

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/02/2009 |
| NAME OF PROVIDER OR SUPPLIER WESTSHIRE NURSING & REHAB CTR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804 | | |
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| F 000 | INITIAL COMMENTS | F 000 | | | |
| F 314 SS=J | <p>Investigation of Complaints:</p> <p>0894772/ IL37955 No Deficiencies 0894911/ IL38107 No Deficiencies 0895119/ IL38333 No Deficiencies 0895262/ IL38488 No Deficiencies 0895467/ IL38700 No Deficiencies 0895190/ IL38401 F314, F444</p> <p>A partially extended survey was conducted.</p> <p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to:</p> <ol style="list-style-type: none"> 1. Monitor residents at risk for pressure ulcers to ensure that pressure ulcers did not develop R1, R11 and R9. R1, R11, and R9 were noted to develop new pressure ulcers that were identified by the survey team. 2. Provide devices to prevent the development of pressure ulcer for: R1, R9, R10. 3. Provide care and services to residents with | F 314 | | 2/1/09 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 314 | <p>Continued From page 1</p> <p>pressure sores to prevent the spread of infection and promote the healing of pressure sores R1, R11, R12, R9, R10. Failed to monitor and accurately assess residents with pressure sores to ensure healing and appropriate wound care for R1, R9, R10 and R11.</p> <p>4. Provide education and training to direct care staff in the policy and procedure for wound care and to ensure accurate assessment and care planing for residents with wounds.</p> <p>This failure resulted in an Immediate Jeopardy. The facility was notified of the Immediate Jeopardy on December, 2008 at 3:15 PM. E1 (Administrator), E2 Assistant Administrator, E3 (DON), E4 (ADON), E5 (ADON) were present. The Immediate Jeopardy was noted to begin on December 30, 2008, when it was determined the facility failed to: assess, monitor, treat, provide preventive measures, notify physician of wound cultures results and provide antibiotics as ordered in a timely manner and promote healing of pressure ulcers for 5 of 8 sampled residents identified by the facility with pressure ulcers. (R1, R9, R10, R11, R12).</p> <p>Findings include:</p> <p>1. R1's diagnosis includes Seizure Disorder, Status/Post Cerebral Vascular Accident and Diabetes Mellitus. R1 is bedfast and requires total assistance from staff for daily activities. R1 has dysphagia and receives all nutritional needs from a feeding tube. Review of R1's latest Braden Scale dated 10/30/08 assessed R1 as at high risk for pressure ulcers.</p> <p>On 12/30/08 at 11:00 AM, surveyor requested E9</p> | F 314 | | | |

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| F 314 | <p>Continued From page 2</p> <p>(charge nurse) to do a skin check on R1. Review of R1's December treatment administration record (TAR) with E9 revealed R1 was to receive the following treatments to right lower right buttock:</p> <p>Cleanse with normal saline apply collagenase and cover with dry dressing and change daily Review of R1's TAR lacked documentation R1 had the ordered treatment on 12/29/08.</p> <p>During treatment observation, R1's diaper was observed soiled with feces. E9 removed a Tegaderm dressing to R1's right upper buttock. The Tegaderm was very soiled with edges of Tegaderm soiled with feces. The wound to the right upper buttock was opened and red. Below the area of the right upper buttock, was a reddened scarred area, with no dressing as ordered in place. Surveyor observed a small open area to the wound with some drainage from area. Surveyor asked E9 if there was drainage from area and E9 stated no. E9 then squeezed area and a gush of sero-sanguinous drainage came out.</p> <p>Surveyor requested to do complete skin check on R1 with E9. Removal of R1's heel suspenders, surveyor observed R1's lower extremities to very, very dry with scaling and flaking To the right heel, surveyor observed a darkened black eschar area. Surveyor asked E9 if R1 had any recent breakdown to the right heel and E1 stated just dry skin. Surveyor requested E1 to assess area, and observed area with the eschar, but also very boggy to touch.</p> <p>R1's wound treatment started at 11:00 AM on 12/30/08 and was completed at 12:15 PM.</p> | F 314 | | | |

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| F 314 | <p>Continued From page 3</p> <p>The treatment cart lacked supplies for R1's treatment, and E9 was unorganized and unfamiliar with the routine and treatment orders/procedure.</p> <p>Review of R1's documentation in physician's progress notes dated 10/16/08 by Z1 (physician's assistant) denotes Z1 was found with lower right buttock ulcer with eschar 4.5 cm x 4 cm with surrounding erythema. Santyl was recommended by treatment nurse will continue to monitor. Z1 further documented "nurses notified pt with skin breakdown on lower right buttock."</p> <p>Review of R1's physician order sheet dated 10/17/08, denotes an order for a low air mattress, turn every 2 hours, and to cleanse lower right buttock with normal saline, pat dry and apply collagenase ointment cover with dry dressing and change daily.</p> <p>R1's record and facility treatment book lacked documentation of any recent wound assessments done on R. Multiple requests were made by surveyor to administration regarding wound assessments and treatment records for R for October and November 2008. Neither documentation were received from facility. Review of R.S.V.P.'s treatment sheets from reveal R had previous wounds/treatments to coccyx, and left buttock. Review of R.S.V.P.'s nurses notes dated 12/14/08 documents R was found to have bilateral open blistered areas noted on inner thigh, transparent dressing applied, endorsed to follow-up with physician in AM. There was no further assessment or documentation of any of these wounds.</p> <p>On 12/30/08, surveyor requested the current</p> | F 314 | | | |

