

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

PRINTED: 11/03/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145647	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/08/2006
NAME OF PROVIDER OR SUPPLIER ROSEWOOD CARE CENTER OF PEORIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 WEST NORTHMOOR ROAD PEORIA, IL 61614		
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F 314	Continued From page 10 completed on 5/25/06.	F 314			
F9999	<p>FINAL OBSERVATIONS LICENSURE VIOLATIONS</p> <p>300.1210 a) 300.1210 b)3) 300.1210 b)5) 300.3240 a)</p> <p>300.1210 General Requirements for Nursing and Personal Care</p> <p>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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.</p> <p>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin</p>	F9999			

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F9999	<p>Continued From page 11</p> <p>breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>300.3240 Abuse and neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements are not met as evidenced by :</p> <p>Based on interviews and record review, the facility failed to monitor and assess one of three residents admitted with a pressure sore. The stage I pressure sore progressed to a stage IV. R3 was admitted to a local hospital and died with the death certificate listing cause of death as: Gangrene of the right heel, right leg cellulitis and septicemia.</p> <p>Findings include:</p> <p>The admission face sheet dated 3/16/06 shows admission to the facility on 3/14/2006 at 1:30 pm for rehabilitation after sustaining a fracture while living independently at home. This face sheet shows diagnoses including: Fractured ankle (closed reduction), Abnormality of gait, Congestive heart failure, Osteoporosis, Hypertension, Senile dementia and Mononeuritis</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>(nerve pain). R3 was admitted to the facility with a long leg cast on the left leg.</p> <p>The admission nursing assessment dated 3/14/06 by E4 (Licensed Practical Nurse/LPN) identifies R3 as a 95 year old resident on non-weight bearing status to the left lower extremity due to a long leg cast. This nursing assessment shows R3 as oriented and requiring assistance of two with transfers and mobility. The right heel of R3 is described on this form as "soft." E4 also identifies R3 as requiring the assistance of two for movement. E4 was unavailable for interview as she is no longer employed at the facility.</p> <p>Nursing note by E2 (Director of Nurses/DON) on R3's medical record dated 3/14/06 states, "Her right heel is soft and mushy to touch. Heel protectors will be used. She is a two person assist with transfers." E2 on 5/24/06 at 1:50 pm stated, "(E4) was new and I wanted to show her what I expected in a nursing admission note. I helped (E4) in completion of the 'CNA Care Guide' upon admission."</p> <p>The facility "CNA Care Guide" was reviewed with E2 at this time. The section titled "Skin care/pressure ulcer prevention" is a check list for guidance to CNAs in delivery of care. This checklist includes the following areas which were not checked by E2 or E4: pressure relief mattress, heel protectors, float heels, heel elevators, boot (heel), trapeze, bed cradle, body pillows, sleeves, elbow protectors, legs, padded side rails and pressure areas.</p> <p>The facility "Activities of Daily Living" form (undated) shows R3 was dependent on staff for</p>	F9999			

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F9999	<p>Continued From page 13</p> <p>transfers and bed mobility.</p> <p>E3 (Rehab/Restorative Registered Nurse) stated on 5/25/06 at 10:52 am "I saw the redness on admit. I have to see every new admit within 24 hours. I initiated the wound sheet when the heel opened on 3/29/06. The opening was small (about 25% of the total area documented) and the surrounding tissue was dark. We do have wound protocols that we follow. Initially there was no boot or lifted heel (on the right heel). The week prior to the heel opening I know I checked it and it was still red, soft and mushy but no open areas ."</p> <p>E3 (RN/Rehab/Restorative Nurse) stated again on 5/25/06 at 10:52 am no pressure relieving boots, floating her heels or any other measure to relieve pressure to the right heel was used except for the use of an air mattress.</p> <p>E2 stated on 05/24/06 "It was probably my fault since I am also fairly new (employed since January, 2006) and did not know a physician's order was required to obtain heel protectors."</p> <p>The initial facility "Wound Documentation" form is dated 3/29/06 which is fifteen days after admission and signed by E3 (RN/Rehab/ Restorative Nurse). The wound is described as 'Unstageable', with the entire wound measuring 5 .1 x 4.2 centimeters (cm) with the entire wound dark red. Of this entire wound, 25% is described as slough and another 25% is described as eschar. The wound was noted to have moderate amount of sero-sanguinous drainage.</p> <p>There is no further description of the wound at</p>	F9999			

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F9999	<p>Continued From page 14</p> <p>the facility until 4/3/06 when E6 (LPN) obtained an order to "culture right heel, copious amounts of drainage, odor and febrile."</p> <p>The facility "Daily Nursing Assessment Tool" dated 3/14/06 through 4/4/06 was reviewed. In the section "Skin Condition" there is no documentation of any pressure areas, including the stage I to the heel. On 3/29/06 a note is made of a stage IV heel ulceration. The areas covered in this section include: site/description (of wound), drainage/odor (of wound) and whether or not the wound was observed by the nurse. These "Daily Nursing Assessment Tools" from 3/29/06 through 4/4/06 do not include any documentation of these aspects (description/ drainage/odor) of the wound. During interviews on 5/23/06, 5/24/06 and 5/25/06, E2 (DON) and E3 (RN/Rehab/Restorative Nurse) were unable to explain why staff did not utilize this area to document changes, deterioration and/or improvement.</p> <p>The initial pressure ulcer assessment dated 3/14/06 by E4 identifies R3 at moderate risk. The interventions noted on the back of this form states to: turn and reposition at frequent intervals /as necessary, utilize pressure relief devices and monitor areas of pressure under splints/braces. These interventions were not implemented until 3/29/06 when the right heel progressed to a stage IV as stated by E3 during interviews on 5/23/06 at 1:50 pm and 5/25/06 at 10:52 am.</p> <p>The facility "Skin Care - Prevention of Pressure Ulcers - Pressure Ulcer Risk Assessment and Prevention Protocols" state: 3) Document skin assessment in the nurses notes. 4) Implement</p>	F9999			

