

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

PRINTED: 04/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/10/2011
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
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F 000	INITIAL COMMENTS	F 000			
F 224 SS=J	<p>Complaint Investigation #1160613 (IL51953) F224, F314 Piggybacked Complaint Investigation #1161062 (IL52465) F224, F314</p> <p>A partial extended survey was conducted.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility neglected to follow the policy for bedpan use for R2, one of six residents sampled for pressure sores in a total sample of nine. As a result R2 developed a stage III pressure sore on her coccyx and buttocks in the shape of a bedpan. After the bedsore was discovered facility staff neglected to follow the facility pressure sore policy including getting a treatment order for the pressure sore from the doctor, and monitoring the condition of the pressure sore. The pressure sore became infected, progressing to a systemic blood infection that necessitated hospitalization, surgical debridement and intravenous antibiotics. After the pressure sore was discovered and R2 was hospitalized the facility neglected to notify the State Agency. The facility also failed to begin</p>	F 224			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	<p>Continued From page 1</p> <p>an investigation into the cause of the pressure sore and the suspected neglect. These failures resulted in an immediate jeopardy situation for R2.</p> <p>While the immediacy was removed on March 6, 2011, the facility remains out of compliance at a severity level two. The facility is still in the process of educating staff and implementing new policies and procedures related to reporting neglect, pressure ulcer identification, assessment and preventions, and monitoring for the effectiveness of these measures.</p> <p>Findings include:</p> <p>Physician's Orders dated January 16, 2011 to February 17, 2011 documents R2 has diagnoses of Morbid Obesity, Cerebrovascular Accident, and Diabetes Mellitus Type II. The Minimum Data Set (MDS) dated 2/4/2011 indicates R2 needs extensive assist with most activities of daily living, including bed mobility and toilet use. R2 is assessed by the MDS as incontinent of bowel and she has an indwelling urinary catheter. The MDS also documents R2 is at risk for pressure sores but currently has no pressure sores at a stage one or higher.</p> <p>A Nurses Note dated 2/18/2011 at 12:15 PM from the hospital reads: "...PT (patient) RECEIVED TO FLOOR, A DIRECT ADMIT FROM (the facility) . PT ALERT, SPEECH GARBLED. RIGHT EXTREMITIES WEAK. PT INC (incontinent) OF URINE, STOOL...WOUND TO COCCYX..."</p> <p>Z3, Registered Nurse (hospital nurse) stated on 3/2/11 at 12:50 PM that she helped to admit R2</p>	F 224			

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F 224	<p>Continued From page 2</p> <p>directly from the facility to the hospital on 2/18/11 at about 12:45 PM. Z3 stated, "...I saw immediately after she was admitted - that she had a pressure sore (in) the shape of a bedpan (on her coccyx and buttocks). I immediately thought it was a bedpan injury. The outline was in a brighter pink, stage II or III. She was a direct admit (from the facility) and she had not been on a bedpan since she was here - also our bedpans are shaped differently..."</p> <p>An incident report signed by the facility Administrator and dated 3/2/2011 states: "...On the day shift of February 17, 2011 resident (R2) was noticed to have a new decubitus ulcer (pressure ulcer) on her coccyx. An assessment of the surrounding area revealed a U-shaped impression. (R2) was unable to report how the impression or ulcer developed...(R2) is frequently incontinent and would periodically use a bedpan..."</p> <p>E13, Certified Nursing Assistant (CNA) stated on 3/3/11 at 2:17 PM that she and another CNA assigned to R2 discovered R2 on a bedpan. E13 stated, "...I took care of (R2). We (E13 and E10 CNA) went to clean (R2) up, and we discovered she was on a bedpan...I am not sure of the time or date but neither me or (E10) put her on the bedpan. She (R2) was out of it (not able to communicate). When we took her off the bedpan we saw the impression of the bedpan. Her (R2's) bottom was broke down. My impression was, somebody left her on the bedpan..."</p> <p>E6, CNA worked with E13 and E10 the day R2 was found on the bedpan. E6 stated on 3/3/11 at 3:05 PM, "...I have taken care of (R2). Some girls found her on the bedpan. (E10), (E13) and I</p>	F 224			