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| F 314 | <p>Continued From page 4</p> <p>pressure ulcer report from E3 (DON). E3 presented a pressure ulcer report dated 12/4/08. Surveyor requested E3 if there was a more recent report, E3 stated "treatment nurse is off, and don't know where she keeps it."</p> <p>The 12/4/08 pressure ulcer report documented R1 was being treated for an acquired Stage 3 pressure ulcer to the right lower buttock, measuring 3cm in length by 2.5 cm. in width with depth 2.2 moderate amount of drainage, 10% eschar, 90% granulation, red, and treated with santyl. There was no documentation on the wound report regarding R1's right heel or right upper buttock. On 12/31/08, facility presented the pressure ulcer report dated 12/22/08-12/26/08. R1's wound was described as a Stage IV, measuring .3 cm in length x .4 cm width, 10 C cm in depth, with small amount drainage with treatment of santyl. There was no documentation on the most recent wound sheet of R.S.V.P.'s right heel and right upper buttock wound.</p> <p>On 12/31/08 facility had EZ and EZ (corporate wound nurses) assess R.S.V.P.'s wounds. E and E provided the following wound assessments and treatment changes for R.S.V.P.'s wounds:</p> <ul style="list-style-type: none"> -Right lower buttock- Stage 3, MS 3 0.3 x 0.5 cm x cm, pink with ser-sanguinous drainage new treatment hydrogel. -Right upper buttock, open blister-non-pressure, measuring 0.5 cm x 2 cm x <0.1 cm, pink partial thickness, with scant sero-sanguinous drainage. -Right heel-non-stageable, MDS 4, measuring 2.2cm x 2.4 cm x undermining, 50% black, 10 %, yellow, 40 % pale pink, scant sero-sanguinous drainage, new treatment Santyl. <p>Review of R1's dietary assessment of 10/31/08 done by E16 (RD) on 10/10/08 denotes R had a</p> | F 314 | | | |

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| F 314 | <p>Continued From page 5</p> <p>healed site, is at nutritional risk, has mild depletion of visceral protein sores, could benefit from Protein supplement, will await for next lab results, will follow-up (prn)as necessary. There was no follow-up regarding a protein supplement for R1 from 10/10/08 until prompting of surveyor there had been no notification of E16 of R1's acquiring new wounds. On 12/31/08, E16 documented the following assessment and recommendation for R1: resident has altered skin right buttocks, and peri area, , decreased visceral protein stores, could benefit, from additional protein. Recommend to provide Prostat three times a day with flush.</p> <p>2. R11's diagnosis includes Seizure Disorder, Borderline Intellectual Functioning. Review of R11's Minimum Data Set (MDS) dated 12/9/08 non-ambulatory , chair fast and requires assistance from staff for activities of daily living, and incontinent of bowel and urine. The MDS further denotes R11 has 2 stage1 ulcers and 2 stage 3 ulcers. R11's Braden Scale dated 12/8/8 assessed R11 at mild risk for pressure ulcers.</p> <p>Review of pressure ulcer report dated 12/4/08 provided by facility on 12/30/08, documented the R11 acquired the following wounds:</p> <p>-Acquired 11/18/08 -right hip, Stage 2, MDS Stage 2, 1cm (l) x 1.5 cm, 100 % granulation, pink in color and treatment of Hydrocolloid.</p> <p>-Acquired 11/6/08-left ankle-Stage 3, MDS Stage 3, 1 cm. (l) x 1.5 cm. (w) x .3 cm (d), with moderate drainage, 100 % granulation, pink in color and Santyl for treatment.</p> <p>-Acquired 11/6/08-right heel, non-stageable,</p> | F 314 | | | |

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| F 314 | <p>Continued From page 6</p> <p>MDS non-stageable, 5 cm. (l) x 3 cm (w) x depth unstageable, moderate amount drainage, 90 % necrotic, 10% granulation, pink in color and treatment of Santyl.</p> <p>Pressure ulcer report dated 12/22/08-12/26/08 denoted R11 had a newly acquired Stage 2 wound to the buttock , measuring 1cm x .5 cm. with treatment of hydrocolloid. Facility treatment book lacked weekly assessments of R11's wounds.</p> <p>Surveyor requested to review R11's weekly pressure ulcer assessments and November 2008 treatment records but were never presented the documents.</p> <p>Review of December 2008 treatment records lacked documentation R11 received ordered treatments to the right heel, left ankle on 12/29/08. E3 stated in interview the treatment nurse has been off due to illness in family.</p> <p>Reassessment completed by Z3 and Z4 on 12/31/08 assessed R11's wounds as the following: -right hip wound had deteriorated from a Stage 3 to Stage 4 (non-stageable) 1.7 cm (l) x 1 cm x undermining, 100 % brown eschar (new treatment -santyl) -right ankle had deteriorated from Stage 3 to non-stageable (MDS4), measuring 1.5 cm x 1.5 cm x 0.4 cm with cartridge exposed -hydrogel (new treatment) -left heel was assessed still as non-stageable (MDS 4) measuring 2.2 x 1.5 x undermining status post debridement 12/3/08, 75 % yellow /tan slough sero-sanguinous drainage using santyl.</p> | F 314 | | | |

