STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BIG MEADOWS	**1000 LONGMOOR SAVANNA, IL 61074**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have a current physician order [REDACTED]. R20's MDS (Minimum Data Set) dated 10/09/19, shows R20 has moderate cognitive impairment, and needs limited assistance eating, and extensive assistance transferring. On 3/4/2020 at 9:43 AM, R20 was yelling she was trapped by her soft padded lap cushion because she could not get her restraint off. On the same day at 12:30 PM, R20 was in the dining area eating lunch in her wheel chair with the soft padded lap cushion on, with a CNA (Certified Nursing Assistant) sitting beside her. V15 CNA said R20's lap restraint does not get removed because staff do not want (R20) to fall out. After lunch, in R20's room with V14 CNA, R20 was asked if she (R20) could remove the lap cushion and R20 said in a raised voice, that's what I've been telling you, I can't take it off! I'm trapped in here! R20 attempted to remove the lap cushion several times, but could not. On 3/5/2020 at 12:12 PM R20 was in the dining room eating lunch with the soft padded lap cushion in place. From 3/3/2020 to 3/5/2020, R20 always had the soft padded lap cushion on if she was in her wheel chair. 03/05/20 09:56 AM, V4 MDS/Careplan Nurse said R20 should have a restraint care plan, but does not. V4 said it is important to have a restraint care plan so staff can utilize restraints appropriately. V4 said there is no current restraint order on the POS. R20's POS dated 3/2020 shows no order for the soft padded lap cushion restraint. The last time it was ordered by a physician was 12/12/18. The 10/07/19 CAA (Care Area Assessment) summary shows #18 Physical Restraints triggered due to the use of a soft padded lap cushion for positioning and safety when (R20) is in her wheel chair. The soft padded lap cushion can be off at meal times and when in visual site of others . R20's current care plans shows no care plan for restraints. 2. R56's face sheet printed 1/22/20 showed R56 is a [AGE] year old male with [DIAGNOSES REDACTED]. On 3/3/20, R56 was observed in the locked dementia care unit in the dining room at breakfast, lunch and during activities. R56 was in his wheelchair with a soft mechanical restraint adjacent to his trunk and extending through both arm rests of the wheelchair. This restraint device extended from his body at least 12 inches. There was staff present in the dining area during meals and activities. On 3/3/20, R56 was not observed without the soft mechanical restraint applied in front of him in the wheelchair. On 3/4/20 at 9:05 AM, V6 Certified Nursing Assistant (CNA) transferred R56 from the bed to the wheelchair. Once R56 was in the wheelchair a soft mechanical restraint was placed across R56's lap and through both arm rests. This restraint was in place during observations of breakfast, lunch and activities throughout the day. On 3/4/20, R56 was not observed without the soft mechanical restraint applied in front of him in the wheelchair. On 3/4/20 at 9:12 AM, V6 said the restraint across R56's lap protects him from falling out of the chair. V6 instructed R56 to remove the restraint. R56 struggled to free the restraint in front of him. R56 grabbed the end and tried to pry it out of the arm rests without success. R56 attempted to grab the end farthest from his body to pull it off without success. R56 pulled the device in one direction then another. V6 suggested R56 pull in a certain direction and the restraint was finally released. On 3/5/20 at 8:19 AM, V5 Dementia Unit Director said R56 has a soft mechanical lap restraint for his safety. He is a big fall risk. The restraint is put on when he gets up in the wheelchair in the morning. R56 is rarely in his room and can sit upright by himself. There are no restraint devices when R56 is in his room. At 8:28 AM, V5 verbally prompted R56 to remove the lap restraint at least five times. R56 struggled to remove the device. V5 said R56 had to struggle to remove the restraint. It didn't come off easily. He might be tired. At 9:55 AM, V4 Care Plan Nurse said restraints should have a care plan. R56 does not have a restraint care plan. Restraints are assessed quarterly and there is no process in place to document evidence of restraint reduction attempts or restraint monitoring on a monthly basis. R56 has not had a current order for a lap restraint since the original order dated 8/16/19 and the restraint has been in use since then. R56's physician telephone order dated 8/16/19 showed to place the lap restraint in the wheelchair for safety and positioning. There is no time frame for the restraint use, a medical diagnosis, or release and monitoring instructions. R56's current physician orders [REDACTED]. R56's fall incidents showed falls occurred on 4/11/19, 5/19/19, 7/12/19, 9/3/19, 9/17/19, 9/18/19, 11/7/19, 12/1/19, 12/4/19, 1/5/20, and 1/30/ 20. All of the fall incidents occurred in the resident's room. R56's facility assessment dated [DATE] showed he has moderately impaired cognition and a trunk restraint is use in the chair when out of bed. R56's care plan was reviewed. There was no care plan for the use of a restraint. The facility's undated Physical Restraint Policy showed the resident will be free of any physical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. The Licensed Nurse will contact the physician for an order prior to the application of a restraint. The order will state type of restraint, time period to be used, reason for use, medical diagnosis, and release and monitoring instructions. Residents who are using restraints will be reviewed monthly by the Restraint Reduction Team. The plan of care will include the reason for the restraint (problem), goals, and interventions used to reduce restraint usage.