

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016406	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2017
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NAME OF PROVIDER OR SUPPLIER ADMIRAL AT THE LAKE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 933 WEST FOSTER AVENUE CHICAGO, IL 60640
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S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a)b) 300.1220b)2)3) 300.3240a) Section 300.610 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 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. Section 300.1210 General Requirements for Nursing and Personal Care	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 04/03/17
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S9999	<p>Continued From page 1</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 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>Section 300.1220 Supervision of Nursing Services</p>	S9999		

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S9999	<p>Continued From page 2</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, 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.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to implement a plan for monitoring and prevention of constipation and a potential fecal impaction for a resident with a known history for one of one resident (R2) reviewed for constipation and fecal impaction in the sample of 10. This failure resulted in R2 experiencing pain and being sent out to the hospital for evaluation and assessed with constipation and a reoccurrence of fecal impaction.</p> <p>Findings include:</p> <p>On R2's Profile Face Sheet lists a diagnosis of "Constipation, unspecified" dated 03/11/16 at R2's initial admission to the facility.</p> <p>On 1/15/17 at 5:00 PM, R2 was transferred to the hospital for evaluation. Facility nursing notes indicate R2 had a "Fever of 100.2 *F (degrees Fahrenheit), lethargy and weak, loss of appetite, congestion." R2's hospital Admission History and Physical Form, dated 1/16/17, notes on page one of four: "had abdominal pain in ED (emergency department)." Page four of four reads in part: "Clinical investigation available at time of admission - Constipation with impacted fecal material in the rectum." A hospital consultation report dated 1/16/17 reads in part: "Of substance, the patient also was found to have constipation with impacted fecal material in the rectum. The rectal measured 9.5 cm (centimeters) in diameter." "CT (computerized tomography) scan as described, I reviewed the images and it appears that mild Hydronephrosis which [R2] has bilaterally extends to the level of the pelvic brim where there is a large amount of stool sitting in [R2's] colon." "Plan: 2. Rigorous</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>bowel regimen to evacuate [R2's] large amount of stool."</p> <p>R2 was readmitted to the facility on 1/27/17 at 8:30 PM. A review of R2's January Physician Order Sheet (POS), Electronic Medical Record (EMAR) and Electronic Treatment Record (ETAR) include one order for "Miralax 17 gram oral powder packet, mix 17 grams with eight ounces of water/juice PO q PM (by mouth every evening); at 1700 (5:00 PM)." The order was dated and active 3/11/16 - 1/15/17 and was reauthorized at readmission 1/28/17. No other orders were present for other medications, scheduled or as needed, or for other interventions to prevent constipation/impaction and monitor R2's bowel activity.</p> <p>Daily charting logs of R2's bowel movements (BM) indicate R2 had no BM on 1/28/17, a medium BM the evening of 1/29/17 and 1/30/17 and no BM 1/31/17. No documentation on the care partner logs or nursing notes indicates if the stools reported 1/29/17 and 1/30/17 were hard, soft or loose/liquid.</p> <p>On 2/1/17, R2's nursing interdisciplinary note created at 2:54 AM reads in part: "Resident complains of epigastric/mid-epigastric region discomfort, states not being able to sleep due to discomfort. Denies pain/discomfort to other area of abdomen. Bowel sounds hyperactive, abdomen soft none distended. Fecal impaction of hard stool noted." "Z1 (Physician) notified with order to administer Tylenol 650 mg (milligrams), Mylanta 30 ml (milliliters) one time only, urinalysis and culture/sensitivity, Sennosides Docusate Sodium one tablet twice daily and fleet enema one time only."</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>Z1's charting on 2/4/17 notes "Found to have fecal impaction which was addressed."</p> <p>Following the second impaction on 2/1/17, R2's POS included a continuing order for Senexon-S 8.6 mg - 50 mg one tablet by mouth twice daily.