

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2013
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NAME OF PROVIDER OR SUPPLIER WALNUT GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1095 TWILIGHT DRIVE MORRIS, IL 60450
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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
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) 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.</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</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>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 that each resident receives adequate supervision and assistance to prevent accidents.</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>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,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</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. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, record review, and interview the facility failed to ensure nursing and therapy staff followed the policy and procedure for safely transferring residents and/or providing care for residents.</p> <p>As a result of this failure R1 sustained skin tears to her legs, R2 sustained skin tears to her legs and feet, R3 sustained a skin tear to his left arm, and R4 fell from her wheel chair when transported by a CNA (Certified Nurses Aide)</p> <p>This is for 4 sampled residents investigated for improper nursing care. (R1, R2, R3, and R4).</p> <p>The findings include:</p> <p>1. Review of R1's closed record admission face sheet showed R1 was admitted to the facility on 8/23/13 with diagnoses which included Late Effect Cerebral Vasclar Accident, Congestive Heart Failure, and Edema. Review of R1's physician's orders (11/2013) showed R1 was discharged from the facility on 11/26/13. The physician's orders also showed R1 was on anticoagulant therapy (Coumadin 3 mg/day) while</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>at the facility.</p> <p>Review of the facility's incident reports showed R1 had 5 incidents with resultant skin tears from 9/22/13 to 10/23/13. Two of R1's skin tears were sustained while R1 was in the care of a family member. Three of the skin tears were sustained while R1 was in the care of facility staff. On 10/17 and 10/21/13, R1 sustained skin tears while in the care of CNA's, and on 10/23/13 R1 sustained a skin tear while in the care of a physical therapy assistant.</p> <p>The incident report dated 10/17/13 at 11:23 a.m., showed R1 sustained a 5.4 cm "U" shaped skin tear to the right lower extremity during a 1 person assist transfer from the toilet to the wheel chair. The incident showed R1's leg was "bumped on the wheel chair where the pedal attaches."</p> <p>On 12/4/13 at 11:00 a.m. during a phone interview, E6 (CNA) stated, " On 10/17/13 I was transferring R1 to her wheel chair from the toilet. R1 didn't straighten her leg out. Her leg got snagged on the area where the leg rest go on the wheel chair. R1 has fragile skin. R1 wasn't a 2 person assist for transfers before this incident."</p> <p>Review of R1's 30 day Medicare MDS (Minimum Data Set) dated 9/19/13 showed R1 should have extensive 2 + person assist for transfers.</p> <p>The incident report dated 10/21/13 at 3:15 p.m. showed R1 sustained a 6 cm x 4 cm skin tear to the right inner calf while in the care of E4 (PTA - Physical Therapy Assistant).</p> <p>On 12/4/13 at 11:55 a.m. E4 stated, "On 10/21/13 I was performing a 1 person transfer from bed to wheel chair with R1 because I was going to walk</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>her. During the transfer R1 had trouble scooting her leg back. Her leg turned outward. I grabbed her on her calf to adjust her foot and her skin stuck to my middle finger." E4 stated, "No one told me about her skin and/or how to handle R1's fragile skin."</p> <p>Again, the MDS dated 9/19/13 showed R1 should have extensive 2 + person assist for transfers.</p> <p>The incident report, dated 10/23/13 at 2:53 p.m., showed R1 received a 8.5 cm x 4.5 cm skin tear to her left outer calf when E5 (CNA) lifted R1's legs when transferring R1 to bed.</p> <p>On 12/4/13 at 2:35 p.m., E5 stated, "On 10/23/13 I had just toileted R1 and she asked to lay down. I had my hands on the bottom of her legs. She still had her shoes on and her foot got caught on the foam memory pad. When I put my hand under her legs she got this skin tear. She was a 1 person transfer."