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| F 314 | <p>Continued From page 7</p> <p>Review of R11's physician progress notes dated 11/26/08 documented R11 informed his physician "sores are really painful." Review of R11's record lacks a completed pain assessment for R11 and review of R11's POS lacked an order for pain management.</p> <p>Review of R11's dietary notes dated 11/24/08 written by diet tech denotes R11 has had a weight decrease of 8 lbs. Dietary noted dated 12/27/08 documented R11's weight as 84 lbs. 20 % decrease, secondary to decrease in meals, was given double portions, and Megace to stimulate appetite. There was no notification of E16 of R11's skin status change or weight loss. E16 assessment of R11 denotes R11 is spoon fed, appetite improving on Megace. R11 receiving ice cream, orange juice with lunch and super to provide extra calories. Current diet therapy is tolerated will follow up. There was no intervention by dietary until prompting by surveyor.</p> <p>E2 (Assistant Administrator) stated in daily status on 12/31/08, the RD is to be notified of any skin changes in residents.</p> <p>3. R12's diagnosis Depression, Chronic Decubiti and Paraplegia. Review of R12's Braden Scale assesses R12 as low risk for pressure ulcers. Review of R12's MDS of 11/08 denote R12 has limitation to both lower extremities with full loss, and requires use of wheel chair. The assessment also denoted R12 had a Stage 2 pressure ulcer, 1 stage 3 pressure ulcer. Review of R12's pressure ulcer report denotes R12 was readmitted back to facility with Stage 3 wound to left buttock and sacral area and was</p> | F 314 | | | |

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| F 314 | <p>Continued From page 8</p> <p>being treated for infected wound with Methicillin Resistant Aeuris (MRSA). Review of R12's record revealed an order for a wound culture to R12's sacral and right buttock dated 11/14/08. Review of facility lab results indicated the wound culture was not obtained until 11/20/08, report faxed to facility on 11/23/06. An order for Augmentin 875 mg times 7 days was written on the results of R12's wound culture results which revealed a acinetobacter calcoaceticu-baumannii growth negative for MRSA. Review of R12's telephone order sheets denoted the order for the Augmentin 875 mg was carried over 2 days after the initial order was given on 11/24/08. Review of R12's Medication Administration Record revealed R12 was given the Augmentin on 11/27/08, but received the antibiotic only on 11/27 and 11/28. The medication was not signed out for 11/28,11/29,11/30.</p> <p>On 112/31/08 the facility reassessed R12's wounds as the following :</p> <p>-left buttock, Stage IV, MDS Stage IV, measuring 2.2 x 1.1 x 1.7, macerated edges 100% granulation. Treatment consist of Aquacel Ag, fluffed 4 x 4 gauzes, pad with foam, secure with tape, until wound vacuum accessible.</p> <p>-sacral wound-Stage 4 ,MDS Stage 4, measuring 9 cm x 10 cm x 2 cm with bone exposed macerated edges, tunnel-2.5 cm at 8 o'clock, undermining -2-3 o'clock (2.5 cm) and 9-12 o'clock (3.5 cm) 75 % granulation, less than 25 % slough.</p> <p>Review of R12's care plan requires to cleanse and dress wounds as prescribed, keep dressings clean and intact, and culture wounds for signs of</p> | F 314 | | | |

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| F 314 | <p>Continued From page 9 infection.</p> <p>Review of R12's dietary assessment of 12/18/08 denoted R12's last albumin level of 2.9 and to continue with mile with meals and extra protein.</p> <p>An assessment by E16 dated 12/31/01, documented R12 could benefit from Vitamin C and Zinc Sulfate. Will speak to MD.</p> <p>4. R9 was readmitted to the facility on December 22, 2008 after hospital stay. R9 is a 68 year old resident with the following diagnosis: Renal Failure, Dialysis, Bipolar Disorder, and Congestive Heart Failure. R9 receives a tube feeding and was placed on isolation for infection of the wound and urine. According to R9's most recent MDS (Minimum Data Set) Assessment dated November 7, 2008, R9 is totally dependent in all areas of personal care. R9 was noted with significant weight loss and Stage II and Stage III pressure ulcers. The survey team was provided with a list of pressure sores on December 30, 2008 and R9 was noted with one sore on the sacral area described as a Stage III pressure ulcer measuring 3cm by 1 cm by 1cm without tunneling. The report states, "improved". The right bunion area is described as "healed". The team was provided a second report on December 31, 2008 dated December 26, 2008 that describes the sacral area as Stage III measuring 1cm by 1cm by 1 cm without drainage or tunneling. No bunion ulcer was listed. The nursing readmission sheet dated December 22, 2008 does not contain a description of the wound nor does it contain a readmission weight. The Braden scale placed R9 at high risk for pressure ulcers. A review of the medical record on</p> | F 314 | | | |

