**Final Observations**

**Statement of Licensure Violations**

300.610a)
300.1210b)
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

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:
NAME OF PROVIDER OR SUPPLIER: HIGHLAND HEALTH CARE CENTER
STREET ADDRESS, CITY, STATE, ZIP CODE: 1450 26TH STREET
HIGHLAND, IL 62249

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
</table>
| S9999     | Continued From page 1  
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 300.3240 Abuse and Neglect  
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident  
These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure staff was aware of their scope of care and treatment for one of three residents (R1) reviewed for incidents/occurrences in the sample of 3. This failure resulted in R1 incurring a burn with blisters and recurring pain to the right hip. Findings include: WRITTEN REPORT/RESIDENT OCCURRENCE dated 5/5/14 documents at approximately 1:40pm on 4/30/14, the Licensed Nurse entered R1’s room to do her daily treatment and noted an area of redness with a fluid filled blister to R1’s right hip. E2, Certified Nurse Aid, CNA, was in the room and informed the nurse that she had applied a hot pack to the resident earlier that day, about 10:30am, due to R1 complaining of right hip pain. E2 went to therapy department and got hot pack with E3’s, Therapist, instructions on properly wrapping it with protective covers and she then placed it to R1 right hip for approximately 30 minutes. R1 presented with a | S9999     |                                                                                                                  |               |
S9999 Continued From page 2

19 centimeter (cm) by 13 cm area of redness to her right hip, with a 2 cm by 2cm fluid filled blister towards the middle aspect of the reddened area. Basic first aid was provided.

On 5/8/14 at 1:03pm E9 was interviewed regarding R1 having hot packs applied to the right hip. E9 stated she saw E2 in the hall with a hot pack but didn't know who it was for. E2 then left for lunch. E1 Licensed Practical Nurse (LPN) later called E9 into R1's room after the hot packs had been removed and noted burn/blister on right hip. R1 was complaining of pain.

Interview on 5/8/14 at 10:10am with E3, Therapist, stated E2 did come into the therapy room and asked for hot packs. E3 gave instructions for padding the hot packs for protection. E2 replied she knew. E3 further states CNA's do come in for hot packs to use on themselves and did not know E1 was going to put them on R1.

Interview on 5/8/14 at 1:40pm with E11 Rehabilitation Director stated staff does come into the therapy room and ask for hot packs for their own use. E11 stated E2 spoke with E3 and said nothing about any resident she was going to use the hot pack on.

Interview on 5/8/14 at 10:10am with E6 CNA, 1:03pm with E8 CNA, 1:03pm with E9 CNA, at 2:20pm with E12 CNA and at 2:24pm with E13 CNA all stated hot packs are not to be applied to any resident by CNA's. Interview at 1:05pm with E10 CNA stated hot packs are only put on and taken off residents by nurse or therapist.

Interview with Z1 Specialized Wound Nurse stated area is doing what it should, dark area will
Continued From page 3

slough off, area without infection and treatment appropriate.

Interview with Z2, on 5/9/14 at 9:50AM by telephone, Nurse Practitioner (NP) stated surround discolored tissue is a concern, uncertain what will become of it.

On 5/8/14 at 2:30pm with E5 Director of Nursing (DON) removed the dressing on R1’s right hip and a foul odor was noted. The area on the right hip was the size of a golf ball and the brown/black area with yellowish slough. Above that was 2 superficial open areas about dime size. The surrounding area of the right hip had about 4.5 inches of light purple tinge E5 stated R1’s right hip was clear prior hot pack incident.

NURSES PROGRESS NOTE & CARE PLAN documented on 4/30/14 at 1:40pm R1 complained of right hip pain. CNA placed hot pack on R1’s right hip. and removed it at 11:00am. No redness or blister noted. E1 went to R1’s room to do treatments E1 pulled cover back and noted burn 19 cm (centimeter) by 13cm and 2cm by 2cm blister to right hip. R1 complained of pain in right hip. Doctor was informed and ordered ointment.

Review of Specialized Wound Nurse form dated 5/1/14 documents Wound Type/Grade Burn 2nd degree to right hip. Length 16cm by 13cm. Area 208cm.

Specialized Wound Management dated 5/8/14 documents length 15cm by 13cm and unable to determine depth. Area 195cm. Center of wound measures 4cm by 5cm necrosis.

Review of Z2’s visit dated May 7, 2014
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td>Continued From page 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

documents patient is under weight and frail. Right trochanter area caused by burn on the trochanter 4cm by 3cm blister denuded. Surrounding tissue has discoloration variegated purplish colored area below the surface of the skin. R1 is uncomfortable and has history or joint pain from arthritis and contractures of joints.

Policy: Compresses, Clean-Warm (General Guidelines) policy dated 2006 documents BASIC RESPONSIBILITY: Licensed Nurse. PROCEDURE. Check physician's order.