FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
08-110-9042
Shawnee Christian Nursing Center
December 2, 2008

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Shawnee Christian Nursing Center, a skilled nursing facility located in Herrin. The facility, which has 159 certified beds, is one of several nursing homes operated by a non-profit corporation. The specific allegations are as follows:

1. Shawnee Christian Nursing Center failed to provide adequate care for a resident.
2. Facility staff failed to inform the resident's family of the seriousness of a resident's condition.

Statutes

If substantiated, the allegations would be violations of the Illinois Administrative Code (Code) (77 Ill Admin. Code 300.1210), the Nursing Home Care Act (Act) (210 ILCS 45/1-117 and 45/2-107) and the Illinois Power of Attorney Act (755 ILCS 45/4-7 (b)).

Section 300.1210 (a) of the Code states, "The facility must provide the necessary care and services to attain or maintain the highest physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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."

Section 300.1210 (b) of the Code defines the general nursing care that should be practiced on a 24-hour, seven day a week basis. The following outline of care is provided in the Code. Oral, rectal, hypodermic, intravenous and intra-muscular medications should be administered. All treatment and procedures should be administered as ordered by the physician. Observations of changes in the resident's condition should be recorded in the resident's medical record ~~in order~~ so that the resident's condition can be analyzed and a determination can be made concerning the appropriate care that is required and/or needed for further evaluations. Residents should have personal care including proper daily attention to skin, nails, hair and oral hygiene, in addition to any other treatments ordered by a physician. A resident should have at least one bath and hair wash each week and as many additional baths and hair washes as necessary for satisfactory personal hygiene. Each resident should have clean, suitable clothing. Bed linens should be changed at least once weekly and more often if necessary. The facility should have a regular program to prevent and treat pressure sores, heat rashes, or other skin breakdown. A

resident who has a pressure sore should receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Precautions should be taken to assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel should assure that each resident receives adequate supervision and assistance to prevent accidents.

Section 45/1-117 of the Act defines neglect as "…a failure in a facility to provide adequate medical or personal care or maintenance which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition."

Section 45/2-107 of the Act states, "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident…"

Section 45/4-7 (b) of the Illinois Power of Attorney Act states, "A health care decision made by an agent in accordance with the terms of a health care agency shall be complied with by every health care provider to whom the decision is communicated, subject to the provider's right to administer treatment for the patient's comfort care or alleviation of pain; but if the provider is unwilling to comply with the agent's decision, the provider shall promptly inform the agency who shall then be responsible to make the necessary arrangements for the transfer of the patient to another provider. It is understood that a provider who is unwilling to comply with the agent's decision will continue to afford reasonably necessary consultation and care in connection ~~wit~~ with the transfer."

Investigation Information for Allegation 1

Allegation 1: Shawnee Christian Nursing Center failed to provide adequate care for a resident. To investigate the allegation, the HRA Team, consisting of one member and the HRA Coordinator, conducted a site visit at the facility. During the visit, the Team spoke with the facility Administrator, a nurse and the resident whose rights were alleged to have been violated. The Coordinator spoke via telephone with the resident's agent under a Power of Attorney (POA). The resident's records were reviewed with written authorization of the POA agent. The Authority also reviewed photos of the resident's injured leg and the type of catheter bag that had caused the injury. Facility Policies pertinent to the allegation were reviewed. The HRA also reviewed the facility's Illinois Department of Public Health (IDPH) Annual Survey and an IDPH Complaint Determination Form pertinent to the allegation.

I.. Interviews:

A …Facility Administrator (Administrator)

According to the Administrator, the resident whose rights were alleged to have been violated was admitted to the nursing center from an area hospital after it was determined that she could not function in her home setting. He stated that in March 2008 while a Nurses' Aide was preparing to take the resident to the bathroom, the hook on her indwelling catheter bag caught in the back of her leg causing a laceration. The Administrator stated that as soon as the accident occurred, the Nurses' Aide notified a Licensed Practical Nurse (LPN) who informed the Director

of Nursing (DON) and the resident's physician. The resident was taken to an area hospital emergency room for treatment and returned to the nursing center with staples in the affected area.

