

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145892</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/27/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUNNY HILL NURSING HOME OF WILL COUNTY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>421 DORIS AVENUE JOLIET, IL 60433</b>		
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F 498	Continued From page 42 Based on observation, record review and interview the facility failed to ensure staff follow policy and procedures for perineal care for one of one resident (R 7) observed for incontinence care in the sample of 30 The findings include: Observation of R 7 on 3/13/2013 at 11:00 am, (E 31) Certified Nursing Assistant (CNA) and (E 32) CNA performed incontinence perineal care for R 7. R 7 was noted to be incontinent of stool during morning care. E 31 was observed to go to the bathroom and wet the end of a towel while E 32 held R 7 to the left side. E 31 took the wet towel and wiped the stool from R 7's bottom. E 31 and E 32 began placing an adult brief on R 7 and his outer clothing. E 31 did not clean R 7's penis. A review of the facility ' s policy for INCONTINENCE PERINEAL CARE: POLICY NO: NRS-328: E 31 did not follow the procedure for item # 5: set up basin of warm water or perineal washing solution. In addition, procedure for a male: Items (a through e) state to cleanse the penis; dry thoroughly; cleanse the scrotum to the anus. Rinse and dry. E 31 did not perform this care. Record review and interview with E 31 and E 32 on 3/13/2013, States R 7 is in contact isolation 2/21/2013 for Vancomycin Resistant Enterococcus (VRE) urine. R 7 has a nephrostomy tube.	F 498			
F9999	FINAL OBSERVATIONS  LICENSURE VIOLATIONS  300.1210b)	F9999			

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F9999	Continued From page 43 300.1210c) 300.1210d)5) 300.1220b)3) 300.3240a)  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 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.  c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.  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:  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,	F9999			

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F9999	<p>Continued From page 44 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. 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. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, interview and record review, the facility failed to develop a comprehensive assessment to address the risk factors for developing pressure ulcers, develop and consistently implement a specific plan of care to promote healing and prevent the development of additional pressure ulcer, evaluate and</p>	F9999			

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F9999	<p>Continued From page 45</p> <p>implement an individualize repositioning plan base on tissue tolerance, assess and correctly identify the type of wound (pressure versus arterial) for 1 (R10) resident.</p> <p>This applies to 1 residents( R 10) reviewed for acquiring pressure ulcer in the facility, in the sample of 30.</p> <p>These failures resulted in R 10 ' s development of a facility acquired- avoidable Stage III pressure ulcer on the left foot.</p> <p>Findings include:</p> <p>R 10 readmitted to the facility 12/23/2012 with an ankle foot orthotic (AFO) device in place. A review of the nurse ' s notes for R 10 dated 12/29/2012 at 2:30 p.m. (E 20) RN treatment nurse documents : R 10 is noted with open area to left lateral foot due to trauma from " Prafo " boots wound measures 1.6 cm x 2.2 cm x 0.2 cm. The wound bed with 60% granulation and 40% yellow slough. There is minimal serous drainage and no odor. R 10 has diagnosis of Diabetes Mellitus pedal pulse is weak.</p> <p>The " Prafo " boot was discontinued and a soft heel suspension boot when in bed and " Darco " shoes when R 10 is up in chair was added.</p> <p>Record review of the wound or pressure sore for 2/5/2013 and 2/13/2013 identify the wound to have 80% slough thick adherent deviated necrotic tissue. In addition, the wound is classified as Arterial / Neuropathic /Diabetic.</p> <p>On 3/18/2013 at 10:30 am the interview with (E 14) RN, Treatment Nurse, Asked how the wound is arterial when the 12/29/2012 nurses notation identified the wound was caused by the boot. E 14 said she would reevaluate the wound. Arterial studies were recommend and refused by power of attorney and Hospice. On 3/19/2013, E 14 submitted a wound report for R10 ' s left lateral</p>	F9999			

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F9999	<p>Continued From page 46</p> <p>foot and identified the wound as a pressure ulcer acquired in the facility. The wound was observed on 3/19/2013 with E 14. E 14 identified the wound as a stage III pressure sore. Measuring 0.5 cm x 0.5 cm x 0.3 cm with small amount serous exudates. A review of the plan of care there is no plan identified to address the AFO device. There is no individualized plan or assessment of the risk factor to prevent this avoidable pressure sore.</p> <p>(B)</p> <p>300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</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>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</p>	F9999			

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F9999	<p>Continued From page 47</p> <p>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.</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 EVIDENCED BY:</p> <p>Based on observation and interview the facility failed to ensure that precautions were taken to prevent a potential accidental burn to residents. The hot buffet steam table in the main dining room was not kept from access by cognitively impaired residents. This had the potential to effect cognitively impaired mobile residents in the facility who could potentially be accidentally burned.</p> <p>Surveyors observed that the buffet/ steam table in the dining room had surface temperatures as high as 147 F. with no staff in attendance to ensure residents do not have access to the hot surfaces in reach. The area had an opening that anyone could walk through with a single chain not locked and easily removed. There was also a space between a Plexiglass guard and the top of the serving line that residents could reach through and touch a hot surface. This applies to seven of ten residents reviewed for ambulation and impaired cognition in the sample of thirty. R5, R10, R27, R12, R20,</p>	F9999			