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F 224	<p>Continued From page 3</p> <p>worked together that day, I'm not sure of the date. The other two (CNAs) found her but I knew about it...It was in February..."</p> <p>E8, CNA also stated she knew about R2 being found on a bedpan and stated it was reported to the nurse. E8 stated on 3/3/11 at 2:00 PM, "...I would take care of her (R2) every once in a while. I took care of her in February. Me, (E13), and (E10) discovered it. We told the nurse (E5, Registered Nurse)... (E13) and (E10) found her on the bedpan when they got her up that morning, I'm not sure what day or date..."</p> <p>E10, CNA stated on 3/4/11 at 11:15 AM that she discovered R2 on the bedpan and that she knows the day was 2/11/2011. She stated she told the nurse E5. E10 stated, "...I have taken care of (R2). I have used the bedpan with her. I went in with (E13), but this was approximately a week or more before (2/18/11), the day the facility stated the pressure sore was discovered. We found (R2) on the bedpan on 2/11/2011. I know because it was a day when we all worked together, (E6), (E13), (E8) and (E5). I looked at her backside and it was split open. When I saw it I said, 'Oh my God' because I saw pink meat. I went and got the nurse. (E13) was still in the room. We asked her (R2) who put her on the bedpan and she did not know. I said to the nurse (E5), 'Do you see this (E5's first name), and she said yes, just put some EPC cream (a protective ointment) on it?' The nurse said it looked like the resident had been on there (on the bedpan) for quite some time."</p> <p>A facility document titled, "Daily Nursing Schedule" shows that (E5), (E6), (E8), (E10), and (E13) all worked together on Unit Two on day</p>	F 224			

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F 224	<p>Continued From page 4</p> <p>shift on 2/11/2011. The schedule shows the five employees did not work together on Unit Two, on day shift, on any other day in February of 2011.</p> <p>A document titled "BEDPAN/URINAL, OFFERING/REMOVING" and submitted by the Administrator on 3/4/2011 as the facility policy on bedpan use reads as follows: "...General Guidelines... 5. Do not allow the resident to sit on a bedpan for extended periods. (Note : This is not only uncomfortable to the resident , it also causes skin breakdown.)..."</p> <p>R2's clinical record including skin report sheets and Nurses Notes does not document a pressure sore as being found on 2/11/2011. Z1, R2's Primary Care Physician stated on 3/4/2011 at 3:30 PM, "...The facility did not notify me of the buttocks wound of (R2) until 2/17/2011. I was not notified on 2/11/11 of any pressure areas."</p> <p>The "Prevention of Pressure Ulcers" policy states, "...The facility should have a system /procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family and addressed..."</p> <p>A "Report of Operation" dated February 20, 2011 reads as follows: "Indications: A 61 -year-old, evidently in (the nursing home), had been on a bedpan 6 hours. Pressure necrosis with decubitus right buttocks measuring 15 cm (centimeters) x 4 cm and then subsequently 3 cm deep about in the deepest. She is for debridement...Description of Procedure:...She had a circumferential area of necrosis both on right and left buttocks cheek, including the</p>	F 224			

