

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ILL6005623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2017
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NAME OF PROVIDER OR SUPPLIER LYDIA HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 13901 SOUTH LYDIA ROBBINS, IL 60472
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S 000	Initial Comments Complaint #1792610/IL93714	S 000		
S9999	Final Observations Statement of Licensure Violation: Section 300.1210 General Requirements for Nursing and Personal Care 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) 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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: 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide effective supervision and carry out a plan of care to prevent subsequent Pica behaviors(eating disorder related to persistent ingestion of non-nutritive substances or items) for two of six (R1 and R6) residents reviewed for behavior in a sample of six. The failure resulted in R1 continuing to ingest foreign objects with the potential for further foreign object removal surgery. Findings include: R1's facility face sheet dated 1/20/2017 documents an initial admission date of 8/14/2015. R1's progress notes dated 9/24/2015 at 10:00AM, documents Z1 (R1's family) called the facility to report R1 has a history of Pica behavior	S9999			

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S9999	<p>Continued From page 2 (consuming objects with metal in them).</p> <p>R1's progress note dated 9/25/2015 at 9:15AM, documents R1 was noted cleaning feces off a battery in R1's toilet. R1 stated "I want my battery back." R1 denied swallowing the battery. The progress note also documents R1's plan of care was to be updated to reflect the behavior. Staff was notified to increase wellness checks that consist of random body and room searches for any objects such as batteries, pens, needles, paper clips etc. (et cetera) X-ray and ultra sound ordered as a safety precaution."</p> <p>R1's Kidney Ureter Bladder x-ray dated 9/26/2015 documents "Impression- two radiopaque areas to the left upper quadrant overlaying artifacts are seen due to either extraneous in nature in the patients shirt versus possible swallowed foreign objects."</p> <p>R1's progress note dated 10/5/2015 documents R1 was sent to the hospital for increased socially inappropriate behaviors, swallowing foreign objects and disorganized thought process for a psychiatric evaluation. R1's Medical Assessment and Follow-up dated 10/5/2015 documents a "history of Present Illness: (R1) was admitted to the Psychiatric Unit because (R1) has been increasingly delusional, bizarre behavior and (R1) is swallowing foreign bodies. X-ray shows some objects in the colon area at the Emergency Room." No medical intervention documented.</p> <p>R1's Initial Psychiatric Evaluation from hospitalization dated 10/6/2015 documents "(R1) has not been taking (R1's) medications repeatedly swallowing foreign objects like dirt and batteries. (R1) had this behavior previously."</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>R1's progress note dated 4/9/2016 through 4/10/2016, documents R1 reported to staff R1 had ingested an inedible object while on unit six of the long term care facility. R1 complained of stomach pain. 1:1 (one to one) monitoring initiated for 72 hours. Ultrasound technician performed ultrasound in facility but could not see an object in R1's abdomen. The Doctor ordered a Kidney Ureter Bladder (KUB) x-ray to be completed at the facility in the morning. No foreign objects found on KUB.</p> <p>R1's progress notes from local hospital dated 12/20/2016 at 11:51AM, documents " "Writer heard a noise in the hallway. Writer then went to the rooms to check out noise. (R1) had a broken light bulb and stated (R1) was going to ingest the bulb. The bulb was retrieved from (R1). (R1) was searched for any other contraband materials. (R1) was then counseled on Pica behavior and again placed on 1:1 monitoring until sent out to the hospital. (R1) was sent to the local hospital for an evaluation."</p> <p>R1's hospital record from 12/20/2016 documents a KUB showing foreign object in the abdomen on admission.</p> <p>R1's progress note dated 12/26/2016 at 1:43PM, documents the hospital called stating R1 will have surgery on 12/27/2016, related to four foreign objects in R1's abdominal cavity. R1's Hospital Progress Note states an exploratory laparotomy was completed on 1/5/17, due to ingestion of foreign objects.</p> <p>R1's Psychiatric Evaluation dated 1/12/2017 documents "Start (R1) back on medication to help work through (R1's) thought process and mood. (R1) will be discharged when (R1) is no longer a</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>threat to (R1's) self or others."</p> <p>On 5/11/2017 at 1:40PM, Z3 (R1's Nurse Practitioner) stated "I would expect staff to move the resident close to the nurses station for closer monitoring with routine checks. There are serious medical issues that can occur from ingesting batteries and light bulbs, such as gastrointestinal tears or bowel obstructions which would require surgical interventions."</p> <p>R1's progress note dated 1/20/2017 at 5:33PM documents R1 returned from the hospital with twenty staples to the abdominal surgical wound.</p> <p>R1's progress note dated 1/22/2017 at 4:05PM, documents R1's family requested R1 to be monitored more closely upon return from the hospital due to R1's recent surgery for Pica behavior.</p> <p>R1's progress note dated 2/15/2017 at 10:08 AM documents "(R1) has been and will continue on 1:1 with staff indefinitely due to current diagnosis of Pica."</p> <p>R1's progress note dated 4/5/2017 at 11:30AM, documents "(R1's) room was searched as care planned for monitoring of random room searches and staff observed (R1's) call light bulb missing. A KUB was ordered." R1 remains on 1:1 monitoring.