The Administrator informed the Team that the type of catheter bag that caused the resident's injury had been used by all ~~of~~ nursing homes owned by the corporation without any complications. However, immediately after the resident's injury, the catheter bags of that category were removed from all of the nursing homes and replaced with bags that do not have the rigid plastic hooks.

The Administrator stated that the Nurses' Aide who assisted the resident when the accident occurred was extremely troubled about the resident's injury. He stated that the staff member was a very responsible employee.

B…Nurse:

The Team also spoke with a nurse on the unit where the resident resides. The nurse stated that she was not working with the resident when the injury occurred. However, she was aware that the resident's lower right leg had been injured by a rigid plastic hook on a catheter bag. She informed the Team that the injured area had healed nicely and there was minimal scarring. According to the nurse, the facility no longer uses the type of catheter bag that caused the resident's injury.

C…Resident:

During the site visit, the Team visited with the Resident in her room. Due to her disability diagnoses, the conversation was minimal. However, the Team noted that the resident was clean, adequately groomed and wore appropriate clothing that fit well. She appeared well nourished and content in her surroundings. With her consent, the Team observed the area on her leg that was injured in the March 2008 incident. The Team noted that there was a very thin scar approximately 8 inches on her leg. There was no indication of poor healing, such as redness or swelling.

D…POA Agent:

When the Coordinator spoke with the resident's POA agent he stated that on the morning of March 22, 2008, he received a phone call from a staff member at Shawnee Christian Nursing Center. He related that the call was to inform him that the resident had sustained a scratch on her leg during the process of transferring her to a wheelchair for toileting. He stated that facility staff informed him that the resident was being sent to the emergency room at an area hospital for evaluation and treatment. The POA agent stated that the resident's injury was described as minimal and might require a "stitch". The POA agent stated that he informed the caller that he was on his way out of town but was close enough to return to the area if necessary. He stated that he was assured that the injury was "just a scratch".

The POA agent stated that approximately two hours later he received a call from a staff member at the nursing center to inform him that the resident had returned to the facility after having twelve staples placed in her leg. He related that the staff member informed him that the resident was resting comfortably and had been given antibiotics to prevent an infection. He stated that he informed the caller that when he was initially notified about the resident's injury, the caller stated that the resident had received a scratch that might require a stitch, not extensive staples. He stated that he questioned the staff member about the manner in which the resident obtained the injury and was informed that the injury occurred when she was transferred from a chair. According to the caller, the catheter bag had been placed down inside the resident's pant let and when staff tried to pull the resident's pants up the prongs on the catheter bag caught the resident's pant leg and then her leg causing the injury.

The POA agent stated that when he returned to the area two days after the resident's injury, he went to the nursing home to see the resident. He related that during the visit he photographed the resident's injuries and the type of catheter bag that caused the injury. He stated that he spoke with the DON and the Administrator about receiving a catheter bag identical to the one that caused the resident's injury and was informed that the facility ceased using that type of bag after the resident's injury.

II.. Record Review:

A….Minimum Date Set (MDS)

Documentation indicated that an MDS, a nursing home resident assessment and care screening, was completed on 03/11/08. The MDS provides the following assessments: 1) information about a resident's background, 2) cognitive patterns, 3) communication/hearing patterns, 4) vision, 5) mood and behavior patterns, 6) psychosocial well-being, 7) physical functioning and structural problems, 8) continence for the previous fourteen days, 9) disease diagnoses, 10) health conditions, 11) oral/nutritional status, 12) skin conditions, 13) activity pursuit patterns, 14) medications, 15) special treatments and procedures, 16) discharge potential and 17) overall status and assessment information.

According to the MDS, the resident required staff assistance for the following: 1) positioning while in bed, 2) transfer between bed, chair and wheelchair, 3) to standing position, 4) locomotion on and off the unit, 5) dressing, 6) eating, 7) toilet use and 8) personal hygiene.

The resident's diagnoses were listed as follows: 1)Adult Failure To Thrive, 2) Alzheimer's disease, 3) Atherosclerosis (coronary) and 4) a history of a breast malignancy.

Documentation in the continence section of the MDS indicated that the resident has an indwelling catheter and a regular bowel elimination pattern.

