| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145629 | A. BUILDING _____ B. WING _____ | C 01/12/2006 |

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| **PRAIRIE MANOR NRSG & REHAB CTR** | **345 DIXIE HIGHWAY CHICAGO HEIGHTS, IL 60411** |

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| F 442 | Continued From page 9<br><br>Per review of the "Contact Precautions" sign posted on R4's door, "Remove gloves before leaving patient room." Review of the facility's policy "Contact Precautions" states: "Wear gloves when entering the room prior to any contact with the resident or environment...remove gloves and wash hands before leaving the resident's room."<br><br>3. On 12/01/2005, E22 was observed cleaning R 4's room. E22 was wearing a mask, gown and gloves. E22 was observed repeatedly leaving and re-entering R4's room with protective garb on .<br><br>E21 stated during interview on 12/01/2005 that Housekeeping staff should not go in and out of isolation rooms without taking protective garb off before leaving room. | F 442 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.610a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. | F9999 | | |

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| F9999 | Continued From page 10<br><br>300.1210a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident ' s comprehensive assessment and plan of care. 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.<br>Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1 -120 of the Act)<br><br>300.1210b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br><br>300.1210b)3) Objective observations of changes in a resident ' s condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident ' s medical record.<br><br>300.1210b)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 | F9999 | | |

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| F9999 | Continued From page 11<br>see that each resident receives adequate supervision and assistance to prevent accidents.<br><br>300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)<br><br>Based on interview and record review, the facility failed to adequately supervise one resident (R2), with a known history of requiring assistance during meals, with a hot liquid. R2 sustained approximately 10% total body surface area burns to perineum, buttocks and thighs including a full thickness/4th degree burn to the right thigh.<br><br>Findings include:<br><br>1. R2 is an 84-year-old resident with diagnoses that include Dementia, Muscle Weakness and PVD (Peripheral Vascular Disease). Review of the most recent MDS (Minimum Data Set 08/03/ 2005) provided by the facility scores R2 as 2/2 in Eating...limited assistance, received physical help in guided maneuvering of limbs...one person physical assist. Vision is scored as "1"..."impaired ."<br><br>The facility provided only one care plan for the resident for alteration in visual function. The stated goal was that the "resident will be able to function within the limits of visual impairment while adjusting to the environment without injury."<br><br>2. E3 (Activity Aid) stated during interview that between 9:00 AM and 9:15 AM, she observed R2 in the 1st Floor Dining Room. "I thought she was having a seizure because she was screaming | F9999 | | |

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| F9999 | Continued From page 12<br>and shaking. I rushed to R2 (with E4, Activity Aid) and asked her what happened. She said she spilled coffee on herself. I saw that she was wet from the breasts down to the lap. We started pulling her clothes away from her. I asked who gave her coffee and E5 (CNA) admitted to giving R2 coffee. E3 stated she's not supposed to have coffee because she shakes."<br><br>3. During interviews on 12/01/2005, E6 (CNA), E 7 (CNA) and E9(CNA) stated that R2 required supervision for hot liquids because she was shaky.<br><br>4. E5 stated during interview on 11/30/2005 that at 9:00 AM or 9:30 AM on the day of the incident, she poured a cup of coffee for R2 from the carafe in the dining room and placed it on table a few inches in front of R2. "Maybe a minute later, I heard resident cry out, I asked what happened and she said, I spilled my coffee." E5 stated she took R2 to the bathroom, removed clothes, dried R2, put on dry clothes and notified E8 (LPN).<br><br>5. E8 stated during interview on 11/30/2005 that E5 informed her that R2 spilled coffee on herself between 10 and 10:30 AM., that R2 still had her soiled clothes on, and that both she and E8 took R2 back to her room, removed wet clothes, E8 assessed R2 (noted nothing), put dry clothes on R2 and placed R2 in wheelchair at nurse's station . E8 stated that she continuously asked R2 if she had any pain or discomfort (which R2 denied) and assessed R2 approximately 30-45 minutes after the incident occurred and again noted nothing.<br><br>E8 stated that at 12 or 12:30 PM she was called | F9999 | | |

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| F9999 | Continued From page 13<br>into the shower room by E6 and E9 to assess R2. E8 stated that she noted redness and blistering ( 1 large and 1 small) to outer, upper left thigh. E8 stated that she had E10 (Unit Manager) assessed R2 and that R2 was sent out of the facility for evaluation.<br><br>E10 stated (during interview on 11/30/2005), "my first words out of my mouth were, she's needs to go to the hospital immediately. E10 noted "huge blisters to the groin area, inner thighs, backs of thighs and the groin and midsection were red."<br><br>6. E6 stated during interview on 12/01/2005 while assisted by E9 she noted "too many blisters to count on R2's thighs...very red, like on fire... making grunting noises when we stood her up," while toileting R2 somewhere between 12:45 PM and 1:00 PM. E6 stated that E8 was notified and came to assess R2.<br><br>7. Z1 was interviewed on 01/10/2006. Z1 stated that R2 had a very deep burn...went to fat layer, which technically is a 4th degree burn. Z1 stated that after the hot, wet clothing was removed and the resident assessed, cool compresses could be applied. Z1 also stated disbelief that no erythema was initially noted when R2 was first assessed.<br><br>8. E11 (RN) stated during interview on 12/01/ 2005 that she assisted in the initial incident investigation. She stated that she questioned E5 and that E5 told her that E5 obtained the coffee from the dispenser in the kitchen.<br><br>On 12/01/2005 at 9:15 AM (utilizing the facility's thermometer) the surveyor, accompanied by E1, E2 and E13 (Food Service Supervisor), had E13 | F9999 | | |

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| F9999 | Continued From page 14<br>dispense a cup of coffee from the 1st Floor Dining Room carafe. The temperature was 138 degrees F. Later that day, the surveyor, E1 and E13 went to the kitchen. E13 dispensed a cup of coffee from the dispenser. The temperature was 170 degrees F.<br><br>9. Review of R2's hospital medical record notes that R2 sustained approximately 10% total body surface area burns to perineum, buttocks and thighs including a full thickness/4th degree burn to the right thigh.<br><br>(A) | F9999 | | |