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PLEASANT MEADOWS CHR VILLAGE	P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924

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F 314	Continued From page 32 recommendations for the supercereal and the gelatin. Z1 signed to approve the nutritional recommendations as listed on the request form. The April 2008 POS lists orders for the Arginaid and multivitamin with mineral, but not for the 2.0 Cal Med Pass. The April Medication Administration Record shows the Arginaid and multivitamin with mineral were initiated on 4/18/08, but does not list the 2.0 Cal Med Pass. On 5/15/08 at 9:00a.m. E2 (DON) confirmed that the Request For Diet Change omitted the RD's recommendations for supercereal and gelatin, and that the 2.0 Cal Med Pass was never documented as administered to R1. On 5/15/08 at 3:20 p.m. E14 (Food Service Supervisor) stated all residents routinely receive whole milk. E14 presented R1's tray card, which listed only a Mechanical Soft diet. The card did not list supercereal or gelatin. E14 confirmed if Dietary is to serve any nutritional supplements they were documented on the card. The MAR documents staff's initials to indicated if R1 took the Arginaid, instead of documenting the percent of the supplement consumed. R1's meal intake was recorded an a percent of the total meal consumed, instead of by food groups. Weekly Wound Documentation show a continued decline of R1's pressure sore of the coccyx, measuring 9 x 9 cm on 4/23/08 and 10 x 14 cm with multiple tunneling on 5/14/08.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a)	F9999		

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F9999	Continued From page 33 300.1210b)3) 300.1210b)5) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. 5) A regular program to prevent and treat	F9999		

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F9999	Continued From page 34 pressure sores, heat rashes or other skin 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met, as evidenced by the following: Based on observation, record review and interview the facility failed to promptly notify the Wound Nurse, Registered Dietitian and Physician of newly acquired pressure sores for 1 of 9 residents sampled for pressure sores (R6). This resulted in a delay in wound treatment, nutritional support and pressure relieving measures. Staff failed to keep the Physician and Wound Specialist informed of the continued decline of R6's multiple pressure sores to ensure aggressive wound management. Staff failed to document R6's nutritional intake in a manner to ensure accurate assessment of R6's nutritional status. Staff failed to suspend R6's heels to prevent pressure. R6's pressure sores deteriorated to unstagable necrotic pressure sores, with R6 requiring hospitalization for Septicemia and surgical debridement. Findings include:	F9999		

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R6's current Physician Order Sheet (POS) for May 2008 documents R6's diagnoses as Alzheimers, Hypertension, Transient Ischemic Attacks, Atrial Fibrillation, Senile Dementia, Coronary Artery Disease, Anxiety, and Pressure Sores. Nurses Notes on 2/06/08 show that R6 returned from the hospital following evaluation of change in behavior and leaning to one side. The Nursing Admission Assessment dated 2/6/08 found that R6 returned with no skin issues. Nurses Note of 2/6/08 shows that R6 was incontinent of bowel. R6 has a Physician's Order (PO) of 2/6/08 for Ativan 0.5 milligrams (mg) at bedtime; a PO of 2/7/08 for removal of the urinary catheter; and a PO of 2/14/08 to start Risperdal 0.5mg twice a day.

Lab report of 2/11/08 for Hematology is as follows:

Hemoglobin	11.0	Normal is 13.5 to 16.1
Hematocrit	31.9	" " 39.3 to 46.7
WBC	6.2	" " 4.0 to 11.7
Eosinophil	1.4	" " 0.0 to 6.3

The assessment dated 3/6/08 documents that R6 is severely cognitively impaired, requires assistance for turning and repositioning, requires a mechanical lift for transfers, is on a pureed diet with nectar thick liquids, and requires total assistance from staff for feeding. The Restorative Care Flow Record dated 2/20/08, shows R6 was still able to stand with maximum assist of 2 staff and ambulated 20 feet twice a day. The current Care Plan dated 3/2/08 says that R6 needs assistance for turning and repositioning.