Documentation in the skin condition section of the MDS indicated that the resident had two stage IV pressure ulcers, one on the heel and another on the buttocks. Skin treatments were listed as follows: 1) a pressure relieving device for her chair and bed, 2) turning/repositioning

program, 3) nutrition/hydration interventions to manage any skin problems, 4) ulcer care, and 5) application of dressings and 6) application of ointments/medications.

B. Resident Care Plan (Plan)

According to the resident's plan dated 03/18/08, the resident was admitted to the nursing center on 12/05/07. At the time of admission, impaired skin integrity was listed as a problem. Documentation indicated that the resident had an ulcer on her left heel, and a Stage IV ulcer on her right buttocks. The record indicated that both areas were healing. However, the potential for unavoidable worsening was possible due to the recipient's failure to thrive diagnosis bowel incontinence, required catheter for bladder elimination and poor food intake. A goal to provide appropriate treatment and preventative measures in order to promote healing of current skin breakdown and to prevent problems was incorporated in the Plan.

Approaches to reach the skin care goal included the following: 1) treatment to the pressure ulcers to the right buttocks and left heel as ordered per infection control guidelines; 2) observation of the affected area to include size, depth and signs of infection (such as fever, redness, swelling, foul odor, and drainage); 3) providing an update of the resident's condition to the resident's physician and the wound specialist as clinically indicated; 4) providing a low air mattress overlay to be placed on her bed; and 5) providing a preventative cushion in her chair. Staff members were to assist her in transfer and positioning in the bed and in the chair at least every one to two hours. She was given a body pillow for positioning and protectors for her heels. The record indicated that the resident had an indwelling Foley catheter for bladder elimination. Catheter care was to be given every shift and when needed. The following specific approaches were to be followed: staff should ensure that there are no episodes of the catheter leaking and prompt care should be provided in the event that leaking occurs. Upon request, staff should assist the resident with toileting for bowel elimination. If incontinence does occur staff should provide prompt and appropriate perineal hygiene. A nurse should conduct a daily skin check in addition to providing routine daily care and bathing. Moisture barriers in the form of creams or lotions should be applied to the resident's skin. Staff should follow-up with the resident's physician in the event any significant skin breakdown is present. Staff should encourage and assist the resident in eating and drinking to improve intake necessary for proper healing. A dietician should periodically review the resident's diet. A mechanical soft, fortified food diet with Resource supplement four times daily was ordered. Vitamins and Arginaid, a nutritional supplement for patients recovering from burns, surgery or wounds, were also ordered. Medication and labs should be conducted as ordered.

A goal to have no catheter related complications throughout the next review was also incorporated in the Plan. Approaches to reaching the goal included changing the catheter as ordered and providing catheter care every shift and as needed per infection control guidelines. Staff members were instructed to not raise the catheter bag above bladder level, to make certain that the bag was not kinked and to ensure that the catheter tubing was properly anchored to prevent pulling and pressure on the resident's fragile skin. Staff members were instructed to

encourage the resident to drink fluids, especially water, and to monitor her input and output every shift.

A goal for the resident to be provided with appropriate nutrition/hydration to minimize weight loss and prevent dehydration was incorporated in the Plan. Approaches to reach the goal were listed as follows: 1) Staff should assist the resident in choosing her menu at each meal; 2) Staff should cater to her food preferences as much as possible; 3) She should be offered substitutes for her dislikes; 4) She should be served the diet as ordered; 5) Staff should assist the resident when she will allow the assistance; and 6) The recipient's intake should be documented and reported to a nurse if the intake is poor.

According to a 04/28/08 handwritten entry in the 03/18/08 Plan, the unstageable decubitus areas were improved and were now considered to be Stage II in appearance. Documentation on 05/23/08 indicated that the areas continued to heal and have the appearance of a Stage II pressure ulcer. An additional entry on 05/23/08 indicated that the resident had gained thirteen pounds during a three month period, a weight gain that was desired. A 03/22/08 hand written entry indicated that the resident had received a laceration that was cleansed and dressed per a physician's order. The staples were to be removed within seven to ten days.