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F9999	<p>Continued From page 48 R21 and R25.</p> <p>Findings include:</p> <p>This facility has a large main dining room on the upper level floor where residents come from all the nursing units. Residents from second avenue, third avenue, fifth avenue on the first floor, and forth and and first avenue on the lower level all are welcome to eat in this dining room for breakfast lunch and dinner. The majority of the 208 residents in the facility eat in this dining room while some remain on their units for a continental breakfast or for lunch and/or dinner for a tray served to them.</p> <p>The buffet line has 2 steam tables along with space for other items, one has 3 wells, and the other has 4 wells. The steam table is turned on about 5:30 am according to E9 one of the dietary service supervisor and remains on until after the dinner meal about 6:30pm.</p> <p>On March 14, 2013, at 3:45 pm the survey team noticed the steam tables in dining room were on. The surface of the steam table was measured to be as hot as 147 F.. This surface is accessible to residents who could put their hands between the acrylic glass sneeze guard and the surface of the steam table.</p> <p>The temperature control gauge on the table has a numerical setting instead of a temperature setting. E9 the dietary supervisor said that the steam tables are turned to high before meal service to number 8 , and turned to the middle point 4 or 5 between meals.</p>	F9999		

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F9999	<p>Continued From page 49</p> <p>On 3:34pm on 3./14/.13 E 38 from the maintain department measured the surface of the steam table with a laser type thermometer. There are two sections that have hot tables. The surface temperatures of the table that has 3 wells showed various temperatures when measured, the center of the wells have alluminum covers when they are not serving food. The center of the covers measured 135 F., 113 F. and 141 F. The edges of the table measured 88-89F. At this time the table control was set at 4. The other steam table has 4 wells, with alluminum covers. These temperatures varied from 124. 123, 144, 145, 147, 141 and 133 Fahrenheit.</p> <p>The dietary cafeteria buffet style policy and procedure number FBS-393 dated 10/1/12 indicates the following meal times:</p> <p>a. Breakfast is served in the main dining room from 7:30am to 9:30am. b. Lunch : 11:30am - 1:00pm c. Supper: 4:30pm to 6:00pm</p> <p>While dietary and nursing staff are in the dining room to supervise residents at meal times, the two hours between breakfast and lunch, and the three and 1/2 hours between lunch and supper are not necessarily supervised by anyone. There are activities in the dining room, but not for this entire time, and no one has been specifically assigned to this duty according to interview with E1 on 3/14/13 at 5:00pm. This was confirmed during an interview with E1 administrator on 3/14/13 at 4:15 pm.</p> <p>R24 stated during an interview on 3/14/13 at the dinner meal at 5:25 pm that " she likes to come</p>	F9999			



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F9999	<p>Continued From page 50 to the dining room at about 6:30am to 6:45 am. R24 said there is no one around. Sometimes it's hard to get a cup of coffee."</p> <p>R25 was observed on 3/14/13 at the dinner meal at 5:35 pm to be seated in her wheel chair wandering in the dining room with no staff present to redirect, R25 is cognitively impaired and requires supervision to prevent accidents.</p> <p>Review of the State Operations Manual (SOM) interpretive guidelines for F323 regarding the hazards of hot water, revealed the following taken from "Studies of Thermal Injury: II. The Relative Importance of Time and Surface Temperatures in the Causation of Cutaneous Burns...Table 1. Time and Temperature Relationship to Serious Burns." Review of this Table revealed that for a water temperature of 148 degrees Fahrenheit, the time required for a third degree burn to occur was two seconds and for a water temperature of 140 degrees Fahrenheit, the time required for a third degree burn to occur was five seconds. When measured on 3/14/13 the top cover of one of the steam table was in access of 140 F.</p> <p>The facility has residents who have cognitive impairment, many of whom may be ambulatory. Part of the MDS ( minimum data assessment) tool used for all residents has a section called Brief Interview for Mental Status (BIMS). The BIMS is a brief screening tool that aids in detecting cognitive impairment. This is according to the state operations manual (SOM) appendix-P. The SOM defined unreviewable residents as one who has sufficient memory and comprehension to be able to coherently answer</p>	F9999			

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F9999	Continued From page 51 questions, and make day to day decisions in a fairly consistent and organized manner. Residents with BIMS scores of 8 to 15 are identified as unreviewable, and residents with 0-7 or 99 are not considered interviewable. The facility report printed at the time of this survey shows BIMS scores for 201 residents. This report indicates 64 residents fall below 8, with a score between 0 and 7, 13 were unable to answer, and 20 had this section skipped. This report would suggest that at least 64 residents have cognitive impairment, and 33 others are not known. Cognitively impaired residents are more at risk to be accidentally burned. There were ten residents in the sample who had scores of less than 8 on the BIMS, and of these seven were ambulatory, R5, R10, R27, R12, R20, R21 and R25. This information was obtained by review of MDS (minimum data set) assessments for these ten residents in the sample of thirty.  (B)	F9999		