The facility's "Pressure Ulcer Prevention" policy

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dated 2005 directs staff to complete a standardized pressure ulcer risk assessment for each resident upon admission, and then weekly for the first four weeks after admission for each resident at risk. Upon readmission from acute care, the "Braden Scale -For Predicting Pressure Sore Risk" was not completed for R6 until 2/22/08, and not again until 4/21/08. Interview with E2 on 5/19/08 at approximately 3:30pm verified this. On 2/22/08 R6 was assessed at mild risk for skin breakdown and on 4/21/08 at moderate risk.

Nurses Notes of 2/19/08 document staff noted an open area on R6's right ear measuring 0.5 centimeters, with the Physician being notified and treatment initiated. Nurses Note of 2/27/08 documents the right ear was healed.

Nurses Notes dated 2/25/08 at 9:00am and signed by E11, Licensed Practical Nurse(LPN) documents that "a Certified Nurse Aide (CNA) discovered a dime sized black area on the outside of Right Heel pressure related mushy. Reported to the wound nurse." The 24 Hour Change of Status Report sheet dated 2/25/08 did not have anything documented on it regarding R6's blackened area on the right heel. The Nurses Note of 2/25/08 is the only documentation of R6's right heel pressure sore, until on 3/4/08. The first documentation of the right heel/ankle on the Weekly Wound Documentation form was dated 3/4/08, stating it is unable to be staged due to "necrosis," measuring 2 centimeters (cm) in length x 2.5cm in width. A Physician Order dated 3/4/08 lists a treatment of Hydrogel for the right heel/ankle pressure sore.

An entry on 2/27/08 on the Restorative Care Flow

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F9999	Continued From page 37 Sheet documents that E13, Restorative Aide (RA) noted that Passive Range of Motion (PROM) was done to all extremities, but no ambulation took place. E13, RA also noted that R6 had some edema of the left ankle, had some dark redness on the outer aspect of his right foot/ankle - (that was covered with a clear covering) and also a small discoloration on the bottom of the left foot, nurse informed. Interview with E13, RA on 5/12/08 at 10:30am found that when the Restorative Aides make notes on their residents they have worked with, the Restorative Aides put the flow records in a pile on the desk of the nurse for review and signature. The Restorative Care Flow Sheet, dated 2/27/08 was not signed by E3, Registered Nurse (RN) until 3/4/08. Review of the 24 Hour Change of Status Report forms for 2/27/08 and 2/28/08, found that there is no documentation of the left heel discolorations found on R6 by E13 as documented on the Restorative Care Flow Records for 2/27/08. This was verified by interview with E3, Director of Nurses (DON) on 5/12/08 at 1:30pm. The Weekly Wound Documentation sheet dated 3/3/08, documents R6's left heel pressure sore as unstagable due to necrosis, measuring 2cm in length by 2.5cm width. A Physician's Order dated 3/3/08 lists a treatment for Hydrogel to the left heel pressure sore. On 5/01/08 at 2:00pm E4, LPN stated she reported R6's pressure sore of the right heel to E3, facility Wound Nurse/LPN on 2/25/08. E3, Wound Nurse/LPN was interview on 5/01/08 at approximately 2:30pm and on 5/14/08 at 9:30am. E3 stated that she was not aware of	F9999		

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R6's pressure sore of the left heel until 3/3/08, when she first documented the left heel on the Weekly Wound Documentation sheet. E3 stated she was not made aware of the right heel pressure sore until 3/4/08. E3 stated Z1 Physician was first notified of each of the pressure sores on the respective dates, with treatment orders obtained for the Hydrogel. E3 said Physician Orders for a pressure relieving air loss mattress, a pressure relieving wheelchair cushion, and padded booties were not obtained for R6 until 3/4/08.