</p> <p>Again as per the MDS of 9/19/13, R1 was an extensive 2 + person transfer.</p> <p>Review of R1's plan of care addressing skin tears/bruising/anticoagulant therapy showed R1 was a 2 person assist for transfers.</p> <p>Review of the facility's policy on Transferring Residents showed documentation "You can plan how to transfer a resident safely by asking yourself the following questions: The questions included:</p> <p>How much assistance do you need?</p> <p>2. Review of R2's admission face sheet showed R2 is a 91 year old female readmitted to the</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>facility on 3/23/13. Review of the facility's incident reports showed R2 had 3 incidents with skin tears (from 10/5 to 11/9/13) while in the care of CNA's.</p> <p>On 10/5/13 R2 sustained a 0.5 cm skin tear while being transferred with a 1 person CNA assist.</p> <p>On 10/20/13 scarce documentation on an incident report and scarce nursing note documentation (no times documented) showed R2 sustained a skin tear to the left leg when she hit her left leg on the wheel chair while getting out of bed.</p> <p>On 11/9/13 (no time documented) an incident report showed R2 sustained 5 cm arch shaped skin tear to the right leg upon transfer.</p> <p>Review of R2's Annual MDS dated 3/14/13 and Quarterly MDS dated 9/6/13 showed R2 is an extensive 2 + person assist for transfers.</p> <p>Review of R2's plan of care addressing skin tears showed R2 is "extensive assist of 2 + persons with mobility, skills, etc..."</p> <p>On 12/4/13 at 2:20 p.m. E3 (Assistant Director of Nurses) stated, "With each of these transfers for R2 the staff used a 1 person assist transfer. They should have used 2 person assists for these transfers."</p> <p>Observation of R2 on 12/4/13 at 3:05 p.m. and 12/5/13 at 11/15/13 noted R2 up in her wheel chair sleeping. R2 was observed with protective sleeves to both arms and both legs.</p> <p>On 12/5/13 at 1:00 p.m. R2 was again observed with the protective sleeves to both arms and legs. R2 stated, I'm not getting injured anymore. They put these sleeves on me and they use 2 people to</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>transfer me now."</p> <p>3. Review of R3's admission face sheet showed R3 was admitted to the facility with diagnoses including Left Hemiparesis and Intravascular Hemorrhage. Review of an incident and nursing note documentation for R3 dated 12/2/13 showed R3 sustained a 2 cm circular skin tear to the left inner forearm during a shower. Review of R3's physician's orders and plan care showed R3 had orders for protective sleeves to his arms.</p> <p>On 12/4/13 at 2:25 p.m. during interview with E3, E3 stated, "R3 did not have the protective sleeves on his arms when this incident happened. R3 was in the shower room with staff. The staff were undressing R3 for his shower. The staff took off the protective sleeves from R3's arms, then pulled R3's shirt off, which rubbed R3's skin and caused the skin tear. The staff should have removed the shirt first, then removed the protective sleeves to prevent the skin tear."</p> <p>Observation of R3 on 12/4/13 at 3:00 p.m. and 12/5/13 at 11:00 a.m. noted R3 to have the protective sleeves in place to both arms.</p> <p>On 12/5/13 at 11:00 a.m. R3 stated, "I don't have any more skin tears. They put vaseline on me, then put these sleeves on me to protect my skin."</p> <p>4. Review of an incident report for R4 dated 10/17/13 at 4:00 p.m. showed a CNA was pushing R4 in her wheel chair to the bathroom and bumped the wall with the wheel chair. When R4's wheel chair bumped the wall, R4 slipped out of the wheel chair on to the floor. Review of post fall documentation dated 10/20/13 showed R4 had a bruise to the left upper extremity.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>No follow up documentation was noted on the fall analysis/investigation as to recommendations to minimize/prevent further falls.</p> <p>On 12/5/13 at 10:00 a.m. R4 stated she did not remember the fall and stated, "I don't remember hurting myself when I fell."</p> <p>On 12/4/13 at 2:25 p.m. E3 (Assistant Director of Nurses), during interview admitted that staff are not using 2 person assists when needed and that staff has to be more careful when transporting residents.</p> <p>(B)</p>	S9999		