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F 463	Continued From page 53 E16 stated the bulb was burn out and he had no bulb. He would have to go out to get one. E16 stated the only way the nurses would know if someone needed help is if the light is on. It is not connected to the panel where room call signals display. On 7/14, 7/15 and 7/16/08 the door to the resident bathroom was open with easy access for residents. Residents were seen using the bathroom on these days.	F 463		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)2) 300.1210b)5) 300.1220b)2) 300.3220f) 300.3240a) 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 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 meed the total nursing and personal care needs of the resident. b) General nursing care shall include at a	F9999		

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F9999	Continued From page 54 minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of Nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104 (b) of the Act)	F9999		

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F9999	Continued From page 55	F9999		

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 requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to perform initial pressure ulcer assessments and do routine skin checks and monitor wound healing progress for 5 residents with skin breakdown . (R14, R12, R18, R7, R9).

The facility failed to implement physician treatment orders for Stage IV pressure ulcers after a resident's (R14) admission to the facility. On 7/14/08 when R14 was admitted to the facility, the nursing staff did not conduct an initial wound assessment and IV medication was not available for administration to the infected wound until 7/17/08 when treatment was initiated. The failure to initiate the intravenous antibiotic (Vancomycin) for an infected wound and the failure to cleanse the infected wound increases the bio-burden of the wound which contributes to non-healing of the wound.

The facility failed to prevent the development of a new Stage II pressure ulcer for R14 (a total of 5 pressure areas on the ischium, both hips and newest one in the groin).

Findings include:

1. The Physician's Order sheet documents R14 is 55 years old and was admitted to the facility on

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F9999	Continued From page 56 7/14/08. The Hospital Discharge Summary for R14 dated 7/14/08 documents "Significant Findings: Patient admitted with severe grade 4 decubitus ulcers on buttocks bilaterally. Also has spinal stenosis with lumbar radiculopathy." The Discharge Summary documents R14's hospital course included, "Seen in consultation by wound care specialists - surgeons who recommend the patient have a consult with a plastic surgeon for muscle flap closure after back decompression surgery. Cultured out MRSA from wounds and started on Vancomycin." The Physician's Wound Consultation report dated 7/11/08 describes R14's wounds, "On the posterior aspect in the sacral area, she does have four decubitus ulcers, the deepest of which is on the left gluteal region; it does go right to the bone. I can see and feel the sacrum with probing. She has one as well on the bottom of the ischial tuberosity; right at the distal sacrum, there is also decubitus ulceration. All of these are granular; they do probe to the bone." The Surgeon Consultation Report dated 7/9/08 documents, "Bilateral lower extremities are contracted. She has bilateral ischial decubiti on examination of her buttocks which are deep to the bone. The one on the right side is smaller but tracks deeper. Inside edges of the ischial bone are ragged and she has pain on palpation of the area.... On the left side this area is bigger approximately 4 x 5 cm in diameter with some necrotic debris around the bone itself. ...Stage IV decubitus on this side as well. The bone is ragged and tender to touch."	F9999		

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F9999	Continued From page 57 On 7/16/08 at 8:15 AM, R14 was sitting in bed, looking at her breakfast tray. R14 stated, "I got here on Monday. I have to have back surgery, but I need to get these decubitus ulcers healed before I can go for surgery. I have had nothing done (for me) since I got here. I might as well go home if this is all they're going to do. Someone put dressings on at 6 AM today, but no one has washed the wounds or anything else since I got here. This is the same gown I had from the hospital. I've not had a towel or washcloth since I came on Monday." R14 stated to E5, "Tell the doctor I want to go home. I have had no relief from my pain. If this is all you're going to do, I might as well go home to be with my baby." (Resident has 12 year old son). On 7/16/08 at 8:30 AM, E5 (Licensed Practical Nurse - LPN) stated, "I don't know anything about her wounds or treatments. I wasn't here yesterday." The Facility Admission Assessment dated 7/14/08 at 3:30 PM, documents R14 had an "Old healed decubitus ulcer" on the coccyx area. The nursing notes state, "Body check, PICC line right, old surgery scar on back and abdomen, several scabbed areas decubitus not measured." The admission physician orders dated 7/14/08 stated to provide, "Wet to dry with Sterile dressings every shift to decubitus and Whirlpool bath daily." R14's treatment record shows that no treatments or whirlpools were provided. On 7/16/08 at 10:15 AM, E1 (Administrator) observed R14's decubitus ulcers. The observations included:	F9999		