</p> <p>On 2/13/17 at 6:07 PM, results of an abdominal X-ray, ordered due to charted complaints of abdominal discomfort, notes "Fecal balls in the distribution of the colon would suggest a degree of dehydration."</p> <p>On 2/17/17 at 10 39 PM, R2's blood pressure was 96/65 and R2 was sent to the hospital for evaluation of lethargy. Facility nursing notes 2/18/17 at 7:48 AM read in part: "[R2's] admitting diagnosis is altered mental status and dehydration." On 2/19/17, R2 was readmitted to the facility. Hospital discharge records indicate diagnoses of "Constipation, Delirium, Fecal Impaction , and Urinary Tract Infection."</p> <p>On 2/23/17, physician orders for an additional dose of Miralax were initiated: Miralax 17 grams twice daily.</p> <p>As of 2/28/17, R2 has no care plans addressing a diagnosis of constipation or interventions for monitoring and addressing R2's bowel patterns to prevent constipation and fecal impaction.</p> <p>On 2/28/17 at 11:40 AM, Z1 stated R2's fecal impaction did not cause, but may have contributed to R2's urinary retention and Hydronephrosis. Z1 stated that, after R2's episodes of fecal impaction, Z1 discussed with facility management the need to be sure care partners understand the importance of monitoring and charting bowel movements accurately.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 3/2/17 at 9:50 AM at a morning feedback presentation, E2 (Director of Nursing) stated being unaware that R2 had a fecal impaction. E2 stated no policy or procedure for bowel regimens could be located, but stated staff record the number and volume (small, medium, large) of resident bowel movements and would notify physicians if residents have not had a bowel movement in two to three days as a standard. No other elements of a bowel regimen were described.</p> <p style="text-align: center;">(B)</p> <p>300.610a) 300.1210a)b) 300.1210d)5) 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</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>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>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 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>	S9999		

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S9999	<p>Continued From page 8</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</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 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>by:</p> <p>Based on observation, interview and record review, the facility failed to follow the pressure sore prevention policy/protocol and conduct a weekly skin assessment and failed to apply wound treatment as ordered by the physician and failed to follow the plan of care pressure sore prevention interventions for one of one resident (R2) reviewed for pressure ulcers in the sample of 10. This failure resulted in R2 having redness noted on the sacral area then assessed 9 day later with an unidentified open stage 2 pressure sore to sacral area.</p> <p>Findings include:</p> <p>On 1/27/17, R2 was readmitted to the facility from the hospital. R2's initial skin assessment on 1/27/17 reads, in part: "Redness to sacral area - moisture barrier cream applied."</p> <p>R2's Braden Scale for predicting pressure sore risk was scored as follows, with a score of 14 or less indicating at risk for pressure ulcer development: 2/2/17 = 11, 2/21/17 = 13. No Braden assessments were recorded between 7/12/16 and 2/2/17. Prior scores were: 3/11/16 = 16, 6/15/16 = 14, 6/23/16 = 14, 7/12/16 = 13.</p> <p>Nursing interdisciplinary (ID) notes on 1/28/17 read "barrier cream applied with each incontinence episode to redness on sacral area." No other description of R2's sacral/coccyx area was charted and no wound assessment of R2's sacral/coccyx skin condition was recorded until 2/7/17.</p> <p>Nurse ID notes created 2/7/17 at 7:43 PM read in</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>part: "Brought to my attention by care partner that resident skin to buttock area is open, writer attended and noted Stage 2 pressure ulcer to coccyx, 2.5 x 0.5 cm (centimeters) beefy red. Right sacral Stage 1 pressure measure 2 cm x 1 cm reddish bluish discoloration, right and left groin reddened macerated skin. E2 (Director of Nursing) notified and assessed sacral/coccyx. Z6 (Nurse Practitioner) called with order for [hydrocolloid] dressing every 72 hours and as needed, Nystatin powder to left/right groin twice daily and reposition every two hours when in bed."</p> <p>Skin Evaluation Forms completed by E3 (Assistant Director of Nurse/Wound Care Nurse) note the following: 2/8/17 - "Coccyx - 2.5 cm x 0.5 cm - Stage 2 with moderate (serosanguinous) drainage noted, surrounding redness noted." 2/19/17 - "Coccyx - 3.0 cm x 2.0 cm x 0.2 cm - Stage 2 pressure ulcer with moderate drainage (purulent) noted, resident readmitted from hospital." 