C… Nursing Progress Notes(Notes)

Documentation in a 03/22/08 Note indicated that the recipient had received a laceration to her left leg at approximately 10:30 AM. The record indicated that the injury occurred during transfer and was caused by a hook on the catheter bag. According to the documentation, pressure was applied to the laceration until emergency personnel arrived to transport the resident to the hospital emergency room at 11:10 AM. The record indicated that the resident's POA agent was notified at 10:40 AM. Additional documentation indicated that the nursing facility received a call from emergency room staff at 12:15 PM stating that the resident had received twelve staples to the injured area, a Tetanus shot, and an antibiotic, Keflex and would be returning to the facility. Documentation indicated that the POA agent was notified about the resident's condition after the call was received from the emergency room. An additional recording on 03/22/08 indicated that the staples were to be removed in seven to ten days.

A progress note dated 03/22/08 completed by a Registered Nurse (RN) at 1 PM indicated that the resident denied have any pain and was resting with her eyes closed. The wound on her leg did not have any signs of infection, and the staples were intact. The writer recorded that she had spoken to the resident's POA agent at 10:40 AM on 03/22/08 and described in detail the size of the wound and the need to send the resident to the emergency room for evaluation and treatment. She stated that she had informed the POA agent that most likely sutures would be applied; however she did not speculate on the number of sutures that would be required because that was beyond her "scope of practice". Additional documentation indicated that at 12:15 PM, a telephone call had been received from the area hospital emergency room giving a report of the resident's condition and informing the facility that staples rather than sutures had been applied due to the resident's "combative behaviors".

D… Skin Care Records;

Documentation in the Treatment Administration Records indicated that the resident had dressings changed twice daily on the affected areas on her right buttocks and left heel. During each review, the areas were assessed for signs of redness, swelling, inflammation, increase in the size of the areas, and for any signs/symptoms of pain. Her nutritional intake was assessed, and staff assisted her in eating and drinking in an attempt to improve the food intake necessary for proper healing. She was given a mechanically soft diet with fortified food and a nutritional supplement four times daily, as well as vitamins. A dietician reviewed the resident's dietary needs on a regular basis.

E…RAP Review Report (Report):

According to the Report, the 80 year old female was admitted to the facility on 12/03/07 following hospitalization for a UTI (urinary tract infection) and failure to thrive secondary to Alzheimer's. Additional diagnoses included a history of a heart murmur, a history of breast cancer with a lumpectomy, a history of colon resection, hypertension, peripheral vascular disease, and coronary artery disease. Documentation indicated that on 12/04/07, the resident had an episode of syncope (temporary loss of consciousness/fainting) in which she was near-arrest status, requiring evaluation at an area hospital. The resident was receiving occupational and physical therapy services in order that she might be able to function at her maximum potential. Documentation in the Report indicated that the resident was receiving skilled nursing care for two Stage IV ulcers, which were healing.

According to the Report, the resident required limited to extensive assistance in bed mobility, extensive assistance with one or two persons during transfers. She required extensive assistance in toileting, hygiene and bathing. She is able to wash her face and hands and perform some grooming and oral care when cooperative. She required total staff assistance with catheter and perineal care.

F…Emergency Room Records:

According to a hospital emergency room report dated 03/22/08 at 11:50 PM, the resident was treated for a laceration to the right leg that was caused by the Foley catheter. While in the emergency room, the resident received local anesthesia and twelve staples to the affected area. The resident was treated and released with instructions for appropriate care of the affected area and a recommendation to return to the hospital to have the staples taken out in seven to ten days. The record indicated that she was given Keflex 250 mg capsules that were to be administered four times daily.

G…Resident Information Form

Documentation in a 03/22/08 Resident Information Form indicated that the resident had received a laceration to the left lower extremity from a catheter bag. As a result of the injury the

resident required treatment in an area emergency room. The record indicated that the family was notified regarding the resident's injury

III…Illinois Department of Public Health (IDPH) Annual Survey (IDPH Survey):

According to a 09/27/07 IDPH Survey, the facility had six health deficiencies. The average number of health deficiencies in the State of Illinois was listed as seven, and the national average was listed as eight.