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F9999	Continued From page 58 A. On the right ischial area of the buttocks, the pressure ulcer measures 2 cm x 2 cm, circular in shape. The wound is open and deep, a tunneling track is noted. The wound is at Stage IV. E1 did not take a depth measurement. On the pad under R14's buttocks, pink tinged drainage was noted. E1 removed a gauze pack from the wound. R14 stated, "That packing is still from the hospital. I know when the packing is inserted and no one has done that since I've been here." B. On the left ischial area of the buttocks, the pressure ulcer measured 4.5. cm x 5.0 cm. A tunneling track was observed in the center of the wound. E1 did not take depth measurements. The wound is at Stage IV. There was no dressing or packing on the wound. C. On the right hip area a thick pad dressing was removed. The pad was positioned over a scarred, healed, reddened area, not over the lower open wound. D. On the left hip a scabbed, red area was noted. No dressing or protective covering was in place. E. On the right inner groin area a 1 cm x 1 cm, Stage II open area was observed. There was no dressing in place. R14 stated, "That is new since I've come here." On 7/16/08 at 3:10 PM, E5 (LPN) stated, "I'm not sure if the physician has been notified that R14's medications and treatments have not been started. I will call him just in case." On 7/16/08 11:22 AM, E3 (RN-Care Plan	F9999		

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F9999	Continued From page 59 Coordinator) stated, "The floor nurse is expected to do the skin assessment on admission. The assessments are expected to be completed within the first shift. The skin checks are to be done weekly. (R14's) Braden (skin integrity assessment) has not been done, and the care plan has not been done." On 7/16/08 at 3:45 PM, R14 stated, "The wounds are less painful after the bath. It makes you feel better, I got my hair washed and changed my clothes." R14 stated she is upset about the wound treatments not being started right away. "It means I will have to stay here longer. I really miss my son, and I want to go home." On 7/17/08 at 1:30 PM, E1 stated, "The night nurse told me she did the dressing change and took measurements of the wounds (on 7/16/08). She said she wrote them down, but forgot to chart the information." On 7/17/08 at 1:30 PM, Z1 stated, "The (intravenous) antibiotic (Vancomycin) was ordered to treat the MRSA infection of the pressure ulcer wounds. It would be significant if the patient missed any of the doses of Vancomycin." The facility policy on Skin Integrity states the purpose of the program is "To provide a systematic approach and monitoring process for skin integrity pressure ulcer care." The program policy states on page 1, "On admission, all residents will be assessed by a licensed nurse for pressure ulcer risk using the Braden scale." On page 2, "Wound documentation will include location, stage, size, depth, undermining and tunneling, exudate (drainage), odor,	F9999		

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F9999	Continued From page 60 eschar/necrotic tissue, pain, periwound skin condition, appearance of the base of the wound and evidence of epithelialization." According to Acute and Chronic Wounds, Nursing Management, Second Edition 2000, Bryant R. on page 60, "Pressure Ulcer Staging. Stage IV - Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle bone or supporting structures (such as tendon, joint capsule)." Page 77, "Undermining or tracts: Location and extent of sinus tracts must be accurately documented so that progress in wound healing and effectiveness at eliminating or reducing the cause can be evaluated." Page 185, "Wounds do not heal until infection is eradicated." Page 186, "The wound should be cleansed routinely. This is a treatment not aimed specifically at curing the infection but rather at reducing the surface contaminants..... When antibiotics are used, it is critical that the blood level be maintained so the therapeutic effect can be achieved. This means that the timing of administration of antibiotics is critical." According to the website, www.medscape.com accessed on 7/24/08 the article "Reducing Bacterial Bioburden in Infected Wounds...", Gabriel, A et al. states, "Infections complicate the treatment of wounds and impede the healing process by damaging tissue and reducing wound tensile strength, and inducing an undesirable inflammatory response. Increased bacterial burden in a wound increases the metabolic requirements of the tissues, stimulates a proinflammatory environment, and encourage the in-migration momcytes, macrophages and leukocytes-all of whcih can negatvely impact wound healing."	F9999		

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F9999	Continued From page 61	F9999		

2. The Physician Order Sheet documents R12 was admitted on 7/1/08. The admitting diagnoses include Sacral Decubitus, Malnutrition, GI Bleed, and Immunosuppression.

The admission resident assessment on 7/1/08 shows on the picture diagram R12 has a decubitus on the coccyx area. There is no other assessment of the pressure ulcer. The picture diagram shows R12 has an open lesion on the elbow 0.5 cm in size, no other assessment information provided. The admission nursing notes states, "Skin assessment complete, see admission form."