E2, DON, was interviewed on 5/1/08 at 2:22pm and on 5/5/08 at 10:00am. E2 stated that any new problems found with a resident should be documented on the 24 Hour Change of Status Report form so that she herself can review them and ensure followed up. E2 said that it is the procedure for her to make sure the facility Wound Nurse was made aware of new pressure sores and that the Physician had been notified. E2 said the the facility has a Weekly Skin and Wound Team meeting that meets weekly to discuss any new pressure areas on residents. The Wound Skin Team consisted of the Wound Nurse, Assistant Director of Nursing, Dietary Supervisor, Charge Nurse from each unit, Registered Dietitian when in house, and Speech Therapist when available.

Nurses Notes dated 2/29/08 state, "Weekly skin and wound team meeting - area on right ear healed 2/27/08." The area on R6's right heel (noted on the 25th) is not addressed in this entry. The area identified on R6's left heel on 2/27/08 is not noted on the Weekly Skin and Wound Team meeting on the 29th of February.

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F9999	Continued From page 39 Documentation on the Wound Specialist Wound Care Evaluation form by Z2, Consultant Wound Specialist, dated 3/5/08, is the only documentation of R6's pressure sores of the right and left heels by Z2. Z2 documented the right heel pressure sore as an "Intact Blister 100% dark" measuring 2.0cm by 6.5cm. The left heel pressure sore is documented as a "100% Intact Blister." Z2 documents the Hydrogel treatment to both heels. The Weekly Wound Documentation of 3/3/08, 3/19/08, 3/26/08 and 4/2/08, completed by E3, facility Wound Nurse/LPN shows the left heel is marked unable to stage "d/t necrosis" with a continued treatment of Hydrogel. The right heel documentation by E3 on the Weekly Wound Documentation on 3/4/05 and 4/9/08 show that this pressure sore is unable to be staged "d/t necrosis" with continued treatment of Hydrogel. R6's Nurses Notes document the following regarding the right buttock pressure sore. On 3/01/08 staff noted, "open area on the right buttock" with Lantiseptic applied. On 3/4/08 the open area measured 2.0cm x 4.0cm and was described as a "deep tissue injury," with the treatment being changed to Calmoseptine, and implementation of a pressure relieving bed mattress and wheelchair cushion. On 3/5/08 the Calmoseptine was discontinued and an order for Collegan daily and as needed for 7 days was received. On 3/8/08 during the dressing change to the right buttock staff noted, "sloughing et (and) drg (drainage)." On 3/11/08 the area is described with, "green colored drainage....discolored area to the right hip bruise like....warm to the touch." Z1 was notified and Augmentin (antibiotic) was ordered to be given	F9999		

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F9999	Continued From page 40 for 10 days. On 3/14/08 the drainage was noted as "Sanguinous" with "green tint." The first notation of R6's right buttock documented on the Weekly Wound Documentation sheet is dated 3/3/08 and signed by E3. The site is described as a 3cm by 4cm area, unable to stage "d/t necrosis," "greenish" purulent drainage, with a note that the treatment was Collagen. E3, Wound Nurse described the right buttock pressure sore as unable to stage "d/t necrosis" on the Weekly Wound Documentation sheet on 3/19/08 and 3/26/08, with a notation to continued using Collagen. E3's entry on 4/2/08, shows 50% eschar in the wound bed, with a notation to change the treatment to Hydrogel. On 3/15/08 at 9:00am E2, DON stated no cultures had been obtained on the green drainage from the buttock pressure sore and that Z1 was not notified of the drainage until 3/11/08. Z2's 3/5/08 skin assessments on the Wound Specialist Wound Care Evaluation also include an assessment of the pressure sore on R6's right buttock, which is described as 3.0cm by 4.0cm area. The wound bed is described as, "75% Red ...25% Dark area" with "reddened" periwound and "Palpate hard area around wound." Z2's recommendation for treatment was Collagen, with a note to re-evaluate in 7 days. Z2's next documentation of R6's right buttock pressure sore is dated 4/8/08, when Z2 recommended changing from the Collagen to Santyl (a debriding agent) and Calcium Alginate due to necrosis. This entry describes the wound bed as, "100% soft black eschar" with periwound redness and the presence of an odor. The wound is	F9999		