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F 224	<p>Continued From page 5</p> <p>sacrum. Superficially necrotic really left side and the area of the sacrum. She had obvious necrosis with tracking by her right buttocks cheek with necrosis as above. Using the cautery only, we removed the necrotic tissue down to the deep subcutaneous tissue..."</p> <p>Z4, Surgeon stated on 3/2/11 at 2:30 PM that the wound was a "pressure necrosis" consistent with someone who was on a bedpan for hours. The surgeon described the wound as a "circular ridge from one side of the buttocks to the other and down the thigh. The wound was infected and it would have taken days for the infection to develop not hours."</p> <p>A report titled "Consultation" dated 2/19/2011 and signed by Z2, Infectious Disease Specialist documents: "...She has a horseshoe shaped decubitus extending from the left to the right gluteal area across the top of the sacrum. On the right side, it is approximately 24 cm. It is 1 to 1.5 cm in width. it is undermined. there is frank purulent drainage..."</p> <p>Z2, Infectious Disease Specialist stated on 3/4/11 at 10:45 AM "...I think blood poisoning (septicemia) was caused by the infection the resident had of the pressure ulcer on (her) backside. I had cultures that verified this..."</p> <p>A Progress Note dated 2/23/2011 and signed by Z5, Attending Physician states, "...Assessment and Plan: 1. Septic Shock: Probably secondary to decubitus ulcer. Patient is improved status post debridement and now on a combination of Zosyn and Vancomycin (intravenous antibiotics)..."</p> <p>A document titled "...(Facility Name) Abuse</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>Prevention Program Facility Policy..." and confirmed by the Administrator as the facility abuse/neglect policy states: "...NEGLECT is the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or in the deterioration of a resident's physical or mental condition...IV. Internal Reporting Requirements and Identification of Allegations... Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator. VI. Internal Investigation of Allegations and Response 1. Initiating an Investigation. Once an allegation of abuse, mistreatment, misappropriation or neglect has been made, the Administrator or designee will initiate a comprehensive investigation...VII. External Reporting of Potential Abuse 1. Initial Reporting of Allegations. Within twenty-four hours of an allegation of abuse , mistreatment, misappropriation (or) neglect, a written report shall be sent to the Department ..."</p> <p>E1, Administrator stated on 3/2/2011 at 2:30 PM that facility staff had full knowledge of the bedpan incident on 2/11/11 and R2 was re-examined by supervisors on 2/18/11 and was sent to the hospital. E1 acknowledged an investigation into the neglect of R2 had not yet (as of 3/2/2011) been initiated and the Department had not been notified of the potential neglect.</p> <p>An Immediate Jeopardy was identified with R2 on 3/4/11 at 2:20 PM. The Immediate Jeopardy was determined to have begun on 2/11/2011 when staff failed to monitor R2's time on the bedpan and when the nurse failed to notify the physician and begin treatment and monitoring of the pressure sore. E1 Administrator, was informed of</p>	F 224			

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F 224	Continued From page 7 the Immediate Jeopardy on 3/4/11 at 2:20 PM. The surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: * On 2/18/2011 R2 was admitted to the hospital and received care and treatment of the pressure ulcer on her sacrum and buttocks. In addition R2 received treatment for infection of the wounds and septicemia. *On 3/2/2011 the facility Administrator initiated an investigation into the alleged neglect of R2. * On 3/4/2011 the unit managers of each unit conducted a visual inspection of the complete body of all residents at high risk for skin breakdown. * On March 2nd through the sixth all staff were educated by the Unit Managers and Shift Supervisors regarding the facility neglect policy, bedpan policy and pressure sore policy...	F 224			
F 314 SS=J	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314			

