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	146093	A. BUILDING _____ B. WING _____	C 11/15/2012

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F 000	INITIAL COMMENTS Complaint Investigation: 1292530/IL58722 Meadowbrook Manor - Lagrange is in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities for this survey.	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.690b) 300.690c) 300.1210b) 300.1210d)2)3)6) 300.1220b)2)7) 300.1610l)2) 300.3240a) 300.3240c) 300.3240d) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for	F9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F9999	Continued From page 1 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 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: 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 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. Section 300.1220 Supervision of Nursing	F9999		

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F9999	Continued From page 2 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. 7) Coordinating the care and services provided to residents in the nursing facility. l) Oxygen may be administered in a facility. The oxygen supply shall be stored and handled in accordance with the National Fire Protection Association Standard No. 99: Standard for Health Care Facilities (2002, no later amendments or editions included) for nonflammable medical gas systems. The facility shall comply with directions for use of oxygen systems as established by the manufacturer and the applicable provisions of the NFPA Life Safety Code (see Section 300.340) and NFPA 99. 2) All personnel who will be handling medical gases shall be trained to recognize the various medical gas labels. Personnel shall be trained to examine all labels carefully. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

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F9999	Continued From page 3 resident. (Section 2-107 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These regulations are not met as evidenced by the following: Based on interview and record review the facility neglected to provide emergency treatment to 1 of 3 residents reviewed for neglect (R1). R1 sustained a chemical burn on July 8, 2012 and was not treated until July 13, 2012. This failure to act resulted in R1 being emergently sent to the hospital and evaluated by a burn specialist and required an emergency surgical procedure of debridement and skin graft. R1 was hospitalized for 18 days. The facility also failed to follow their Liquid Oxygen Storage Policy for 2 residents (R1, R3) of 3 residents reviewed for liquid oxygen usage, and the facility failed to follow their abuse policy for reporting of possible abuse/neglect or injuries of unknown sources to the state agency for (R1) 1 of 3 residents reviewed for abuse/neglect. Findings Include:	F9999		

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R1 is 84 years old with a diagnosis of Diabetes Mellitus Type II (DM), End Stage Renal Disease (ESRD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and Hypertension (HTN). The burn unit at the hospital documented the burn resulted from liquid oxygen exposure to the left hip over a 4 day period. R1's diagnosis was a "Chemical burn; Second Degree Burn of Left Hip".

October 23, 2012 at 1:05 pm, E5 Certified nursing assistant (CNA) stated she does not remember the exact date but she can remember passing by the television room (TV) and R1 saying " PAIN, PAIN. ' E5 walked over to R1 and R1 touched E5's arm. E5 asked R1 what was wrong. " R1 said my leg, it hurts." E5 pulled back the covering off R1 ' s legs and saw the liquid portable oxygen tank on R1's lap. E5 stated she does not know how the liquid oxygen tank got on R1's lap. E5 stated she removed the liquid oxygen tank from R1's lap and placed it on the table. E5 stated the tank was very cold and had white froth on it.

October 23, 2012 at 1:45 pm, E3 (Nurse) stated that on July 8, 2012 at approximately 9:15 pm; E6 (nurse) told her that R1's portable oxygen tank had turned over on her lap. E3 stated she was on break, off the unit when the incident occurred. E6 told E3 that R1 needed to be put to bed because the liquid oxygen had spilled on R1's left hip. E3 assessed R1's hip and found the area to be red and cold to touch. E3 stated there was no dressing applied to the injured area. E3 stated she continued to monitor R1's injured area, about 12 midnight the area was getting redder and was still cold to touch.