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify a pressure injury prior to becoming a stage 2, failed to notify a physician and obtain a treatment for [REDACTED]. The findings include: 1. R54's care plan documents he is at risk for pressure injury due to [DIAGNOSES REDACTED]. The care plan shows he currently has a Stage 3 pressure injury to the sacral/ coccyx area. R54's weekly pressure injury record documents the onset of his wound as 1/1/2018, and measured 2cm (length) x 1cm (width) x less than 0.2 cm (depth) with moderate drainage. The weekly pressure injury records show the pressure injury declined to a stage 3 on 8/2/18 per the wound nurse. R54's weekly wound assessment of 7/5/19 documents the wound as declining, and the nurse did not obtain new treatment orders or notify the physician. R54 did not have a change in the treatment until 8/6/19. 03/05/20 at 12:09 PM V13 RN (Registered Nurse) said the wounds are measured weekly by the nurse working the weekend. There is no set day it has to be done, it is either Saturday or Sunday. The documentation should include size, tissue appearance, and if there is drainage. If the wound is not getting any better after 2 weeks I would say notify the primary doctor to obtain a new treatment order. That is why the wound has to be evaluated every week. The wound nurse comes every month and will make treatment recommendations for wounds and the doctor orders them. The weekly pressure injury record for R54 shows missing assessments for weeks of June 2, July 6, August 16 thru September 8 no assessments of the wound were documented. The week of December 1, no assessment was documented on the stage 3 pressure injury. R54's January POS (Physician order [REDACTED]. The dressing was ordered to be changed every other day. Following the order, an assessment was done on 8/12, then missed for 3 weeks. R54's weekly pressure injury record for 9/8/19 documents the wound was Stage 3 measuring 0.5cm x 0.3cm, no documentation on the wound bed or surrounding tissues, and 2 weeks later on 9/22/19 the wound is now 1.0cm x 0.8 cm with a red wound bed. On 11/9/19 the wound was 2.0 cm x 1.0

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

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) cm. No new treatments were attempted until January 9, 2020 and the wound was 3.5cm x 0.8cm On 3/05/20 at 10:50 AM V3 RN, ADON (Assistant Director of Nursing) said which ever nurse is working the weekend does weekly wound measurements. V3 said the nurse can do them on Friday, Saturday, or Sunday when they have time. The assessment should be done every week. Our wound nurse consultant is here once a month, otherwise any changes would be left to nursing judgement. If we are trying something new, then after a couple weeks then we can call the doctor if the treatment is not working or no improvement, that is part of why we measure every week. Usually when the wound nurse is here I will go on wound rounds with her,but I don't' always get the sheet back, she may have been here more to see R54, but there is no copy of it on file in the facility. V3 said the wound nurse had an in-service on documentation. It included how to measure the wounds, because some of the measurements were off, and inconsistent on the records. The wound nurse documentation for R54 was requested and it shows R54 was seen in April, July, and August. The next visit was February 2020. On 3/5/20 at 11:00 AM, V3 said these visits were the only documents she had in her file, there may be more but she would have to call the wound nurse. The facility's 7/6/2018 policy for skin integrity documents the purpose of the policy is to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing , prevent infection and prevent new ulcers form developing. 8) Weekly documentation to include ulcer location, stage, size, exudates amount, pain, wound bed characteristics and description of ulcer margins, surrounding skin, and odor noted. 9) If no progress is noted within 2-4 week time frame, the nurse will reassess the pressure ulcer for change in treatment. 2. R59's undated face sheet shows his [DIAGNOSES REDACTED]. R59's MDS (Minimum Data Set) dated 2/17/2020, shows he has moderate impairment in his cognitive abilities, and is totally dependent on transfers and bed mobility. On 3/3/2020 at 1:30 PM during a dressing change on R59, his right buttocks pressure ulcer was observed to be the size of a quarter with 20% slough at the base. On 3/3/2020 at 1:30 PM, R59 was alert and oriented, and said his right buttocks pressure wound started about a month ago. On 3/5/2020 at 10:59 AM, V3 ADON (Assistant Director of Nursing) said R59's pressure ulcer was facility acquired, and was discovered on 1/18/2020. V3 did not know who discovered the pressure ulcer on R59, and did not know why the Physician was not notified, and why treatment didn't start until 9 days later (1/27/2020). V3 said a delay in treatment could cause a pressure wound to worsen unnecessarily. V3 said a pressure wound should be discovered before it's a stage 2. The facility was unable to provide a weekly assessment from 1/18/2020 to 2/1/2020, and from 2/1/2020 to 2/15/2020. The Weekly Pressure Injury Record dated 2/1/2020 shows the wound worsened from 2/1/2020 (2.0 x 1.0 x 1.0 centimeters) to 2/15/2020 (2.0 x 2.5 x unable to determine due to slough). The Weekly Pressure Injury Record dated 2/1/2020, shows the date of onset for R59's right buttocks pressure ulcer was 1/18/2020. The same document