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F9999	<p>Continued From page 15</p> <p>appropriate protocols to prevent impairment of skin integrity based on the Pressure Ulcer Risk Assessment scores. 5) Perform weekly skin assessment after showers or as assigned and document results in the nurse's notes.</p> <p>The second part of this protocol directs the Rehab/Restorative Nurse to: 1) Complete a skin assessment of the guest on admission and document on the Pressure Ulcer Risk Assessment form. If the assessment and Pressure Ulcer Risk Assessment has been completed by the admitting nurse, assess the guest and review the documentation for accuracy . 2) Implement appropriate prevention protocols based on the Assessment scores. 3) Repeat the Ulcer Assessment quarterly or when significant changes in condition (such as decline in Activities of Daily Living, skin condition, nutritional status) make re-evaluation appropriate. 5) Monitor that preventative protocols are consistently carried out. These areas of the protocol were not carried out until 3/29/06 as E3 stated in two separate interviews on 5/23/06 at 1:50 pm and 5/25/0 at 10:52 am that no boots, heel lifts or other pressure reducing measures were noted being used by E3.</p> <p>The "Rosewood Care Center Clinical Practice Quick Reference Guide" identifies a "reddened area" as a stage I ulceration. Treatment objectives for this stage are to "protect, remove cause." The interventions listed for stage I ulcers due to pressure are: Lotion as needed (prn) and monitor every shift until resolved.</p> <p>E3 stated in initial interview on 5/23/06 at 1:50 pm, "When she was admitted I knew the right heel</p>	F9999			

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F9999	<p>Continued From page 16</p> <p>was soft but not open. It just opened up. I would check on it every few days. We did have her on an air mattress. I should have staged it as a stage I and documented follow up. There were no boots or a heel lift being used on the right heel."</p> <p>The medication administration record (MAR) on 4/2/06 at 10:15 pm shows medication dispensed for "increased temperature." No recording of this temperature was located. On 4/3/06 at 9:00 am, an order was obtained from E5 (physician/medical director) for a wound culture due to "copious amounts of drainage, odor and febrile." On 4/4/06 R3's temperature increased to 104 degrees Fahrenheit (F) as noted on the transfer record of R3 to a local hospital.</p> <p>Nursing notes at 2:00 pm on 4/4/06 by E3 show R3 had developed an additional pressure area on the right buttock as a stage II but there is no documentation regarding the condition of the right heel ulceration.</p> <p>The hospital admission record shows R3 was admitted on 4/4/06 with gangrene to the right heel, right leg cellulitis, hypotension and septicemia. Blood cultures obtained at the hospital on 4/4/06 were positive for Methicillin Resistant Staphylococcus Aureus (MRSA). The initial nursing assessment of the wound at the hospital states, "Right heel and right lower leg is red. Right heel red, foul smelling, blackened and draining. The open area of the wound measuring 4 x 6 centimeters with minimal surrounding erythema and cellulitis extending from her right foot up to the calf." The wound culture was received by the facility on 4/7/06 (after discharge to hospital) and was noted positive for MRSA.</p>	F9999			

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F9999	Continued From page 17 Z2 (hospital physician) was interviewed on 5/24/06 at 3:05 pm. Z2 stated,"She (R3) was admitted to the hospital with gangrene and extensive cellulitis to her right heel/leg. I was her hospital attending when she had the fracture of her left leg early in March 2006. What concerned me most was what appeared to have been lack of treatment to the ulceration. Her daughter said she had given permission for a wound specialist to see (R3) while at Rosewood but no one had come yet. (R3) had MRSA -- septicemia (in her blood). It was most likely due to the heel ulcer. It was not open when she left the hospital for rehab after the fracture." Z2 further stated,"In a situation like (R3) I would expect the staff to take aggressive action to prevent pressure on her heel; lamb skin boots, elevating her heel. (R3) was non-ambulatory due to the cast. In order to even move in bed she would have only had her right foot/heel for leverage. I would expect staff to do all they could to protect that heel. It should have been debrided sooner....much sooner. It was black and gangrenous. It was a drastic change from when she was discharged (on 3/14/06)." Z3 (podiatrist/wound consultant) was interviewed on 5/24/06 at 3:50 pm and stated,"I was asked to see her for an ulcer on her right heel. It was gangrenous and foul smelling. The goal for someone, especially with one leg in a cast is to use aggressive preventative measures to protect the heel of the other foot (R3's right heel). It is critical to protect the elbows and heels even more if they can't walk. You would need to keep the pressure off the heel. The use of foam boots,	F9999			

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F9999	<p>Continued From page 18</p> <p>waffle boots and/or lifting the leg so the heel is off to prevent shearing or friction are some measures. If her heel was soft and mushy an ulcer was probably developing. To prevent it from progressing further, the staff/family if at home should check the heel twice a day at least, three times a day would be better. They should be observing for a blister or any color changes. These would be early signs and even more prevention measures could be taken."</p> <p>E5 (attending physician/medical director) stated on 5/24/06 at 4:00 pm "I saw her during the day (3/29/06). Her heel was not open then so it may have opened that evening so the nurses would have talked to the on call physician for orders. I was gone 4/1/06-4/5/06. The facility didn't call me about the ulcer. When I got back I found out she had gone to the hospital."</p> <p>The death certificate documents cause of death as: "Sepsis due to or as a consequence of Multiple Organ Failure due to or as a consequence of Infected Leg Wound."</p> <p>(A)</p>	F9999			