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F9999	Continued From page 41 measured as 3cm x 4 cm. Z2, Consultant Wound Specialist was interviewed on 5/15/08 at 9:50am. Z2 stated that she only comes to the facility every 28 days, and only sees the residents she is told to see. Z2 stated she would come more frequently if requested by staff. Z2 stated that she gets her information on the status of pressure sores from E3 (facility's Wound Nurse/LPN) and does not review the facility's wound documentation. Z2 confirmed that she assessed R6's pressure sores of the right buttock, right heel, and left heel on 3/5/08. Z2 stated her entry of 3/5/08 made no mention of the green drainage from the right buttock that was noted by staff on 3/3/08 because she was not aware of it. The next time Z2 was in the facility was on 4/8/08. On that date Z2 was only asked to look at R6's right buttock pressure sore. Z2 stated on 4/8/08, the right buttock had the black eschar, so she recommended using an enzymatic debrider in place of the Collagen. Z2 explained that Collagen does not work on dead tissue and needs a clean wound bed to work, and that Collagen is contraindicated on necrotic tissue. Z2 sated she was not made aware of the green drainage from the buttock pressure sore as noted on 3/11/08. Z2 said if she had known about the green drainage she would have recommended a culture and recommended something to reduce the bacteria load and absorb the drainage. Z2 said that on 4/8/08 she was told by E3, LPN that R6's heel blisters were still intact. Z2 explained the Hydrogel was use to soften the blister. Z2 said that if she had been told of the necrotic tissue of the heels she would have recommended replacing the Hydrogel with an enzymatic debrider. Z2 stated, "nothing can regenerate once dead tissue is present" so they	F9999		

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F9999	Continued From page 42 needed to debride the necrotic tissue. Z2 said that once the blisters opened the Hydrogel should have been discontinued. Nurses Notes document the following: On 4/8/08 a "foul odor" was present at the right buttock pressure sore. On 4/10/08 R6 was started on Vibratab 100mg for 7 days for a urinary infection. On 4/11/08 the right buttock pressure sore had drainage and a "foul odor" were present. On 4/12/08 R6 had an elevated temperature of 101.9 degrees, the right buttock dressing was, "saturated (with) brownish drng (drainage) strong foul odor noted." Z1 was notified and Z1 ordered R6 transferred to the Emergency Room for evaluation, with a note to obtain blood and wound cultures if R6 was kept at the facility. On 5/12/08 at 1:20pm, E2, DON said how the Registered Dietitian (RD) is notified of new pressure sores. E2 stated that staff usually wait until the RD's next visit to the facility to be made aware of any pressure areas. E2 confirmed that Z3, RD was not notified of R6's pressure sores of the feet and ankle until 3/5/08. R6's Nutritional Assessment dated 3/5/08, found that Z3, RD, recommended to change R6's diet to a mechanical soft diet with 8 ounces of Arginaid Extra, 2.0 Med Pass twice a day, 2 extra dietary supplements during the day, whole milk with breakfast, supper and mid day and supercereal at breakfast. Z3 also noted to inform her of any significant change. E2, DON was interviewed on 3/15/08 at 9:00am. E2 stated that Z3's Dietary recommendations were not faxed to Z1 until 3/07/08. On 3/7/08 Z1 ordered Arginaid and Med Pass 2.0 four times a day for R6. The March 2008 Medication Administration Record (MAR) documents the Arginaid was started on 3/8/08,	F9999		