The facility was cited for the following: 1) proper care of residents needing special services; 2) screening residents when they are first admitted to send them to an area with special care for persons with developmental disabilities or mental illness; 3) failure to immediately tell the resident, doctor and a family member if the resident was injured, if there was a major change in a resident's physical/mental health, if there is a need to alter treatment significantly, and if the resident must be transferred or discharged; 4) providing services to meet the needs and preferences of each resident; 5) keeping the rate of medication errors less than 5%; and 6) making sure that the nursing home is free of dangers that cause accidents.

On a scale of one to four, all citations were listed as two with minimal harm or a potential for actual harm to a few residents. Documentation indicated that the facility had issued a plan of correction for each of the citations and that the plan was approved by the IDPH.

IV…Illinois Department of Public Health (IDPH) Complaint Determination Form

According to a 4/02/08 IDPH Complaint Determination Form pertinent to the allegation, IDPH cited the facility for failure to ensure that a resident's environment remained free of accident hazards and failure to provide a resident with adequate supervision and assistive devices to prevent accidents. The allegation that the facility was neglectful was considered invalid. However, the allegations that the resident received an injury and the facility failed to provide proper nursing care were substantiated.

Documentation indicated that based on staff interviews, record reviews, equipment and resident observation, the facility staff failed to adequately assess accident hazards in the environment to prevent a resident's injury. According to the resident's medical record, the 80 year old female who was admitted to the facility on 12/03/07 with a diagnosis of Alzheimer's disease received an eight inch laceration on her lower right extremity from a catheter bag during transfer. The incident occurred at 10:30 AM on 03/22/08 in the resident's room. A Certified Nursing Assistant (CNA) was noted as the witness.

The record indicated that the resident was wearing slacks and sitting in a wheelchair in her room when the CNA prepared her to be transferred to a bedside commode for bowel training. According to the record, the CNA folded the catheter bag and placed it up into the resident's right pant leg so her pants could be lowered for placement on a bedside commode. During the process the point of the hook on the catheter bag caught in the resident's skin causing the

laceration. The CNA contacted a Licensed Practical Nurse (LPN) when she realized that a skin tear had occurred. Both staff assessed the affected area and applied pressure. The resident's physician, family and the Director of Nursing were notified, and she was sent to the emergency room for treatment.

The IDPH investigator recorded observation of the same brand of catheter bag and tubing that had caused the laceration. It was noted to have a 0.4cm plastic pointed tip on the hook that supports the plastic bag.

V…Observation of Photos

HRA members observed photos of the resident's injury and the type of catheter bag that caused the laceration. It was noted that at the end of the tubing on the catheter bag there was a hook, which appeared to be a hard plastic substance. When the HRA members reviewed the photos of the resident's injury, they observed that twelve staples been used to closed the affected area on the resident's leg.

VI: Facility Policies

A…Pressure Ulcer Risk Assessment Policy

According to the Policy Statement, "It is the policy of this facility to assess all residents for additional factors that place them at risk for developing ulcers. The purpose of the policy is to establish a consistent and objective method of assessing a resident for the development of an ulcer, and to implement a standardized plan for pressure ulcer prevention.

The procedure includes using the Braden or Norton Ulcer Risk Assessment Tool upon admission to the facility. All residents are to be reassessed weekly for the first four weeks and then quarterly thereafter, unless that was a significant change in cognition or functional ability. A reassessment will occur if there is a significant change. All factors in the risk assessment tool will be addressed even if the total risk score does not place the resident at risk for developing a pressure ulcer. All residents assessed to be at high risk will receive a documented daily visual inspection of their skin by a RN, LPN or CNA.

B…Skin Assessment Policy

The Policy Statement is as follows: Intact, healthy skin is the body's first line of defense. It is the policy of this facility to monitor the skin integrity for signs of injury and irritation. In addition to ongoing assessment of the skin, the facility will implement measures to protect the resident's skin integrity and to prevent skin breakdown. Upon admission to the facility the following will be assessed: (1) Risk for developing pressure ulcers using valid assessment of pressure ulcer risk; (2) General skin condition; (3) History of ulcers and skin condition; (4) Current ulcers."

The purpose of the skin assessment was to continually inspect the resident's skin for early signs of any pressure ulcer development or other skin abnormalities.