R12's care plan goal dated 7/7/08 states, "R12's open area on his coccyx will show improvement toward healing." A Braden assessment was not completed for R12. R12's risk factors and wound assessment were not completed at the time of survey.

On 7/16/08 at 11:53 AM, Z2 stated, "(R12) needed more nursing care, this facility is known for good wound care. He has sacrum and elbow breakdowns."

R12 was not identified on the facility list of residents being treated with pressure ulcers.

3. The Physician Order Sheet dated 7/1/08 documents R18 was admitted to the facility on 3/8/08. Listed diagnoses include Dementia and History of Right Hip Surgery. R18 was identified as 1 of 2 residents with pressure ulcers.

The facility Decubitus Ulcer Report dated 7/9/08 documents assessments for R18's 2 open areas.

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F9999	Continued From page 62 R18 acquired a pressure ulcer on the right buttock on 6/10/08. The assessment is 4.5.cm x 4.5 cm with pink center, Stage II. The current treatment is to apply Moisture Barrier and use normal saline cleansing until healed. A second pressure ulcer identified on the right hip acquired (while in the facility) on 6/25/08 measured 1.5 cm x 1.5 cm. On 7/17/08 at 1:50 PM, R18 was observed lying in bed. E4 (LPN) turned R18 to his side for observation of the pressure ulcer. A deep pink area was noted over the coccyx (on both sides). Within the deep pink area were 3 open areas. On the right side of the coccyx, an opening 0.5 cm x 0.3 cm was observed. On the left side of the coccyx, 2 openings 1.8 cm x 1.4 cm and 0.5 cm x 0.5 cm were observed. R18's care plan states he is at risk for skin breakdown because of decreased mobility and incontinence of urine. No open areas are identified. 4. The Minimum Data Set of 4/19/08 and the resident re-admission assessment form dated 4/12/08 documents R7 does not have any pressure ulcers or previous history of ulcers. R7 was identified on 7/14/08 as 1 of 2 residents within the facility being treated for pressure ulcers. R7's care plan updated on 4/26/08 states, "(R7) does not walk, she is dependent of staff for transfers, requires assist with repositioning. She is sometimes incontinent of bowel. She is at risk for pressure ulcers. (R7) has a urostomy." Nursing interventions include apply barrier cream	F9999		

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F9999	Continued From page 63	F9999		

after peri care and monitor.

On 7/17/08 at 2:10 PM, R7 was observed receiving peri care after being incontinent of stool. R7's rectal area was deep red and very tender with cleansing.

The facility Decubitus Ulcer Report dated 6/18/08 assessed R7 having a facility acquired Stage II pressure ulcer of the right buttock on 6/18/08. The stage II measurement was 1.6 cm x 1.0 cm. The Decubitus Ulcer Report on 7/9/08 documents R7's decubitus ulcer increased in size to 1.5 cm x 1.5 cm.

The facility Skin Integrity Wound Care Program states, "Failure to demonstrate progress in healing within 10 days calls for reassessment regarding the adequacy of the overall treatment plan and the need for modification of the treatment plan."

5. On 7/14/08 at 10:50am, R9 was observed sitting in her wheelchair with urine soaked pants. R9 had removed her lap buddy and right arm rest to her chair.

On 9/5/07 a podiatry note for R9 showed, "Ulcerated blister to the left foot." There is no other note after that to show the facility identified the wound to R9's foot prior to the podiatrist, or monitored and treated the wound after the podiatrist saw the wound.

The resident assessment-data collection form dated 1/18/08 for R9 showed she was admitted to the facility with 2 stage II pressure ulcers to the left buttock. One pressure ulcer was documented as "3cm in diameter" and the other

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F9999	Continued From page 64 was "pea-sized." No other description of these pressure ulcers were documented. The facility's skin wound log dated 1/22/08 showed no record of pressure ulcers for R9. A hospital wound healing center note for R9 showed the following: On 1/28/08 R9 had 2 openings to the buttock, 2 openings to the left lower extremity and 2 openings to the right knee. On 2/4/08 R9 had orders for a treatment and dressing to the left medial ankle to be done every day. On 4/15/08 R9 had a dressing and treatment order for the right lower extremity dorsal ankle. The facility's skin/wound log dated 2/21/08 showed R9 had one open lesion to the left calf that was getting dressings applied to the site. R9's wounds had incomplete assessment and documentation. (A)	F9999		