

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Ignite Medical McHenry		STREET ADDRESS, CITY, STATE, ZIP CODE 550 Ridgeview Drive McHenry, IL 60050	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observation, interview, and record review, the facility failed to perform ADL (Activities of Daily Living) assistance for a resident that requires assistance and failed to replace a soiled blanket for one of three residents (R4) reviewed for ADL assistance in the sample of four.</p> <p>The findings include:</p> <p>R4's Admission Record dated October 15, 2024 shows she was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, peripheral vascular disease, diabetes mellitus, asthma, major depressive disorder, obesity, osteomyelitis, and heart failure.</p> <p>R4's Care Plan initiated May 12, 2021 shows she has an ADL self care performance deficit and limited physical mobility related to limited mobility and pain. R4 requires one staff member for personal hygiene and dressing. R4 requires the assistance of two staff members for bed mobility and toileting.</p> <p>On May 15, 2024 at 10:50 AM, V3 CNA (Certified Nursing Assistant) provided incontinence care for R4. V3 checked R4's incontinence brief and said, Oh, your definitely wet. R4's incontinence brief was saturated with dark urine from the front of the brief to the back of the brief. There was urine noted to the blanket underneath R4's buttocks. R4 said, I've been in bed too long, my body hurts. At 11:05 AM, V3 said she last performed incontinence care to R4 at about 8:00 AM. V3 said that R4 is a heavy wetter. V3 laid R4 back onto the soiled blanket and left R4's room.</p> <p>The facility's ADL policy reviewed April 2023 shows, The facility will provide all residents with care, treatment and services according to the resident's individualized care plan. The facility's Linen Management Infection Control policy revised May 2023 shows, Dirty/soiled linens are contained in a closed container or bag.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observation, interview, and record review, the facility failed to have pressure injury prevention interventions in place and failed to change a soiled pressure injury dressing for two of three residents (R2, R4) reviewed for pressure injuries in the sample of four.</p> <p>The findings include:</p> <p>1. R2's Admission Record dated October 15, 2024 shows R2 was admitted to the facility on August 23, 2024 with diagnoses including wedge compression fracture of first lumbar vertebra, paraplegia, diabetes, spinal stenosis, osteoarthritis, depression, and dysphagia.</p> <p>R2's Care Plan shows she was admitted to the facility with a stage four pressure injury to her sacrum and provide skin/wound treatments as ordered.</p> <p>R2's Order Summary Report dated October 15, 2024 shows sacrum cleanse with normal saline, apply moistened gauze to wound bed. Secure with foam until resolved. Every day shift every Monday, Wednesday, and Friday. It also shows an as needed order.</p> <p>R2's Risk Profile dated September 20, 2024 shows she is at high risk for developing pressure injuries. Protect elbows and heels if being exposed to friction.</p> <p>R2's Treatment Administration Record shows her dressing to her sacrum was last changed October 14, 2024.</p> <p>On October 15, 2024 at 9:49 AM, R2 was observed laying on her back in bed. There was a strong malodorous smell in R2's room. There was a contact isolation sign outside of R2's door. At 10:33 AM, V3 CNA (Certified Nursing Assistant) provided incontinence care to R2. There were two pairs of heel protectors/heel boots located on R2's closet and chair. R2's heels were directly on the bed. There was a lidocaine patch to R2's back dated October 15, 2024. There was a foam dressing to R2's sacrum that was half intact. The dressing was completely saturated with dark drainage. There was a strong odor.</p> <p>On October 15, 2024 at 11:53 AM, V6 WCN (Wound Care Nurse) said R2's pressure injury dressing is changed every Monday, Wednesday, Friday, and as needed. V6 said the dressing should be changed if it becomes soiled or not intact. V6 said dressing changes are done by him or the floor nurses can do them if he is not in the facility. V6 said if the dressing on R2's sacrum is soiled, then it should be changed. V6 said the floor nurse let me know the dressing needed to be changed a few hours ago.</p> <p>On October 15, 2024 at 1:50 PM, V6 changed R2's dressing to her sacrum. R2's pressure injury to her sacrum was large, approximately a softball size. There was dead tissue in R2's pressure injury. The gauze that was in R2's wound was saturated with brown drainage. V6 placed R2's heels back onto the bed after changing the foam dressing to her heels. The protective boots were in the same spot in R2's room.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. R4's Admission Record dated October 15, 2024 shows she was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, peripheral vascular disease, diabetes mellitus, asthma, major depressive disorder, obesity, osteomyelitis, and heart failure.</p> <p>R4's Care Plan initiated May 17, 2021 shows R4 has actual impairment to skin integrity related to pressure injuries to bilateral buttocks. R4's Care Plan shows she has a history of an unstageable pressure injury to her left heel. Follow facility protocols for treatment of injury.</p> <p>R4's Order Summary Report dated October 15, 2024 shows an order for Right Isthium: Cleanse with normal saline, apply oil emulsion dressing to wound bed, then cover with foam dressing until resolved every Monday, Wednesday, Friday, and as needed.</p> <p>R4's Pressure Injury Risk assessment dated [DATE] shows she has a moderate risk of developing pressure injuries.</p> <p>R4's Wound Assessment Details Report dated October 15, 2024 shows R4 has a stage II pressure injury to her right ischial tuberosity (right buttocks).</p> <p>R4's Treatment Administration Record shows her dressing was last changed on October 14, 2024.</p> <p>On October 15, 2024 at 10:50 AM, V3 CNA provided incontinence care to R4. Both of R4's heels were directly on the bed. There were heel protector boots noted on R4's chair. R4 complained of pain when V3 wiped her buttocks. There was an open area noted to R4's right upper buttocks. R4 said she has a sore on her buttocks that is painful. R4 said she has had that sore for a few days. There was no dressing in place to R4's open area. V3 finished wiping R4's buttocks, placed cream to R4's buttocks, and then laid R4 back onto her back after placing a clean incontinence brief on.