

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/11/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MADO HEALTHCARE - UPTOWN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4621 NORTH RACINE AVENUE CHICAGO, IL 60640</b>
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S 000	Initial Comments  Complaint Investigations: #1782434/IL93521-No Deficiency #1782667/IL93770----F314G	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b) 300.1210d)2)5) 300.1220b)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 b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/01/17

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>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 and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</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>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.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These requirements were not met based on evidence by;</p> <p>Based on observation, record review and interview the facility failed to follow their Pressure ulcer policy to appropriately care for one resident (R2) of three residents reviewed for pressure ulcer in a sample of 3 residents. This failure resulted in R2's development of pressure ulcers which progressed to Stage 4..</p> <p>Findings included:</p> <p>Medical record for R2 documented a 73 year old with initial admission to facility on 3/26/2002 and latest readmission on 4/24/2017. Minimum Data Set (MDS) for R2 dated 4/11/2017 did not document a score on the Brief Interview for Mental Status(BIMS). According to MDS, R2 did not ambulate and required extensive to total assistance for all Activities of Daily Living Skills(ADLS). She had an indwelling catheter and she was incontinent of bowel. Upon admission on 3/26/2002, R2's skin was intact. BRADEN scale for R2 dated 2/1/17 scored 19 which was not considered high risk according to E2(Director of Nursing, DON) There was no other skin assessment after pressure ulcers were identified on 3/4/2017.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>On 3/4/2017 weekly wound report noted measurements of R2's wounds were as follows: Left Trochanter--3.0centimeter(cm)x 5.0 cm; Left buttock--2.0cm x 5.0cm; Right great toe--4.0cmx2.5cm. There was no mention of wound to right foot.</p> <p>On 3/6/2017 at 8:00PM, R2 was sent to community hospital for psychiatric evaluation.</p> <p>On 3/8/2017, hospital record documented the following pressure ulcers as present upon admission: Sacrum stage 2 measured 0.5cmx0.4cmx0.1cm; Left greater trochanter unstageable and measured 3.8cm x 5.2cm and treated with Hydrogel and foam dressing. Left Ischial tuberosity stage 3 and measured 3.0cm x 3.2cm x0.1cm and treated with foam dressing and Hydrogel. Right inner Bunion /foot, unstageable Right medial foot- unstageable and measured 2.0cm x 2.2cm and treated with foam and Hydrogel dressing. Right medial heel suspected deep tissue injury which measured1.0cm x 0.6cm and treated with foam dressing.</p> <p>While in hospital, R2 was placed on stage 4 mattress and an indwelling catheter was placed and the wound on sacrum was debrided according to records.</p> <p>On 4/24/2017 facility documented the following pressure ulcers upon R2's readmission from hospital: Sacrum---10cm x 9.0cm x 5.5cm Left trochanter--5.0cm x 4.0cm and Right inner bunion--1.5cm x 2.0cm</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>On 5/10/2017 at 12:30PM, R2 laid on her back in bed with no pressure relieving mattress on bed. There was no posting or sign over bed in relation to turning and repositioning. There was no intervention of turning and repositioning as an intervention on care plan. R2 had no heel protectors on heel. Physician orders for R2 for 3/1/2017 noted, "Heel protectors at all times". Indwelling urinary catheter had 200 cc. dark amber urine to drainage bag. R2 was awake and answered simple questions very slowly. She was not able to turn in bed without assistance.</p> <p>One Intervention noted in care plan for R2 initiated on 3/17/2017 documented, "heel protectors" as the only intervention for Healing of R2's wounds.</p> <p>Sacral ulcer was large and bed of wound reached to the bone and with areas of necrosis in the wound but was treated with wet to dry dressing. Left trochanter was a deep circular wound with yellow slough and treated with Santyl ointment. There was no treatment orders for wounds on bilateral feet.</p> <p>On 5/10/2017 at 12:35PM, E3(Assistant Director of Nursing, ADON) said there was no order written for the sites on feet and there should have been orders. She treated right foot bunion and necrotic area on left heel with wet to dry dressing and said she will call the physician for orders. On 5/10/2017 at 1:00PM, E3 said R2 should have had heel protectors on. She said R2 was not referred to community wound care services and the facility did not have a wound nurse.</p> <p>On 5/11/2017 at 9:30AM, R2 sat in wheelchair</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>with no pads in chair. She was assisted in bed for wound measurements.</p> <p>On 5/11/2017 at 10:30AM, measurement of R2's wounds were done by E3 and E7(Licensed Practical Nurse, LPN). During wound care, R2 said she was in pain. E7 said, "I gave her Tylenol at 9:00AM". E3 said, "I will call Physician and get a stronger pain medication". They stopped the treatment at that time.</p> <p>On 5/11/2017, the wounds measured as follows: Sacral---10cm x 12.0cm x3.5cm with necrosis in upper areas. Left trochanter--5.0 cmx 3.0cm x 1.8cm. Right foot inner bunion---2.6cm x 3.0cm. Left heel was necrotic and dry. R2's leg and feet were extremely dry and flaky. E3 said,"She needs some lotion on her feet.</p> <p>Care plan for R2 initiated on 3/17/2017 documented skin impairment with generalized interventions and with no individualized implementation of treatment to promote wound healing.</p> <p>On 5/11/2017 at 3:00PM,E6 (Care Plan Coordinator, LPN) said those were all the interventions that were implemented for R2's wounds. He did not answer most of questions asked about the care plan for R2.</p> <p>On 5/10/2017 at 2:45PM, E2(Director of Nursing, DON) said the only mattresses they used for pressure ulcers were water mattress or egg crate. She said R2 should have one water mattress on her bed.</p> <p>On 5/11/2017 at 3:20PM, Z2 (Physician) said,"We tried everything including air mattress and the</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>wounds got worse". Z2 was surprised when he was told R2 had no special mattress on bed. He said she should have had a special mattress.</p> <p>Facility's undated policy on Pressure ulcers documented,"1. Any resident admitted with Decubitus ulcer(s) use of special, pressure relieving mattress must be initiated (i.e water mattress or egg crate mattress). 2. Reposition every two hours or as needed, if resident is unable to shift weight".</p> <p>Facility's undated policy on wound assessment noted in #4,"Any resident with wounds, ulcers and other skin abnormality will be referred to Home Physician's Wound Specialist for consultation and management.</p> <p>Facility's undated policy on Care plan documented,"Care plans are revised as changes as changes in residents' condition dictates".</p> <p>(B)</p>	S9999		
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