does not show a Physician was notified or an order for [REDACTED]. The TAR (Treatment Administration Record) for R59, dated 1/1/2020-1/31/2020 shows treatment to the right buttocks was to start on 1/18/2020, but did not start until 1/27/2020 according to nurses signatures on the TAR however no entry was found in the nursing progress notes, scripts, or POS that any treatment was ordered. The Skin Integrity Policy and Procedure revised 7/6/18 shows under the heading, Purpose: Based on a comprehensive assessment of a resident, the facility ensures that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with a pressure ulcer receives necessary treatment and services, consistent with professional standards of practice, to promote healing .and prevent new ulcers from developing. Under the heading, Skin Care Protocol: #1 CNA's (Certified Nursing Assistants) are to notify the nurse of any changes of the skin while performing daily cares .The nurse is then to notify the DON (Director of Nursing). #2 The Nurse will start a Newly Acquired Skin Care Sheet. #3 The Nurse will then notify the MD and obtain orders for appropriate treatment. #6 Wounds will be assessed with [REDACTED]. They will be measured and charted accordingly. #8 Weekly documentation to include ulcer location, stage, size, exudate amount, pain wound bed characteristics and description of ulcer margins, surrounding skin, and odor noted. #9 If no progress is noted within 2-4 week time frame, the Nurse will reassess the pressure ulcer for changes in treatment. 3. R32's face sheet printed 1/22/20 showed R32 is an [AGE] year old male with [DIAGNOSES REDACTED]. R32 resides in the facility's locked dementia unit. On 3/3/20 at 10:18 AM, R32 was in bed on his left side. V10 Registered Nurse removed the dressing from R32's bottom. R32's wound is open and is continuous over the right and left upper buttocks and coccyx area. The area is approximately 10 centimeters (cm) X 10 cm X 0.3 cm deep. There was no foul odor and the wound bed was granulated and wound edges were pink. On 3/5/20 at 10:18 AM, V3 wound nurse said pressure wounds should be identified prior to becoming a Stage 2. V3 said R32 had not been seen by the wound nurse consultant. R32's skin assessment dated [DATE] (date of admission) showed there were no pressure injuries or open wounds present. R32's pressure injury record dated 2/3/20 showed two new wounds discovered 2/3/20. The wound to the left sacral area was a Stage 2 pressure injury measuring 1.5 cm X 1cm X 0.2. The wound to the left buttock was a Stage 2 pressure injury measuring 1.5 cm X 2 cm X 0.2 cm. R32's pressure ulcer log for the weekend of 2/29/20 showed three pressure wounds (left buttock, right buttock, and coccyx) had merged into one open wound measuring 11 cm X 10 cm X 0.3 cm. R32's pressure injury risk assessment dated [DATE] showed R32 was a moderate risk for developing pressure sores. R32's facility assessment dated [DATE] showed R32 had moderately impaired cognition. This assessment showed R32 required extensive assistance of two plus persons to physically assist with bed mobility, transfers and bathing. R32 was totally dependent on two plus persons for dressing, toilet use, and personal hygiene. R32 was always incontinent of bowel and bladder and no pressure injuries were present for the 1/14/20 assessment period.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's catheter tubing was not in contact with the floor for a resident with a history of urinary tract infections. This applies to one of one resident (R38) reviewed for catheters in the sample of 16. The findings include: R38's face sheet printed 1/22/20 showed an [AGE] year old male with [DIAGNOSES REDACTED]. R38 resided on the facility's locked dementia unit. On 3/4/20 at 1:45 PM, V8 Certified Nursing Assistant assisted R38 into the bathroom to empty the catheter drainage bag. R38 was seated in a wheelchair. R38's dignity bag and catheter tubing were dragging on the floor. R38 stepped on and got his foot tangled in the tubing during the navigation into the bathroom. R38's supra pubic catheter was connected to a drainage bag and not a leg bag. On 3/4/20 at 12:45 PM, V12 (R38's family member) said that is not sanitary. They're always dragging on the floor and yes, he has a history of urinary tract infections. They don't keep the tubing secured like they're supposed to. On 3/5/20 at 8:19 AM, V5 Dementia Unit Director said a resident's dignity bag and tubing shouldn't be dragging on the floor. It should be up off the ground for infection control. I'm not sure if R38 has a history of UTI's. I can ask the nurse. At 11:24 AM, V3 Assistant Director of Nursing (ADON) said catheter tubing dragging on the floor and being stepped on is not appropriate and has the potential to cause a fall or have bacteria enter the tubing. Dignity bags and catheter tubing should not be touching or dragging on the floor. That would increase R38's risk for a UTI. The facility's undated Urinary Catheter Care Policy showed that catheter care will be provided in a manner that will promote and provide acceptable infection control for the resident. R32's suprapubic catheter care plan initiated 8/6/19 showed to change the urinary drainage bag to a leg bag daily. R38's facility assessment dated [DATE] showed R38 was severely cognitively impaired and had an indwelling catheter. This assessment showed R38 required extensive assistance of one to two plus persons for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. R38's urine cultures dated 7/28/19, 9/19/19, and 12/13/19 showed evidence of a urinary tract infection. R38's 3/20 physician order [REDACTED].