

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PIATT COUNTY NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1111 N STATE ST MONTICELLO, IL 61856</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Annual Recertification and Licensure Survey  Investigation of Facility Reported Incident of 3/23/22/IL145333	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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  a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	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

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S9999	<p>Continued From page 1</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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>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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>that each resident receives adequate supervision and assistance to prevent accidents.</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 evidence by:</p> <p>Based on interview, and record review the facility failed to ensure that a resident was not subjected to manual restraint by staff during incontinence care, failed to follow care plan interventions and failed to follow facility policies. This failure affects one (R16) of three residents reviewed for abuse in a sample list of 35. This failures resulted in R16 sustaining skin tears to hands and multiple bruises to R16's arms after calling out for help when staff held R16's hands down during incontinence care.</p> <p>Findings include:</p> <p>R16's resident dashboard dated 4/5/22 includes the following diagnoses: Normal Pressure Hydrocephalus, Dementia, Palliative Care, History of Fall, Generalized Anxiety Disorder, and Type II Diabetes.</p> <p>R16's MDS (Minimum Data Set) dated 1/21/22 documents R16 is severely impaired and requires extensive assistance of two or more staff members for transfer, bed mobility, and toileting.</p> <p>R16's Care Plan documents (R16) exhibits agitation and may become at times combative. Lorazepam as ordered. Date Initiated: 10/28/2021 Revision on: 3/29/2022 (R16) will exhibit</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>agitation less than 5x by next review. Date Initiated: 10/28/2021 Revision on: 01/24/2022 Target Date: 04/22/2022. Check to determine if behavior is due to pain or discomfort; address as appropriate. Date Initiated: 10/28/2021 Engage by smiling, small-talk, conversation, and redirection. Date Initiated: 10/28/2021 If combativeness is observed, document on reverse of Behavior Tracking Log and notify the nurse. Date Initiated: 10/28/2021 Monitor and record behavior via behavior tracking document; include response to interventions. Notify nurse if behavior persists or worsens. Date Initiated: 10/28/2021 Provide reassurance and re-orient to surroundings and staff. Date Initiated: 10/28/2021 Re-approach with two caregivers. Date Initiated: 10/28/2021.</p> <p>The facility's final report to state agency dated 3/25/22 documents "On 3/23/22 (V21) CNA (Certified Nurse's Aide) reported to V23, LPN (Licensed Practical Nurse) (R16) had been calling out for help and it sounded like he was in pain. (V21) went into the room to help (V20) transfer (R16). (V20) told (V21) he had to hold (R16's) hands down to change (R16)."</p> <p>On 4/5/22 at 2:15PM V20, CNA (Certified Nurse's Aide) stated " (on 3/23/22) I went into (R16's) room to change him. (R16) was incontinent of urine and Bowel Movement (BM). (R16) had started to take off his clothes and (incontinence garment). (R16) was fighting me and I held (R16's) wrists down to clean (R16) and change (R16). I did know if (R16) was being difficult I should have got more staff to help. (R16) was covered in urine and BM. I wanted to keep (R16's) hands out of it. I am a permanent CNA on the hall (R16) is on."</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>On 4/5/22 at 2:22PM V21, CNA (Certified Nurse's Aide) stated "(On 3/23/22) I was in the hall outside (R16's) room. I heard (R16) screaming out 'help me help me'. (R16) sounded like (R16) was in pain so I went into (R16's) room. (V20) was already in the room. (V20) told me he had to hold (R16) down because (V16) was fighting. I noticed (R16's) hand was bleeding. (R16) said 'get your brother (V20) out of here. He is too rough.' (R16) was pointing at (V20) when (R16) said your brother. I helped (V20) finish cleaning (R16) up. Something about it just didn't seem right to me so I reported it to (V23) LPN (Licensed Practical Nurse). Soon after that, (V20) was out of the facility."</p> <p>On 4/5/22 at 3:00PM V23 stated "On 3/23/22 I was the nurse responsible for (R16). I was actually giving report to the next shift when (V21) came to me and reported that she had heard (R16) calling out as if (R16) was in pain 'help me'. (V21) said she went in (R16's) room and (V20) told her he had to hold down (R16) because (R16) was fighting him when he tried to clean (R16) up. (V21) said she thought (R16) was bleeding from (R16's) hands. I immediately reported it to Administration and (R20) was suspended so they could investigate. I did a full body assessment of (R16). I found actively bleeding skin tears on both (R16's) hands and bruises on both (R16's) forearms. I cleaned and dressed the skin tears. The bruises were red and purple like new bruises. I had seen (R16) within the hour before this and (R16) did not have the skin tears or bruises. I documented it. (R16) can be combative and resists care, but if you explain what you are doing and get help (R16) will usually be OK."</p> <p>R16's Progress note dated 3/23/2022 at 5:24PM</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>by (V23 LPN) documents "New areas noted to residents skin; Skin tear to Right dorsum (back of hand), Skin tear to Left dorsum (back of hand). Bruises noted to Right dorsum, Right outer wrist, Right hand 1st digit, Right inner forearm, Left inner forearm, Left inner wrist Left hand 5th digit. Power of Attorney notified.</p> <p>On 4/5/22 at 4:00PM V1, Administrator stated "I was notified shortly after the incident on 3/23/22 (V16), our Finance Manager was the Manager on call and she called me as soon as she had initiated the investigation. By the time I was called (V20) had already been escorted out of the building by the Registered Nurse in the building at that time. We investigated and concluded since there were no witnesses in the room at the time we could not prove it was abuse, but we all agreed it was a bad choice (V20) made to attempt to provide care without help when (R16) was resistive. The RN supervisor has done one-on-one education with (V20) concerning how to approach residents when they resist care.</p> <p>The facility's policy Abuse, Neglect, Involuntary Seclusion, Misappropriation of Resident Property, Injuries of Unknown Origin, and Social Media dated 8/22/16 under "Prevention of Abuse) states "19. Appropriate interventions to address identified behaviors will be included on Resident Care Plans, and reviewed as/when change occurs. These interventions will be communicated to the direct care givers."</p> <p>(B)</p>	S9999		