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| F 314 | <p>Continued From page 10</p> <p>December 30, 2008 indicated that the RD had not evaluated R9 for her nutritional needs and the adequacy of the feeding. The last nutrition note was dated November 18, 2008. R9 's readmission orders state, "cleanse the sacral area with Normal Saline, pat dry, apply Aquacel and cover with hydrocolloidal dressing every 3 days and as needed". "Low air loss mattress, turn every two hours, daily skin checks, and heel lift at all times while in bed".</p> <p>R9 was observed in her room on December 30, 2008 at 11:25am with E6 (Nurse) and E7 (Nurse Aid). During the observation, it was noted that R9 had no pressure relieving devices in place. R9 was noted with no padding between the knees and furthermore lacked any pressure relieving devices for the heels. R9 did not have the pressure relieving mattresses. E6 and E7 were present when surveyor observed R9's wounds. No treatment was noted in place on the sacral ulcer. An odor was noted from the wound. In addition, the staff was not aware of the areas on the left bunion. E6 stated that the area was "Healed". E6 stated that the treatment nurse does the treatments and she did not know about the bunion. Both E6 and E7 confirmed that the area was without treatment on December 30, 2008. E6 stated that the nurse aids had not told her that R9's treatment had been removed.</p> <p>A review of the facility's treatment record indicates that from time of readmission until observation by the surveyor, the treatment had only been done to the sacral area on December 28, 2008. There is no documentation to support that a treatment was done December 22 and 25 as ordered. Furthermore, a review of the record for daily skin checks indicate that on the following</p> | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/02/2009 |
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| F 314 | <p>Continued From page 11</p> <p>days the facility documented skin check when the resident was in the hospital from December 15 to December 22, 2008: December 16, 17, 18, and December 21, 2008.</p> <p>R9's care plan dated November 7, 2008 states, "provide pressure relieving devices, tuning every 2 hours", "Monitor the wound", and "Maintain body alignment in bed and chair."</p> <p>Z3 and Z4 documented R9 wounds on December 31, 2008 as follows: "sacral wound 2.2cm by 1.0 cm by 0.4cm Stage IV with macerated edges, and scant serious drainage". "Left Bunion Stage II 1.2cm by 1cm by 0.1cm". Z3 and Z4 confirmed that R9 should have a pressure relieving mattress as well as other pressure relieving devices. R9's wounds were noted to deteriorate. E16 assessed R9 on December 31, 2008 and noted a 20% weight loss and recommended the addition of a protein supplement.</p> <p>The facility failed to provide treatment as ordered to R9, failed to provide preventative measures to R9 and failed to provide care to prevent new ulcers. This caused R9 to show a deterioration in the wound.</p> <p>5. R10 is 82 year old resident that developed a sacral ulcer in the facility. R10 per her MDS assessment of November 7, 2008 is totally dependent upon staff for all care and uses a feeding tube for nutrition and fluid needs. R10 was readmitted to the facility on December 20, 2008 and was noted with a pressure sore on the sacral area described as 2-1/2 inches circular. The readmission note does not contain a weight</p> | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F 314 | <p>Continued From page 12</p> <p>or an evaluation of R10's nutritional status. R10's readmission order states, "heel lift at all times, pressure relieving mattress and reposition every two hours." R10 was also placed in contact isolation for the infected pressure sore. The last measurement of R10's wound was dated December 8, 2008 and was noted to be "Stage III measuring 5cm by 4cm by 1cm with small amount of drainage".</p> <p>During the observation of December 30, 2008, R10 was noted with heels on the bed, and lacking padding to the bony areas. Upon observation with E6 and E7, the wound was noted to be soiled with feces and appeared to be to the bone. The edges of the wound were noted to be unattached with evidence of tunneling. E6 was unaware of how to stage the wound. Both E6 and E7 were noted to need to leave the room which is an isolation room to wash their hands. This room did not have a handwashing sink.</p> <p>Z3 and Z4 measured R10's wounds on December 31, 2008 and noted the following: "Sacrum wound Stage IV 5cm by 3.5cm by 1.1cm with a frail wound bed, pale pink and area macerated." Z3 and Z2 agreed with the survey team that R10 required heel protectors and padding between bones. E16 (Dietitian) evaluated R10 on December 31, 2008 and documented, "protein status severely depleted". R10 had been evaluated by the Diet Tech in November and at that time recommended weekly weights, this was not done. The increased needs with the pressure sore was not evaluated by E16 until prompted by the survey team.</p> <p>The facility neglected to monitor the status of R10's wound, obtain a timely nutritional</p> | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F 314 | <p>Continued From page 13</p> <p>intervention and provide preventative devices to prevent additional pressure ulcers. This failure caused R10's wound to deteriorate to a Stage IV wound.</p> <p>The Immediacy was removed on 12/31/08 at 2:30 pm. The facility remains out of compliance at a severity level two in order to allow for the implementation of the facility plan of correction F314 and allow time for the facility to evaluate the efficacy of their interventions.</p> <p>Plan of action:</p> <p>1. The facility took the following action for the cited residents:</p> <p>R1: The physician has been notified of the hematuria and lab tests were ordered. The wound consultant has assessed the wounds and the physician has been notified of the current status. New treatments have been ordered. Heel suspension boots and padding have been implemented as preventative measures. The resident was weighed and reassessed by the RD on December 31, 2008 and dietary implantations with orders. The care plan and treatment record and clinical record have been updated.</p> <p>R12: The wound consultant has reassessed the wounds and the physician has been notified and treatment has been changed. THE resident is in isolation for infection to the sacral wounds. THE RD assessed the resident and new recommendations were carried out. Heel suspension boots and padding separating bony prominences has been implemented as a preventative measures. The care plan, treatment</p> | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F 314 | <p>Continued From page 14 record and clinical record have been updated.</p> <p>R11: The wound consultant has reassessed the wounds and the physician has been notified and the treatment has been changed. Heel suspension boots and padding separating bony prominences have been implemented as a preventative measure. The care plan, treatment record and clinical record have been updated to reflect the status. The resident was reassessed by the RD on 12-31-08 and new recommendations were implemented after physician notification.</p> <p>R10: The resident was reassessed by the RD on 12-31-08 and new recommendations were implemented after physician notification. The wound care consultant has reassessed the wounds with new orders obtained from the physician. The care plan has been updated and current wound descriptions have been documented in the clinical record. Heel suspension boots and padding separating bony prominences have been implemented as a preventative measure.</p> <p>R9: The resident was reassessed by the RD on 12-31-08 and new recommendations were implemented after physician notification. The wound care consultant has reassessed the wounds with new orders obtained from the physician. The care plan has been updated and current wound descriptions have been documented in the clinical record. Heel suspension boots and padding separating bony prominences have been implemented as a preventative measure.</p> <p>2. Additional Facility Action:</p> | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F 314 | Continued From page 15 A. A skin assessment has been completed for all residents identified as immobile or bed bound. This was completed December 30, 2008. B. All residents with wounds identified have been assessed by the wound consultant, completed December 31, 2008. The physician has been notified of recommendations and new treatment orders. The wound assessment will be documented in the clinical record. C. All residents will be identified as severe, high, moderate, or mild risk for wound development using the Braden assessment. The Braden assessment will be updated on all residents. This will be completed by January 9, 2009. The wound consultant will re-inservice the nurses completing the Braden assessments and will test for competency. This will be completed by January 5, 2009. D. A NAR (Nutrition At Risk)/wound meeting will be held weekly with multidisciplinary attendance including the RD, restorative nurse, treatment nurse, MDS nurse, care plan nurse, social service, and DON/and or designee. The administrator will monitor for compliance. E. Residents identified at high risk requiring daily skin checks completed by the evening supervisor or designee. The wound/treatment nurse will be notified of any change in skin condition. The treatment nurse will notify the physician, obtain orders complete wound measurements, and notify the wound consultant of any new stage III or IV wound. The DON will complete weekly audits to ensure completion. The audit will be submitted to the NAR/Wound committee weekly. | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F 314 | Continued From page 16 F. Weekly skin checks will be completed by the charge nurse and will be done per the shower schedule. The skin assessments will be audited by the unit manager weekly to ensure compliance and to monitor for any change. The wound/treatment nurse will be notified of any change in skin condition. A summary of audit findings will be submitted to the NAR/Wound committee weekly. G. All residents with wounds will have weekly measurements completed and documented in the clinical record. Weekly measurements will be completed by the treatment nurse. The wound consultant will complete rounds weekly which will include auditing wound assessment records, review of any new stage III or IV wounds, NAR/wound committee minutes, the pressure ulcer report, TAR, and observation of wounds and preventative measures. The wound consultant will also provide ongoing education for assessment, treatment, and prevention; specifically staging, Braden assessment/risk evaluation and use of preventative measures. H. Rounds will be completed daily by the Administrator/DON or designee to monitor for preventative measures and to ensure dressings are in place. A summary of round findings will be presented to the Q/A Committee monthly for review. I. The charge nurse will notify the RD of all new admissions, readmission and any new skin breakdown. K. The care plan will be updated with any wound change, change in condition and with any | F 314 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F 314 | Continued From page 17 new wounds. The MDS nurse will be responsible for review and update of all care plans. L. The charge nurses will be re inserviced on January 5, 2009 regarding the completion of skin assessments for new admissions and re admissions. Charge nurses will also be trained to complete complex dressings changes for advance wounds (Stage III and IV). The wound consultant will observe charge nurse dressing changes weekly for compliance and competency. M. The wound consultant will re inservice Certified Nurse Aids on January 5, 2009 on completion of shower sheets. The charge nurse will be required to sign off on all shower sheets, and any new area will be reported to the treatment nurse. The wound consultant will monitor shower sheets during weekly visits for compliance. N. An emergency Q/A committee will be held on January 9, 2009 with the medical director. The QA will review the current plan of action related to wound care. The will be reviewed monthly until compliance is met. Completion Date: January 12, 2009. | F 314 | | | |
| F 444 SS=E | 483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: | F 444 | | 2/1/09 | |