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F9999	Continued From page 5 October 23, 2012 at 1:00 pm (E4) Treatment nurse, stated she remembers being called on her cellular phone the day after the incident. E9 (nurse), told E4 that R1's hip was red and R1 had been burned by liquid oxygen. E4 stated she saw R1 on July 10, 2012, the physician order for July 9, 2012 stated Silvadene cream to hip; but the ointment had not arrived from pharmacy. E4 stated she called Z1(physician) to let him know Silvadene cream had not arrived yet, Z1 told E4 to continue with dry dressing until Silvadene cream arrives. July 8, 2012 at 9:15 pm, nursing notes indicated physician was called with" no new orders, family made aware of incident". July 9, 2012 at 9 pm - Physician notified New Order: "Apply silvadene cream to blister area Lt. hip bid cover with dry dressing until healed". July 10, 2012 at 12:30 pm , "dressing to left hip to be replaced". No documentation of Silvadene cream or any other topical ointment applied to the burn site. July 10, 2012, no time was noted on the treatment notes. Per E3 the area was "intact with deep red skin due to burn . Treatment in progress. Silvadene hasn't arrived from pharmacy at this time. MD made aware per E4 nurse. July 10, 2012 at 8:00 pm, "dressing to Lt. hip changed"; no documentation of Silvadene cream or any other topical ointment applied to the burn site.	F9999		

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July 11, 2012 , no time noted on treatment note, E4 documented area beginning to blister upon dressing change, noted fluid filled blister to lower aspect of burn. Z1 made aware of change in appearance and that silvadene will not arrive until tomorrow in the am.

July 11, 2012 at 5:00 am, "dressing to Lt. hip intact , R1 was transferred from the 3rd floor".

July 12, 2012, no time noted on treatment note, E4 documented all blister is now open, skin purple in color. Pharmacy unable to send silvadene due to R1 being allergic to Sulfa. Z1 made aware no new orders, will refer R1 to wound MD for evaluation and treatment.

July 13, 2012 at 7:00 am, nursing notes stated (R1) was evaluated by the wound specialist. R1 was in pain and yelling "it hurts, it hurts". Wound specialist stated he could not treat R1 at the bedside and that R1 needed to be sent to the hospital. Dressing was applied but no documentation of Silvadene cream or any other topical ointment applied to the burned site at that time either.

July 13. 2012, no time noted on treatment note, E4 documented R1 was seen by (Z2)wound MD this am, Z2 evaluated (L) hip of R1 and stated area could not be treated at the bedside; R1 needs to be sent to the hospital for pain medication and treatment.

Review of the wound treatment notes state the wound was first observed on July 8, 2012 by (E6) floor nurse.

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July 13, 2012 at 2:15 pm, review of the hospital's emergency room notes stated that R1 arrived by ambulance to the emergency room with a second degree oxygen burn on left hip. R1 had fever, signs of infection, erythema and blisters; a rapid heart rate and seemed to be having pain on the Lt. hip. Patient (R1) is registered as an Emergency patient. The percentage of burn to R1's body was 5%.

July 13, 2012, the Burn Surgeon notes for R1 stated: " It appeared to be a full thickness burn, the area is eschar covering most of the burn, it appears to be a deep burn. " Therefore I have elected to take the patient (R1) to the operating room for debridement and for placement of a split thickness skin graft. R1 had an excisional debridement of the skin, subcutaneous tissue with placement of a 300 square centimeter split skin graft taken from the left thigh; with a 1-1.5 inch mesh.

November 9, 2012 at 9:30 a.m., review of the facility's Pharmacy Policy # 2: 2.3 states," If the medication is not available in the emergency medication supply, the facility staff should notify Pharmacy and arrange for an emergency delivery".

November 9, 2012 at 9:45 am, Pharmacist (Z4) was called to verify the order dated
July 9, 2012 at 9 pm for Silvadene cream. Z4 stated there was never an order faxed by the facility or called in by the facility on July 9, 2012. The last order for R1 was on July 11, 2012, the order was sent to (Z5) pharmacy technician for 1% silver sulfadiazine cream and cover with foam

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dressing. Z4 stated he called the facility back, talked to E8 (nurse) and informed her that the order could not be filled because R1 was allergic to Sulfa.

November 2, 2012 at 11:00 am during review of R1's hospital record on July 13, 2012; R1 was transferred via ambulance to a local hospital emergency room. R1's diagnosis was a Chemical burn; Second Degree Burn of the Hip. R1 was evaluated by a burn specialist and sent to surgery. Preoperative Diagnosis was a left hip full thickness burn. Per the surgeon the burn appeared to be a deep burn, a large black covering (eschar) was covering most of the burn. R1 had an excisional debridement of the skin, subcutaneous tissue with placement of a 300 square centimeter split skin graft taken from the left thigh; with a 1-1.5 inch mesh. R1 was hospitalized for 18 days as a result of the accident on July 8, 2012, when R1 was found with a liquid oxygen tank on her lap.