</p> <p>On October 15, 2024 at 11:53 AM, V6 WCN said R4 should have medihoney, oiled gauze, with a foam dressing in place to her right buttocks. V6 said he did not know that R4's dressing to her buttocks was not in place. V6 said pressure injury prevention interventions include air mattresses, wedge cushions, repositioning every two hours, and off loading. V6 said the purpose of pressure injury dressings and dressing changes are to see if the wound is getting better. Dressings keep the wounds clean. V6 said if soiled dressings are kept in place, then chances are that the skin around the wound will become macerated. V6 said the goal of dressings and dressing changes are to heal the wounds. V6 said if a pressure injury dressing is not in place or it is not changed, then the wound can get worse or bigger.</p> <p>The facility's Wound Care Program Policy reviewed April 2023 shows, the goal of the wound care program is to promote optimal skin integrity of all residents and guests and prevent acquired skin conditions by implementation of the following: In addition to scheduled skin assessments, skin will also be assessed with ADL (Activities of Daily Living) care is provided, as well as when treatments are being completed. Round will be conducted frequently throughout all shift by the licensed nurse and/or nursing administration to ensure wound care interventions are in place and being completed.</p> <p>The facility Wound Policy and Procedure policy reviewed May 2023 shows, any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Risk reduction measures such as use of heel protectors, elevation of lower extremities, participation in bowel and bladder program, etc are initiated if determined appropriate.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observation, interview, and record review, the facility failed to wear PPE (Personal Protective Equipment) for residents on enhanced barrier precautions (EBP) and failed to change their gloves and perform hand hygiene in a manner to prevent cross contamination for three of four residents (R2, R3, R4) reviewed for infection control in the sample of four.</p> <p>The findings include:</p> <p>1. R2's Admission Record dated October 15, 2024 shows R2 was admitted to the facility on [DATE] with diagnoses including wedge compression fracture of first lumbar vertebra, paraplegia, diabetes, spinal stenosis, osteoarthritis, depression, and dysphagia.</p> <p>R2's Care Plan shows she was admitted to the facility with a stage four pressure injury to her sacrum.</p> <p>On October 15, 2024 at 9:49 AM, R2 was observed in her bed. There was a contact isolation sign on R2's door. V3 CNA (Certified Nursing Assistant) said that R2 is on isolation for MRSA in her wound. At 10:33 AM, V3 provided incontinence care to R2. V3 wiped R2's front peri area, touched R2's body to help her turn onto her right side, and proceeded to wipe R2's buttocks. There was a saturated dressing to R2's sacral area. V3 touched R2's pillow, rubbed her hair, touched her shirt, bed controls and blanket. V3 did not perform hand hygiene or change her gloves.</p> <p>2. R4's Admission Record dated October 15, 2024 shows she was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, peripheral vascular disease, diabetes mellitus, asthma, major depressive disorder, obesity, osteomyelitis, and heart failure.</p> <p>R4's Care Plan initiated May 17, 2021 shows R4 has actual impairment to skin integrity related to pressure injuries to bilateral buttocks. R4's Care Plan shows she has a history of an unstageable pressure injury to her left heel. Follow facility protocols for treatment of injury.</p> <p>On October 15, 2024 at 10:50 AM, V3 went into R4's room to perform incontinence care on her. There was an enhanced barrier precaution sign on R4's door. R4's incontinence brief was saturated with dark urine from the front to the back of the brief. V3 wiped R4's front peri area, helped R4 turn onto her left side, proceeded to wipe R4's buttocks. There was an open area noted to R4's buttocks. V3 placed cream onto R4's buttocks and then wiped her gloves with a wet wipe. V3 then placed R4's clean incontinence brief on, turned R4 back onto her back, retrieved a wet wash cloth and proceeded to wipe R4's face. V3 did not change her gloves nor did she have a gown on.</p> <p>3. R3's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, osteomyelitis, congestive heart failure, extended spectrum beta Lactamase (ESBL) resistance, leukemia, abnormal uterine and vaginal bleeding, weakness.</p> <p>R3's Orders dated June 26, 2024 shows enhanced barrier precautions every shift.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's Care Plan intitiated October 15, 2024 shows R2 requires enhanced barrier precautions. Verify that proper isolation notifications are in place and appropriate protective equipment is inside and outside room and follow facility policy for enhanced barrier precautions.</p> <p>On October 15, 2024 at 9:54 AM, V3 CNA provided peri care for R3. R3 had a urinary drainage device in place. R3 had a dressing to her buttocks. V3 wiped R3's front peri area, touched R3's bed controls, and then wiped R3's buttocks. V3 touched R3's clean incontinence brief and R3's body. V3 did not change her gloves, perform hand hygiene, nor did she have a gown on. There was an enhanced barrier precaution sign on the outside of R3's door.</p> <p>On October 15, 2024 at 2:43 PM, V2 DON (Director of Nursing) said, gloves should be changed and hands should be cleaned after touching dirty items and before touching clean items. V2 said gloves and gowns should be worn when caring for residents on enhanced barrier precautions to protect from cross contamination.</p> <p>The facility's Enhanced Barrier Precautions policy dated March 2024 shows, Contact precautions refers to infection control precautions intended to prevent transmission of infectious agents including epidemiologically important microorganisms which are spread by direct of indirect contact with the resident or the resident's environment. Enhanced barrier precautions refers to an infection control intervention designed to reduce transmission of multidrug resistant organism that employs targeted gown and glove use during high contact resident care activities.</p>		