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

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| F 444 | <p>Continued From page 18</p> <p>Based on observations, interview and record review the facility failed to ensure that direct care staff followed acceptable standards of handwashing to prevent the spread of infection for R1, R9, R10, R11 and R12. R9, R10 and R12 are all on isolation precautions due to infections.</p> <p>Findings include the following:</p> <ol style="list-style-type: none"> 1. During the observation of R9's treatment on December 30, 2008 at 11:25am, it was noted that the isolation room lacked paper towels for handwashing. The room had a private bathroom, however the paper towel dispenser was noted to be malfunctioning and unable to supply paper towels after handwashing. E6 (Nurse) and E7 (Nurse Aid) confirmed that they had to go to the nursing station to obtain paper towels. R9 was noted to be in isolation for an infection of the pressure ulcer. 2. During the observation of R10's treatment it was noted that this room lacked handwashing facilities. Staff providing care had to leave the room and use the hand wash sink located across the hall. Again, it was noted that this handwashing sink lacked paper towel and the automatic dispenser was without power and paper towels. Once again, staff had to go to the nursing station to obtain paper towels. E7 was noted to wash her hands and dry them on her nursing uniform. E6 was noted to wash her hands and then turn the water off and "air dry" her hands until she reached the nursing station. R10 is also on isolation for an infection of her wound. | F 444 | | | |

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

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| F 444 | <p>Continued From page 19</p> <p>3. During the observation of wound care for R1 on December 30, 2008 with E9, it was noted that the hand wash sink in the hallway lacked paper towels. R1 was observed to be soiled with stool and R1's room did not have a handwash sink and E9 was noted to leave the room and to keep trying to air dry her hands since she lacked hand towels. In addition, E15 (Nurse Aid) was also observed to air dry her hands after washing due to lack of paper towels.</p> <p>4. R12 is on isolation for infection of his wounds and R12's room was observed without a hand wash sink during the survey. R11 also has a pressure ulcer with no hand wash sink in her room and the only handwash sink in the area was without paper towels on observation 12-30-08.</p> <p>A review of the facility's policy for handwashing indicate that staff is to dry hands and turn the water off with the towel. The lack of towels prevented this.</p> <p>4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment 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</p> | F 444 | | | |