Upon admission, a head-to-toe assessment of the resident's skin is to be completed by a licensed nurse along with the admission nursing history. Residents who are determined to be at risk for development of pressure ulcers will be provided with a head-to-toe skin assessment completed by a licensed nurse or CNA daily and then documented on the Daily Skin Assessment record or the Treatment Administration Record. All residents, regardless of risk will have a documented weekly review of their skin condition.

C. Wound Assessment Policy.

According to the Wound Assessment Policy, it is the facility's policy to do a systemic, ongoing wound assessment of all wounds in order to determine the appropriate nursing care and treatment modalities. The purpose of the policy is listed as to provide a systemic, comprehensive approach to assessment of wounds, and to provide accurate documentation in the resident's medical record of the ongoing assessments of the wound.

The procedure includes documentation of the presence of a wound in the nursing assessment when a resident is admitted to the facility. Wound and wound dressings are to be monitored daily and assessments documented. A complete wound assessment is to be completed on a weekly basis by a licensed nurse. A comprehensive wound assessment is to be documented listing the wound type, location, pressure ulcer staging or description of the tissue damage, wound measure and associated pain.

D… Additional Wound Policies

The facility has policies for wound cleansing and wound culturing. According to the Wound Cleansing Policy wounds are cleansed of all exudates, bacterial contamination and debris to promote optimal healing so that inflammation-producing substances are removed. Wound cleaning is done by a licensed nurse in accordance with a physician order.

The procedure includes the following: 1) using a physiologically safe solution; 2) irrigating the wound; 3) discarding all syringes, needles, etc. used solely for the wound cleaning; 4) documentation of the treatment in the Treatment Administration Record; and 5) following established wound assessments and 6) documentation established on the Wound Assessment Flow Sheet.

According the facility's Wound Culture Policy a swab wound specimen will be obtained per physician's order or whenever clinical signs of acute infection are noted. The procedure includes assessing for signs of infection, obtaining a physician's order for the wound culture and sensitivity, culturing the wound, documenting on the Treatment Administration Record and/or Nurses' Notes, and notifying he physician of the culture and sensitivity results and obtaining treatment orders.

E… Incontinence and Catheter Management Policy

According to documentation in the Incontinence and Catheter Management Policy, the facility should ensure the following: 1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary. 2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 3) A resident, with or without a catheter, will receive appropriate care and services to prevent infection to the extent possible. 4) Indications for ~~to~~ treatment of a Urinary Tract Infection (UTI) are outlined. Fever, increased burning pain, frequency/urgency for urination, flank pain and/or tenderness, change in character or urine and/or worsening of mental or function status are listed as signs and symptoms. 5) Continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy. 6) Recurrent UTI's (two or more in six months) in a non-catheterized resident may warrant additional evaluation.

Residents are evaluated upon admission and whenever there is a change in their cognition, physical ability, or urinary tract function. Additional assessment information found throughout a resident's medical record will be assessed to determine if any modifications are necessary and for development of a plan for removal of a catheter. Voiding and fluid intake patterns will be documented. Referrals may be made to various practitioners specializing in diagnosing and treating conditions that affect the urinary function. Resident specific interventions will be developed and documented, and care plans will be revised.

Summary

According to the complaint, the facility failed to provide adequate care for a resident resulting in that resident receiving a significant injury to her leg. According to the POA agent the facility Administrator, documentation in the resident's chart and an IDPH Complaint Determination Form, the resident was injured when a hook at the end of the tube on the catheter bag lacerated her leg. The recipient's record indicated that the injury occurred when a CNA was assisting the resident in ~~a~~ transfer for toileting. Documentation and interviews indicated that the resident required twelve staples to close the wound. The resident's record indicated that she received adequate skin assessments and treatment for skin ulcers that were present when she was admitted to the facility. The resident's skin care and wound treatment were in accordance with existing facility policies. An IDPH investigation pertinent to the incident indicated that the facility was not cited for neglect. However, there were citations for inadequate nursing care and client injury. According to the Administrator, the same type of catheter bag had been used for a considerable amount of time in all of the facilities owned by the corporation without any adverse incidents. Conversely, immediately following the resident's injury, that type of catheter bag was removed from all of the nursing facilities and replaced with another type of bag without the rigid hook.