2/23/17 - "Coccyx - 3.0 cm x 2.0 cm x 0.1 cm - Stage 2 pressure ulcer with moderate purulent drainage, surrounding skin with redness and excoriation, wound bed with slough and noted dark black and yellow in color."</p> <p>R2's POS includes an order dated 2/23/17 to start on 2/24/17: "Cleanse area with normal saline, apply nickel thick layer of Santyl ointment to wound bed, apply zinc oxide to surrounding redness, cover with sacral size [self-adherent absorbent foam] dressing daily at 6:00 AM. Document appearance of wound in ID notes."</p> <p>On 2/28/17 at 1:30 PM, E4 (Nurse) removed R2's coccyx dressing and the wound was observed to</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>be mostly covered with slough with a small darkened/black area at the base. After cleansing the wound with normal saline, E4 changed gloves and dispensed Santyl cream directly from the tube onto the gloved fingertip, then used the fingertip to apply the Santyl to the wound. E4 patted and spread the Santyl onto the area; unable to determine if a "nickel thick layer" was applied as ordered. E4 again changed gloves without hand hygiene and dispensed Zinc oxide from the tube directly onto a gloved fingertip and applied zinc oxide in an arch approximately one half inch wide to half of the wound perimeter, then used another fingertip to obtain zinc oxide from the tube and applied it to the other half of the wound perimeter. E4 did not apply zinc oxide to the entire reddened area as directed in the treatment order, leaving approximately a two inch band of redness untreated around the perimeter. E4 did not perform handwashing or use hand gel after each observed glove removal and prior to donning new gloves.</p> <p>On 3/1/17 at 1:53 PM, E3 stated Braden assessments should be done on admission and quarterly. E3 stated R2's sacral/coccyx wound was initially charted as redness on readmission 1/27/17, but that E3 "might have seen more." E3 stated she was not informed about R2's wounds to assess them before 2/8/17. E3 stated the air mattress is usually put at the highest setting unless the resident requests something else for comfort. E3 stated "The Static setting is what is usually used so it stays flat; otherwise it would be alternating."</p> <p>On 3/1/17 at 11:40 AM, Z1 (Physician) stated that R2's initial skin redness would be manageable "ideally with barrier cream and proper turning and cleaning." Hospital records listed R2's weight at</p>	S9999		
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S9999	<p>Continued From page 12</p> <p>132 lbs (pounds) at discharge and Z1 reported R2 had swallowing issues while in the hospital that were improving. Z1 described working with dietary and "sacrificed glycemic control to get calories, and adjusted Metformin to allow [R2] more intake." Facility weights for R2 were 137.4 lbs on 2/1/17, 133 lbs on 2/9/17, 135 lbs on 2/15/17, 137.2 lbs on 2/23/17 and 136.8 lbs on 3/1/17.</p> <p>R2's Physician Order Sheet (POS) includes an order starting 2/19/17 for a "low air loss mattress." On 2/28/17 at 1:40 PM, E4 completed wound care and left R2's room. R2 was in bed on an air mattress with the pressure setting dial fully turned toward "Firm" and the "Static" light on. On 3/1/17 after wound care at 8:22 AM, R2 was again in bed with the air mattress set to Firm and Static. E17 (Nurse) stated "It's always set like that."</p> <p>The operating manual for the low air loss mattress instructs that the pressure-adjust knob should be set based on the "Hand-check procedure: Check if the pressure is properly adjusted by sliding one hand between the air mattress and the foam base to feel the patient's buttock. Users should be able to feel the space in between, and the acceptable range is 25 to 40 mm (millimeters). This hand check procedure is issued by AHCPR (Agency for Health Care Policy and Research)."</p> <p>The facility's policy, Pressure Ulcer Prevention, revised November 2012, reads:</p> <ol style="list-style-type: none"> 1. Pressure ulcer risk assessments are completed for each resident on admission and weekly for three weeks after the admission utilizing the Braden Scale. 2. After the initial assessments, pressure ulcer 	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016406	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/06/2017
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S9999	Continued From page 13 risks will be assessed quarterly, annually and for a significant change if needed. 9. Each resident will have a pressure reducing mattress. If nursing or therapy assess that a resident is at greater risk when he/she is in bed, the mattress will be upgraded to an alternating pressure mattress. (B)	S9999		
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