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F 314	<p>Continued From page 8</p> <p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor the bedpan use of R2, one of six residents sampled for pressure sores in a total sample of nine. As a result R2 developed a stage III pressure sore on her coccyx and buttocks in the shape of a bedpan. After the bedsore was discovered facility staff failed to get a treatment order for the pressure sore from the doctor, and failed to monitor the condition of the pressure sore. The pressure sore became infected, progressing to a systemic blood infection that necessitated hospitalization, surgical debridement and intravenous antibiotics. These failures resulted in an immediate jeopardy situation for R2.</p> <p>While the immediacy was removed on March 6, 2011, the facility remains out of compliance at a severity level two. The facility is still in the process of educating staff and implementing new policies and procedures related to pressure ulcer identification, assessment and preventions, and monitoring for the effectiveness of these measures.</p> <p>Findings include:</p> <p>Physician's Orders dated January 16, 2011 to February 17, 2011 documents R2 has diagnoses of Morbid Obesity, Cerebrovascular Accident, and Diabetes Mellitus Type II. The Minimum Data Set (MDS) dated 2/4/2011 indicates R2 needs extensive assist with most activities of daily living,</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>including bed mobility and toilet use. R2 is assessed by the MDS as incontinent of bowel and she has an indwelling urinary catheter. The MDS also documents R2 is at risk for pressure sores but currently has no pressure sores at a stage one or higher.</p> <p>A Nurses Note dated 2/18/2011 at 12:15 PM from the hospital reads: "...PT (patient) RECEIVED TO FLOOR, A DIRECT ADMIT FROM (the facility) . PT ALERT, SPEECH GARBLED. RIGHT EXTREMITIES WEAK. PT INC (incontinent) OF URINE, STOOL...WOUND TO COCCYX..."</p> <p>Z3, Registerd Nurse (hospital nurse) stated on 3/2/11 at 12:50 PM that she helped to admit R2 directly from the facility to the hospital on 2/18/11 at about 12:45 PM. Z3 stated, "...I saw immediately after she was admitted - that she had a pressure sore (in) the shape of a bedpan (on her coccyx and buttocks). I immediately thought it was a bedpan injury. The outline was in a brighter pink, stage II or III. She was a direct admit (from the facility) and she had not been on a bedpan since she was here - also our bedpans are shaped differently..."</p> <p>An incident report signed by the facility Administrator and dated 3/2/2011 states: "...On the day shift of February 17, 2011 resident (R2) was noticed to have a new decubitus ulcer (pressure ulcer) on her coccyx. An assessment of the surrounding area revealed a U-shaped impression. (R2) was unable to report how the impression or ulcer developed...(R2) is frequently incontinent and would periodically use a bedpan..."</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>E13, Certified Nursing Assistant (CNA) stated on 3/3/11 at 2:17 PM that she and another CNA assigned to R2 discovered R2 on a bedpan. E13 stated, "...I took care of (R2). We (E13 and E10 CNA) went to clean (R2) up, and we discovered she was on a bedpan...I am not sure of the time or date but neither me or (E10) put her on the bedpan. She (R2) was out of it (not able to communicate). When we took her off the bedpan we saw the impression of the bedpan. Her (R2's) bottom was broke down. My impression was, somebody left her on the bedpan..."</p> <p>E6, CNA worked with E13 and E10 the day R2 was found on the bedpan. E6 stated on 3/3/11 at 3:05 PM, "...I have taken care of (R2). Some girls found her on the bedpan. (E10), (E13) and I worked together that day, I'm not sure of the date. The other two (CNAs) found her but I knew about it...It was in February..."</p> <p>E8, CNA also stated she knew about R2 being found on a bedpan and stated it was reported to the nurse. E8 stated on 3/3/11 at 2:00 PM, "...I would take care of her (R2) every once in a while. I took care of her in February. Me, (E13), and (E10) discovered it. We told the nurse (E5, Registered Nurse)... (E13) and (E10) found her on the bedpan when they got her up that morning, I'm not sure what day or date..."</p> <p>E10, CNA stated on 3/4/11 at 11:15 AM that she discovered R2 on the bedpan and that she knows the day was 2/11/2011. She stated she told the nurse E5. E10 stated, "...I have taken care of (R2). I have used the bedpan with her. I went in with (E13), but this was approximately a week or more before (2/18/11), the day the facility stated the pressure sore was discovered. We found</p>	F 314			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/10/2011
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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) COMPLETION DATE	
F 314	<p>Continued From page 11</p> <p>(R2) on the bedpan on 2/11/2011. I know because it was a day when we all worked together, (E6), (E13), (E8) and (E5). I looked at her backside and it was split open. When I saw it I said, 'Oh my God' because I saw pink meat. I went and got the nurse. (E13) was still in the room. We asked her (R2) who put her on the bedpan and she did not know. I said to the nurse (E5), 'Do you see this (E5's first name), and she said yes, just put some EPC cream (a protective ointment) on it?' The nurse said it looked like the resident had been on there (on the bedpan) for quite some time."</p> <p>A facility document titled, "Daily Nursing Schedule" shows that (E5), (E6), (E8), (E10), and (E13) all worked together on Unit Two on day shift on 2/11/2011. The schedule shows the five employees did not work together on Unit Two, on day shift, on any other day in February of 2011.</p> <p>E5, RN stated on 3/3/11 at 1:20 PM that the pressure area was not pointed out to her on 2/11/2011. E5 stated, "...I don't remember anyone pointing out anything to me on the 11th (2/11/11). If I did not chart it, I did not see it..." E5 also stated R2 could not be depended on to use her call light. E5 said, "...The CNAs used a bedpan to toilet. She (R2) would have good days and bad days. She was very inconsistent cognitively. You really could not trust her to do what she was supposed to do..."</p> <p>R2's clinical record, including skin report sheets and Nurses Notes, does not document a pressure sore as being found on 2/11/2011. Z1, R2's Primary Care Physician stated on 3/4/2011 at 3:30 PM, "...The facility did not notify me of the buttocks wound of (R2) until 2/17/2011. I was not</p>	F 314			

