only had mild arthersclerotic disease and not severe, and the soft tissues were normal. By the time (R1) got to the hospital her right leg was cold and dead, and nothing could be done to save the leg. When the staff received the results of the doppler, treatment should have been obtained immediately to try and save (R1's) leg. Less invasive treatment could have been done initially to try and clear the obstruction. (R1's) right leg ischemia was the first domino leading up to (R1's) death. The lack of, and delay in treatment, of getting the dopplers and getting the resident treatment when they (the facility) know there was an obstruction of the right femoral artery was neglectful."</p> <p>(A)</p>	S9999		
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