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

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| F 444 F9999 | Continued From page 20 services to promote healing, prevent infection, and prevent new pressure sores from developing. FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210a)5) 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. Restorative measures shall include at a minimum the following procedures: 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. | F 444 F9999 | | | |

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

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| F9999 | <p>Continued From page 21</p> <p>These regulations were not met as evidenced by:</p> <p>Based on observations, record review and interviews the facility failed to:</p> <ol style="list-style-type: none"> 1. Monitor residents at risk for pressure ulcers (R1, R11 and R9) to ensure that pressure ulcers did not develop. R1, R11, and R9 were noted to develop new pressure ulcers that were identified by the survey team. 2. Provide devices to prevent the development of pressure ulcers for: R1, R9, R10. 3. Provide care and services to residents with pressure sores to prevent the spread of infection and promote the healing of pressure sores (R1, R11, R12, R9, R10). Failed to monitor and accurately assess residents with pressure sores to ensure healing and appropriate wound care for (R1, R9, R10 and R11). 4. Provide education and training to direct care staff in the policy and procedure for wound care and to ensure accurate assessment and care planing for residents with wounds. <p>Findings include:</p> <ol style="list-style-type: none"> 1. R1's diagnosis includes Seizure Disorder, Status/Post Cerebral Vascular Accident and Diabetes Mellitus. R1 is bedfast and requires total assistance from staff for daily activities. R1 has dysphagia and receives all nutritional needs from a feeding tube. Review of R1's latest Braden Scale dated 10/30/08 assessed R1 at high risk for pressure ulcers. <p>On 12/30/08 at 11:00 AM, surveyor requested E9 (charge nurse) to do a skin check on R1. Review</p> | F9999 | | | |