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F9999	Continued From page 43 but there is no documentation that the Med Pass was started until 4/1/08. E2 confirmed the Med Pass was not documented as given until 4/1/08. On 5/13/08 at 11:30am Z3 stated the facility had not informed her of the continued deterioration and development of additional pressure sores. The next documentation from the Registered Dietician is dated 4/16/08 after R6 was readmitted from the hospital and after debridement of the pressure areas. Z2 recommended to change R6's diet to a pureed diet with thickened liquids, as well as multi vitamins and possibly medication to stimulate his appetite to aide in increasing the chance for healing. E14, Food Service Supervisor, stated on 5/15/08 at 3:20pm that R6 had not received any of the supercereal that was ordered because it was not listed on the tray card used in Dietary to prepare the food trays at meals. Review of the Dietary intake sheets found that the facility staff are not documenting meal intake by individual food groups, just documenting the percentage intakes of the whole meal. The nutritional supplement intake sheet on the medication treatment sheets have only the nurses initials and no amounts recorded as to how much R6 took in. This was verified by interview with E2, DON on 5/5/08 at approximately 2:30pm. This does not allow the Dietitian to make an accurate assessment of R6's nutritional intake. Z1, Physician was interviewed on 5/6/08 at 2:00pm and on 5/14/08 at 10:00 a.m. Z1 stated he first was notified about R6's right heel/ankle and left heel areas on 3/4/08. Z1 stated that if he had known about these necrotic areas sooner the healing process could have begun sooner and	F9999		

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(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
F9999	Continued From page 44	F9999		

the areas may not have gotten so bad. Z1 stated, "early treatment is always the best and usually the nursing home is good to fax me right away. I don't know what happened. They need to keep the heels off the bed and have no pressure on the feet." Z1 also stated that he did not observe R6's pressure sores until R6 was in the hospital on 4/12/08. Z1 stated the pressure sores were much worse than what he was led to believe by facility staff.

The Health Information Management Report from the hospital, dated 4/12/08 found R6 was having periods of apnea and febrile. When R6 arrived in the hospital the History of Present Illness documents that R6, "required admission for aggressive treatment with antibiotics." The initial assessment says R6 had "Multiple Acute Decubitus and Septicemia" and R6's "overall condition is poor." R6's Laboratory Workup showed that his hemoglobin was 8.4, white blood count was 13.1, neutrophils 81, total protein low at 5.6 and albumin low at 2.5. The Plan of Action documents R6 was to be started on intravenous Vancomycin and Zosyn, and have debridement of his decubitus ulcers following a blood transfusion.

At the hospital the wounds were documented as follows: "Right Heel Ulcer was about 3cm x 6cm, left heel was smaller than the right about 2.5cm to 3 cm x 4cm, and the right ankle ulcer was 6cm x 10cm, necrotic right hip ulcer 4cm x 5cm x 1/2cm, sacral ulcer had a wound about 2cm x 3cm. These are all necrotic slough, seeping." Surgical Debridement was done on 4/16/08. The Surgical Report dated 4/17/08 showed that 3 of the 4 areas debrided were skin and soft tissue with gangrenous necrosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. BUILDING _____ B. WING _____	C 05/21/2008

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F9999	Continued From page 45 Observation of these areas on 5/1/08 at approximately 11:00am found the right heel to be a deep stage 4, reaching around from one side of the foot back all the way around to the other side of the foot, 9cm in length x 4cm in width and 1cm deep. The right lower buttock area was approximately 8cm length x 11cm wide and 5cm deep. The coccyx area was approximately 2cm x 2cm round and 0.8cm deep, left heel measured 2cm in length x 3cm width and 0.2cm deep, and the right ankle measured 1.2cm in length x 1cm in width by 0.4cm deep with bone exposure, since debridement. The Care Plan dated 3/3/08 states as a problem, "multiple decub," the Wound Nurse only addresses the right buttock and the left heel on 3/3/08 and she addressed the right heel on 3/4/08 when it was already a 2cm x 6.5cm necrotic area. An updated care plan notation dated 4/13/08 has listed as a problem, "unstagable wounds on ankle, buttocks, and coccyx." The right and left heels pressure sores are not addressed. R6 was observed laying in bed on his back on 5/1/08 at 9:30am, on 5/5/08 at 12:30pm, and on 5/6/08 at 9:00am. Each time R6's feet were in the soft padded bunny boots, but they were laying directly on the mattress and not floating as ordered. The POS sheet dated April 2008 directs staff to float R6's feet at all times. On 5/4/08 at 9:05am and 5/14/08 at 9:00am R6 was in bed with the bunny boots on his feet, but his feet were not floating as ordered. (A)	F9999		