According to R1's clinical record progress notes dated July 13, 2012 at 7:00 am, (R1) was evaluated by wound specialist, R1 was in pain and yelling "it hurts, it hurts". Wound specialist stated he could not treat R1 at the bedside, that R1 needed to be sent to the hospital. Dressing applied, no documentation of silvadene cream or any other topical ointment to the burn site.

October 23, 2012 at 12:50 pm, Z2 wound doctor stated R1 had significant burns when he went to her bedside and could not be treated at the bedside. Z2 stated the injured area was necrotic, black in full thickness area. Z2 stated R1 was in pain and needed to have pain medication from

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F9999	Continued From page 9 the hospital as well as treatment. Z2 stated " I knew it was bad because I am a trauma specialist." October 23, 2012 at 2:00 pm, (E2) Director of Nursing was asked why the facility did not follow their policy of reporting incidents of unknown origins for R1 to the state agency. E2 stated "we was so busy with the annual survey process going on that she really did not think of it." November 1, 2012 at 3:25 pm, Z1 primary physician stated he was told there was contact to the skin by the oxygen cylinder. Z1 said he did not know the liquid oxygen spilled out of the cylinder and made contact with R1's skin. Z1 stated " If I knew R1 had contact with liquid oxygen, I would have ordered patient out to hospital for evaluation." November 1, 2012 at 10 am, while checking for oxygen signage on resident's room doors, R3 and son (Z3) was in room with door open. R3 was lying in bed talking to his son (Z3). There was uncovered oxygen tubing attached to the large stationary oxygen cylinder. Z3 was sitting in a chair on the side of the bed facing the television. R3's left side of the bed had a large stationary oxygen cylinder at the head of the bed. Alongside the same wall was the heater that was on for warmth. The temperature outside was 40 degrees and very windy. At the foot of the bed there was a portable unsecured oxygen cylinder on the floor resting up against the heater. Z3 stated he visits his Dad daily and the portable oxygen tank was on the floor in that spot for a couple of days. Z3 stated his dad does not really use oxygen that	F9999		

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F9999	Continued From page 10 much. Writer went out to the nurses ' desk and asked (E7) nurse to please walk with her to R3's room. E7 came into room and was asked why the portable oxygen tank was unsecured on the floor and resting up against the heater? E7 lifted the tank off the floor, writer asked to hold tank to feel if the tank was full and it appeared to be full. E7 proceeded down the hallway with the portable oxygen tank in her hand. October 23, 2012 at 11:30 a.m. review of the facility's liquid oxygen system policy states the following: WARNING: Do not touch liquid oxygen or parts that have been in contact with liquid oxygen. Liquid oxygen is extremely cold (-297 degrees Fahrenheit (F) / -180 degrees centigrade (C). When touched liquid oxygen, or parts of the equipment that have been carrying liquid oxygen, can freeze skin and body tissue. Keep and use liquid oxygen cylinder in an upright position at all times. If the portable unit is turned over, gaseous or liquid oxygen will escape. Should a liquid spill occur, ventilate the area by opening doors and windows and call your liquid oxygen supplier immediately. Keep portable liquid oxygen equipment away from open flames, equipment such as furnaces, water heaters and stoves may contain open flames.	F9999		

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F9999	Continued From page 11 Keep portable liquid oxygen in a well ventilated area at all times. The unit periodically releases small amounts of oxygen gas that must be ventilated to prevent buildup. Do not store liquid oxygen in a closet, car trunk or confined area. Do not place blanket, draperies or other fabrics over equipment. Do not carry the Portable unit under clothing. The unit normally vents oxygen. Wearing a portable unit under clothing may saturate fabrics with oxygen and cause them to burn rapidly if exposed to spark or flame. November 2, 2012 at 2:00 pm during review of facility's Oxygen Storage Policy # 1 & 4 1. All oxygen systems will be stored in the oxygen storage rooms. 4. When the tanks are no longer in use or need to be refilled they will be refilled or returned to the storage area. November 9, 2012 at 1:00 p.m. review of the facility's Policy for Abuse and Neglect defines; Neglect as the failure to provide goods and services to avoid physical harm, mental anguish or mental illness. B	F9999		