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

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| F9999 | <p>Continued From page 22</p> <p>of R1's December treatment administration record (TAR) with E9 revealed R1 was to receive the following treatments to right lower right buttock: Cleanse with normal saline apply collagenase and cover with dry dressing and change daily. Review of R1's TAR lacked documentation R1 had the ordered treatment on 12/29/08.</p> <p>During treatment observation, R1's diaper was observed soiled with feces. E9 removed a Tegaderm dressing to R1's right upper buttock. The Tegaderm was very soiled with edges of Tegaderm soiled with feces. The wound to the right upper buttock was opened and red. Below the area of the right upper buttock, was a reddened scarred area with no dressing as ordered in place. Surveyor observed a small open area to the wound with some drainage from area. Surveyor asked E9 if there was drainage from area and E9 stated no. E9 then squeezed area and a gush of sero-sanguinous drainage came out.</p> <p>Surveyor requested to do complete skin check on R1 with E9. Upon removal of R1's heel suspenders, surveyor observed R1's lower extremities to very, very dry with scaling and flaking To the right heel, surveyor observed a darkened black eschar area. Surveyor asked E9 if R1 had any recent breakdown to the right heel and E1 stated just dry skin. Surveyor requested E1 to assess area, and observed area with the eschar, but also very boggy to touch.</p> <p>R1's wound treatment started at 11:00 AM on 12/30/08 and was completed at 12:15 PM. The treatment cart lacked supplies for R1's treatment, and E9 was unorganized and</p> | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/02/2009 |
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| F9999 | <p>Continued From page 23</p> <p>unfamiliar with the routine and treatment orders/procedure.</p> <p>Review of R1's documentation in physician's progress notes dated 10/16/08 by Z1 (physician's assistant) denotes Z1 was found with lower right buttock ulcer with eschar 4.5 cm x 4 cm with surrounding erythema. Santyl was recommended by treatment, nurse will continue to monitor. Z1 further documented "nurses notified pt with skin breakdown on lower right buttock."</p> <p>Review of R1's physician order sheet dated 10/17/08, denotes an order for a low air mattress, turn every 2 hours, and to cleanse lower right buttock with normal saline, pat dry and apply collagenase ointment cover with dry dressing and change daily.</p> <p>R1's record and facility treatment book lacked documentation of any recent wound assessments done on R1. Multiple requests were made by surveyor to administration regarding wound assessments and treatment records for R1 for October and November 2008. The requested documentation was not received from facility.</p> <p>Review of R.S.V.P.'s treatment sheets from reveal R1 had previous wounds/treatments to coccyx, and left buttock. Review of R.S.V.P.'s nurses notes, dated 12/14/08, document R1 was found to have bilateral open blistered areas noted on inner thigh, transparent dressing applied, endorsed to follow-up with physician in AM. There was no further assessment or documentation of any of these wounds.</p> <p>On 12/30/08, surveyor requested the current</p> | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F9999 | <p>Continued From page 24</p> <p>pressure ulcer report from E3 (DON). E3 presented a pressure ulcer report dated 12/4/08. Surveyor asked E3 if there was a more recent report. E3 stated "treatment nurse is off, and don't know where she keeps it."</p> <p>The 12/4/08 pressure ulcer report documented R1 was being treated for an acquired Stage 3 pressure ulcer to the right lower buttock, measuring 3cm in length by 2.5 cm. in width with depth 2.2 moderate amount of drainage, 10% eschar, 90% granulation, red, and treated with santyl. There was no documentation on the wound report regarding R1's right heel or right upper buttock. On 12/31/08, facility presented the pressure ulcer report dated 12/22/08-12/26/08. R1's wound was described as a Stage IV, measuring .3 cm in length x .4 cm width, 10 C cm in depth, with small amount drainage with treatment of santyl. There was no documentation on the most recent wound sheet of R1's right heel and right upper buttock wound.</p> <p>On 12/31/08 facility had Z3 and Z4 (corporate wound nurses) assess R1's wounds. E and E provided the following wound assessments and treatment changes for R1's wounds:</p> <ul style="list-style-type: none"> -Right lower buttock- Stage 3, MS 3 0.3 x 0.5 cm x cm, pink with ser-sanguinous drainage new treatment hydrogel. -Right upper buttock, open blister-non-pressure, measuring 0.5 cm x 2 cm x <0.1 cm, pink partial thickness, with scant sero-sanguinous drainage. -Right heel-non-stageable, MDS 4, measuring 2.2cm x 2.4 cm x undermining, 50% black, 10 %, yellow, 40 % pale pink, scant sero-sanguinous drainage, new treatment Santyl. <p>Review of R1's dietary assessment of 10/31/08 done by E16 (RD) on 10/10/08 denotes R1 had a</p> | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
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| F9999 | <p>Continued From page 25</p> <p>healed site, is at nutritional risk, has mild depletion of visceral protein sores, could benefit from Protein supplement, will await for next lab results, and will follow-up prn (as necessary). There was no follow-up regarding a protein supplement for R1 from 10/10/08 until prompting of surveyor, and there had been no notification of E16 of R1's acquiring new wounds. On 12/31/08, E16 documented the following assessment and recommendation for R1: resident has altered skin right buttocks, and peri area, decreased visceral protein stores, could benefit from additional protein. Recommend to provide Prostat three times a day with flush.</p> <p>2. R11's diagnosis includes Seizure Disorder, and Borderline Intellectual Functioning. Review of R11's Minimum Data Set (MDS), dated 12/9/08, describes R11 as non-ambulatory, chair fast and requires assistance from staff for activities of daily living, and incontinent of bowel and urine. The MDS further denotes R11 has 2 stage 1 ulcers and 2 stage 3 ulcers. R11's Braden Scale dated 12/8/8 assessed R11 at mild risk for pressure ulcers.</p> <p>Review of pressure ulcer report dated 12/4/08 provided by facility on 12/30/08, documented R11 acquired the following wounds:</p> <p>-Acquired 11/18/08 -right hip, Stage 2, MDS Stage 2, 1cm (l) x 1.5 cm, 100 % granulation, pink in color and treatment of Hydrocolloid.</p> <p>-Acquired 11/6/08-left ankle-Stage 3, MDS Stage 3, 1 cm. (l) x 1.5 cm. (w) x .3 cm (d), with moderate drainage, 100 % granulation, pink in color and Santyl for treatment.</p> | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F9999 | <p>Continued From page 26</p> <p>-Acquired 11/6/08-right heel, non-stageable, MDS non-stageable, 5 cm. (l) x 3 cm (w) x depth unstageable, moderate amount drainage, 90 % necrotic, 10% granulation, pink in color and treatment of Santyl.</p> <p>Pressure ulcer report dated 12/22/08-12/26/08 denoted R11 had a newly acquired Stage 2 wound to the buttock, measuring 1cm x .5 cm. with treatment of hydrocolloid.</p> <p>Facility treatment book lacked weekly assessments of R11's wounds. Surveyor requested to review R11's weekly pressure ulcer assessments and November 2008 treatment records but the facility were presented the documents.</p> <p>Review of December 2008 treatment records lacked documentation R11 received ordered treatments to the right heel, and left ankle on 12/29/08. E3 stated in interview the treatment nurse has been off due to illness in family.</p> <p>Reassessment completed by Z3 and Z4 on 12/31/08 assessed R11's wounds as the following:</p> <ul style="list-style-type: none"> -right hip wound had deteriorated from a Stage 3 to Stage 4 (non-stageable) 1.7 cm (l) x 1 cm x undermining, 100 % brown eschar (new treatment -santyl) -right ankle had deteriorated from Stage 3 to non-stageable (MDS4), measuring 1.5 cm x 1.5 cm x 0.4 cm with cartridge exposed -hydrogel (new treatment) -left heel was assessed still as non-stageable (MDS 4) measuring 2.2 x 1.5 x undermining status post debridement 12/3/08, 75 % yellow /tan slough sero-sanguinous drainage using | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F9999 | <p>Continued From page 27 santyl.</p> <p>Review of R11's physician progress notes dated 11/26/08 documented R11 informed his physician "sores are really painful." Review of R11's record lacks a completed pain assessment for R11 and review of R11's POS lacked an order for pain management.</p> <p>Review of R11's dietary notes dated 11/24/08 written by diet tech denotes R11 has had a weight decrease of 8 lbs. Dietary notes dated 12/27/08 documented R11's weight as 84 lbs. 20 % decrease, secondary to decrease in meals, was given double portions, and Megace to stimulate appetite. There was no notification of E16 Registered Dietician) of R11's skin status change or weight loss. E16's assessment of R11 denotes R11 is spoon fed, appetite improving on Megace. R11 receiving ice cream, orange juice with lunch and supper to provide extra calories. Current diet therapy is tolerated will follow up. There was no intervention by dietary until prompting by surveyor.</p> <p>E2 (Assistant Administrator) stated in daily status on 12/31/08, the RD is to be notified of any skin changes in residents.</p> <p>3. R12's diagnoses include Depression, Chronic Decubiti and Paraplegia. Review of R12's Braden Scale assesses R12 as low risk for pressure ulcers. Review of R12's MDS of 11/08 denotes R12 has limitation to both lower extremities with full loss, and requires use of wheel chair. The assessment also denoted R12 had a Stage 2 pressure ulcer, and a stage 3 pressure ulcer.</p> | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| F9999 | <p>Continued From page 28</p> <p>Review of R12's pressure ulcer report denotes R12 was readmitted back to facility with Stage 3 wound to left buttock and sacral area and was being treated for wound infected with Methicillin Resistant Aeuris (MRSA). Review of R12's record revealed an order for a wound culture to R12's sacral and right buttock dated 11/14/08. Review of facility lab results indicated the wound culture was not obtained until 11/20/08, report faxed to facility on 11/23/06. An order for Augmentin 875 mg times 7 days was written on the results of R12's wound culture which revealed a acinetobacter calcoaceticu-baumannii growth negative for MRSA. Review of R12's telephone order sheets denoted the order for the Augmentin 875 mg was carried over 2 days after the initial order was given on 11/24/08. Review of R12's Medication Administration Record revealed R12 was given the Augmentin on 11/27/08, but received the antibiotic only on 11/27 and 11/28. The medication was not signed out for 11/28, 11/29 and 11/30.</p> <p>On 11/31/08 the facility reassessed R12's wounds as the following :</p> <p>-left buttock, Stage 4, MDS Stage 4, measuring 2.2 x 1.1 x 1.7, macerated edges 100% granulation. Treatment consist of Aquacel Ag, fluffed 4 x 4 gauzes, pad with foam, secure with tape, until wound vacuum accessible.</p> <p>-sacral wound-Stage 4 ,MDS Stage 4, measuring 9 cm x 10 cm x 2 cm with bone exposed macerated edges, tunnel-2.5 cm at 8 o'clock, undermining -2-3 o'clock (2.5 cm) and 9-12 o'clock (3.5 cm) 75 % granulation, less than 25 % slough.</p> <p>Review of R12's care plan requires to cleanse</p> | F9999 | | | |