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F 314	<p>Continued From page 12 notified on 2/11/11 of any pressure areas.</p> <p>A "Report of Operation" dated February 20, 2011 reads as follows: "Indications: A 61 -year-old, evidently in (the nursing home), had been on a bedpan 6 hours. Pressure necrosis with decubitus right buttocks measuring 15 cm (centimeters) x 4 cm and then subsequently 3 cm deep about in the deepest. She is for debridement...Description of Procedure:...She had a circumferential area of necrosis both on right and left buttocks cheek, including the sacrum. Superficially necrotic really left side and the area of the sacrum. She had obvious necrosis with tracking by her right buttocks cheek with necrosis as above. Using the cautery only, we removed the necrotic tissue down to the deep subcutaneous tissue..."</p> <p>Z4, Surgeon stated on 3/2/11 at 2:30 PM that the wound was a "pressure necrosis" consistent with someone who was on a bedpan for hours. The surgeon described the wound as a "circular ridge from one side of the buttocks to the other and down the thigh. The wound was infected and it would have taken days for the infection to develop not hours."</p> <p>A report titled "Consultation" dated 2/19/2011 and signed by Z2, Infectious Disease Specialist documents: "...She has a horseshoe shaped decubitus extending from the left to the right gluteal area across the top of the sacrum. On the right side, it is approximately 24 cm. It is 1 to 1.5 cm in width. it is undermined. there is frank purulent drainage..."</p> <p>Z2, Infectious Disease Specialist stated on 3/4/11 at 10:45 AM "...I think blood poisoning</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>(septicemia) was caused by the infection the resident had of the pressure ulcer on (her) backside. I had cultures that verified this..."</p> <p>A Progress Note dated 2/23/2011 and signed by Z5, Attending Physician states, "...Assessment and Plan: 1. Septic Shock: Probably secondary to decubitus ulcer. Patient is improved status post debridement and now on a combination of Zosyn and Vancomycin (intravenous antibiotics)..."</p> <p>An Immediate Jeopardy was identified with R2 on 3/4/11 at 2:20 PM. The Immediate Jeopardy was determined to have begun on 2/11/2011 when staff failed to monitor R2's time on the bedpan and when the nurse failed to notify the physician and begin treatment and monitoring of the pressure sore. E1 Administrator, was informed of the Immediate Jeopardy on 3/4/11 at 2:20 PM.</p> <p>The surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:</p> <ul style="list-style-type: none"> * On 2/18/2011 R2 was admitted to the hospital and received care and treatment of the pressure ulcer on her sacrum and buttocks. In addition R2 received treatment for infection of the wounds and septicemia. * On 3/4/2011 the unit managers of each unit conducted a visual inspection of the complete body of all residents at high risk for skin breakdown. * On March 2nd through the sixth staff were educated by the Unit Managers and Shift Supervisors regarding the assessment of residents at risk for the development of pressure 	F 314			

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F 314	Continued From page 14 ulcers, the development and implementation of a plan to prevent pressure ulcers (including re-education on bedpan protocol), staff responsibilities regarding response to an identified wound and protocol for the ongoing management of wounds.	F 314			