Conclusion

Based on interviews and documentation, the Authority substantiates that the resident received an injury and that injury might have been prevented if facility staff had assessed the

potential for harm associated with the hook on the end of the catheter. However, the HRA does not substantiate that the facility failed to provide adequate skin care prior to and after the injury. The HRA acknowledges that as soon as the injury occurred, all the same types of catheters were removed from all of the facilities owned by the corporation. Therefore, the allegation that the facility failed to provide adequate care for a resident is unsubstantiated.

Recommendation

The facility should be proactive and ensure that resident environments remain free of accident hazards as possible, pursuant to the Illinois Administrative Code for skilled facilities.

Suggestion

During HRA's investigation, it was noted that there was consistent information to indicate that there was a defect in the type of catheter bag that caused the resident's injury. The Authority acknowledges that the facility ceased using that type of catheter bag immediately after the March 2008 incident. However, there continues to be a potential for harm to others in various other settings that use that type of catheter bag. Therefore, the Authority suggests the following:

Facility administrative staff should contact the manufacture of the affected catheter bags in order that the company is made aware of the potential for injury to the user.

Allegation 2: Facility staff failed to inform the resident's family of the seriousness of the resident's condition. To investigate the allegation, the Coordinator spoke via telephone to a family member who is the resident's POA agent. During a site visit the Team spoke with the facility Administrator, and the Authority reviewed copies of information from the resident's clinical chart.

Interviews:

A…POA Agent

When the Coordinator spoke via telephone to the POA agent for the resident's medical needs, he stated that he received a phone call from a staff member at the nursing home informing him that the resident had received a scratch on her leg during the process of transferring her from a wheel chair for toileting. The POA agent stated that he was informed that the resident's injury was a scratch; however, she was being sent to an area emergency room for evaluation and treatment. The POA agent stated that when he received the call he was traveling out of the area, but informed the caller that he could return if necessary. He stated that within a couple of hours, he received a call from staff at the facility to inform him that the resident had returned to the facility after receiving treatment which included twelve staples to the affected area. The POA agent stated that he felt that the facility should have adequately informed him of the resident's injuries when the initial call was made.

B…Facility Administrator

When the Team spoke with the Administrator during the site visit, he stated that as soon as the CNA noted that the resident had received an injury, she notified a LPN. The DON, the resident's physician, and the POA agent were contacted regarding the injury shortly after the LPN was notified. He stated that as soon as the resident returned from the emergency room, the POA was contacted the second time. The Administrator stated that the POA agent was informed of the specifics about the resident's injury each time via telephone, and staff documented the contacts in the resident's clinical chart.

C…Record Review:

According to a 03/22/08 RN's progress note, the resident's POA agent was contacted at 10:40 AM after the resident's injury at 10:30 A.M. The RN documented that she had described in detail the size of the wound and the need to send the resident to the emergency room for evaluation and treatment. She recorded that she had informed the POA agent that most likely sutures would be applied; however, she did not speculate on the number of sutures that would be required because that was something that she did not feel qualified to determine.

Documentation in a 12:15 PM progress note indicated that a report had been received from the hospital emergency room to give a summary of the residents' condition and to inform the facility that staples had been applied instead of sutures due to the resident's combative behaviors.

Summary

According to the POA agent, he was informed that the resident had a minor injury that would require an evaluation and treatment at an area emergency room. He stated that a staff member informed him that the resident might require a suture. However, after the resident was treated, facility staff called the second time to inform him that the resident had received twelve staples in her leg to close the affected area. According to the facility Administrator and documentation in the resident's chart, the POA agent was informed of the nature of the injury when the initial call was made.

Conclusion

Since there was conflicting information regarding the content of the initial conversation to the POA agent, the Authority does not establish a rights violation. Therefore, the allegation that facility staff failed to inform the resident's family of the seriousness of a resident's condition is unsubstantiated. No recommendations are issued.

Suggestion

Even though the allegation is unsubstantiated, the HRA does not discount the POA's account of the conversation. Therefore, the following suggestion is issued:

When a change in a resident's condition occurs, facility staff should provide accurate information in a timely manner to a resident's representative.