</p> <p>R1's progress note dated 4/6/2017 at 11:27AM, documents "(R1) was noticed with a pen top, battery and an unidentified object in (R1's) mouth. R1's progress note dated 4/6/2017 at 12:00PM documents "Writer spoke to (Z1, Family) related to (R1's) transfer to the local hospital related to KUB results indicating dense objects in the pelvic</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>and abdomen." R1's Computed Tomography report from the hospital dated 4/7/2017 at 1:15PM, documents "Impression- there are multiple foreign bodies in (R1's) bowel. Approximately six are identified."</p> <p>On 5/5/2017 at 9:50AM, E1 (Administrator) stated "(R1) did not have a Pica behavior on admission. (R1) was sent out in April of 2017, because a dense object was seen on a KUB. (R1) was on 1:1 at that time. I was not aware of the diagnosis of Pica until January of 2017."</p> <p>On 5/5/2017 at 10:15AM, E2 (Director of Nursing) stated "I was not aware (R1) had the Pica behavior until January of 2017 when the first Pica incident occurred. The January incident (R1) had ingested batteries and the plastic cover to a syringe. (R1) had open abdominal surgery to remove these objects. When (R1) returned to the facility (R1) was placed on indefinite 1:1 supervision. (R1) remained on 1:1 supervision until (R1) was sent to the hospital in April for again ingesting batteries and call light bulbs. The Pica diagnosis (Eating disorder) was added to (R1's) diagnosis after the January incident." E2 also stated, "Possible sources of batteries would be television remotes, radios and other handheld electronic devices. (R1) is the only consumer who ever resided at the facility who had Pica behavior."</p> <p>On 5/10/2017 at 8:45AM, E6 (Operational Director) stated "The light bulb that (R1) removed was a call light bulb above the room door in the hallway. There is a plastic cover over the light bulb, which easily pops off to expose the light bulb. The light bulb glass and the bulb filament are each one half inch in length. The day that (R1) went out to the hospital I had to replace at</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>least four call light light bulbs. The light covers were found in (R1's) room. The hallway camera had been broken by someone that day, so there is no film documenting who removed the bulbs."</p> <p>On 5/9/2017 E2 stated "I reviewed the care plans from when (R1) was admitted. There was a care plan for a history of swallowing objects on the admission care plan dated 8/27/2015 , the 11/27/2015 and the 3/18/2016 care plans then the behavior was dropped. I'm not sure what happened. I re-added a care plan dated 2/2/2017 after the January Pica incident. (R1) did not have a diagnosis of Pica behavior until after that January 2017 incident. I (E2) was not aware of this behavior before January 2017."</p> <p>R1's admission care plan dated 8/27/2015 documents an identified problem, history of swallowing foreign objects. The care plan dated 11/27/2015 and 3/18/2016 continue to document this problem. There is no further documented plan of care for history of swallowing foreign object behavior until 2/2/2017 at which time 1:1 monitoring with staff "indefinitely" was an approach.</p> <p>On 5/5/2017 at 10:15AM, E2 (Director of Nursing) stated, "When staff are providing 1:1 supervision they are to be within eye sight of the consumer at all times. There is no form where staff document 1:1 supervision."</p> <p>On 5/5/2017 at 1:20PM, E8 (Resident Services Assistant) stated" (R1) was 1:1 (within eye sight) after January 2017. I took care of (R1) most of the time. I would take (R1) to eat, smoke and monitor (R1) the rest of the time, except when (R1) was sleeping or using the bathroom. I did round on other residents at that time.</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>On 5/5/2017 at 1:20PM, E8 (Resident Services Assistant) also stated "I am currently doing 1:1 with (R6) so (R6) doesn't pick out (R6's) sutures."</p> <p>On 5/5/2017 at 1:20PM, E8 was standing at the charting room door talking to E9 (Mental Health Professional) upon entering the unit. R6 was sitting in the day room. (R6) then got up and started walking down the long hall on unit six. There was a door and wall in E8's line of vision. R6 could not be seen from where E8 was standing.</p> <p>On 5/5/2017 at 1:30PM, E9 (Mental Health Professional) stated "I don't know if (R1) had the behavior of ingesting objects before the first incident in January. When staff is 1:1 with a resident they are to be in eye sight of the resident unless they are sleeping (They can sit out side the residents bedroom door) or if the resident is using the bathroom. (R6) is currently on 1:1 supervision to ensure the sutures stay in above (R6's) left eyebrow."</p> <p>On 5/9/2017 at 11:25AM, Upon entering unit 6, R6 was sitting in the day room with three peers with no staff present.</p> <p>On 5/9/2017 at 11:25AM, E2 (Director of Nursing) asked who was assigned to 1:1 supervision with R6 at the unit 6 nurses station. E7 stated "I am 1:1 with (R6). " E2 stated "You are to be in the same room as (R6) not walking in the hallway where (R6) is out of your sight." E2 also stood at the chart room door verifying staff were not able to see the day room from there. E2 stated "(E8) should not have been standing at the chart room on 5/5/2017 when (R6) was in the day area if (E8) was assigned to 1:1 with (R6)."</p>	S9999		
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S9999	Continued From page 8 The facility "1:1 Policy" dated 1/5/2016 documents "Statement: It is the policy of the facility that any consumer experiencing a behavioral crisis and/or requires supervision to maintain safety due to their behavior of medical issue will be evaluated by a member of the clinical team." The policy also documents "The staff will be with the consumer at all times on and off the unit ." "If a consumer is sleeping, the staff will be present outside the consumer's room and will continue to monitor the consumer upon them waking up." <p style="text-align: center;">(A)</p>	S9999		
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