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

PRINTED: 04/18/2009
FORM APPROVED
OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER WESTSHIRE NURSING & REHAB CTR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804 | | |
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| F9999 | <p>Continued From page 29</p> <p>and dress wounds as prescribed, keep dressings clean and intact, and culture wounds for signs of infection.</p> <p>Review of R12's dietary assessment of 12/18/08 denoted R12's last albumin level of 2.9 and to continue with mile with meals and extra protein.</p> <p>An assessment by E16 dated 12/31/01, documented R12 could benefit from Vitamin C and Zinc Sulfate. Will speak to MD.</p> <p>4. R9 was readmitted to the facility on 12/22/08 after hospital stay. R9 is a 68 year old resident with the following diagnosis: Renal Failure, Dialysis, Bipolar Disorder, and Congestive Heart Failure. R9 receives a tube feeding and was placed on isolation for infection of the wound and urine. According to R9's most recent MDS (Minimum Data Set) Assessment dated 11/7/08, R9 is totally dependent in all areas of personal care. R9 was noted with significant weight loss and Stage 2 and Stage 3 pressure ulcers. The survey team was provided with a list of pressure sores on 12/30/08 and R9 was noted with one sore on the sacral area described as a Stage 3 pressure ulcer measuring 3cm by 1 cm by 1cm without tunneling. The report states, "improved." The right bunion area is described as "healed." The team was provided a second report on 12/31/08 dated 12/26/08 that describes the sacral area as Stage 3 measuring 1cm by 1cm by 1 cm without drainage or tunneling. No bunion ulcer was listed. The nursing readmission sheet dated 12/22/08 does not contain a description of the wound nor does it contain a readmission weight. The Braden scale placed R9 at high risk for pressure ulcers. A review of the medical</p> | F9999 | | | |

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

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FORM APPROVED
OMB NO. 0938-0391

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| F9999 | <p>Continued From page 30</p> <p>record on 12/30/08 indicated that the RD had not evaluated R9 for her nutational needs and the adequacy of the feeding. The last nutrition note was dated 11/18/08. R9 's readmission orders state, "cleanse the sacral area with Normal Saline, pat dry, apply Aquacel and cover with hydrocolloidal dressing every 3 days and as needed." "Low air loss mattress, turn every two hours, daily skin checks, and heel lift at all times while in bed."</p> <p>R9 was observed in her room on 12/30/08 at 11:25am with E6 (Nurse) and E7 (Nurse Aid). During the observation, it was noted that R9 had no pressure relieving devices in place. R9 was noted with no padding between the knees and furthermore lacked any pressure relieving devices for the heels. R9 did not have the pressure relieving mattresses. E6 and E7 were present when surveyor observed R9's wounds. No treatment was noted in place on the sacral ulcer. An odor was noted from the wound. In addition, the staff was not aware of the areas on the left bunion. E6 stated that the area was "Healed." E6 stated that the treatment nurse does the treatments and she did not know about the bunion. Both E6 and E7 confirmed that the area was without treatment on 12/30/08. E6 stated that the nurse aids had not told her that R9's treatment had been removed.</p> <p>A review of the facility's treatment record indicates that from time of readmission until observation by the surveyor, the treatment had only been done to the sacral area on 12/28/08. There is no documentation to support that a treatment was done 12/22 and 12/25 as ordered. Furthermore, a review of the record for daily skin checks indicates that on the following days the</p> | F9999 | | | |

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

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FORM APPROVED
OMB NO. 0938-0391

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| F9999 | <p>Continued From page 31</p> <p>facility documented skin checks when the resident was in the hospital from 12/15 to 12/22/08: 12/16, 12/17, 12/18, and 12/21.</p> <p>R9's care plan dated 11/7/08 states, "provide pressure relieving devices, tuning every 2 hours," "Monitor the wound", and "Maintain body alignment in bed and chair."</p> <p>Z3 and Z4 documented R9's wounds on 12/31/08 as follows: "sacral wound 2.2cm by 1.0 cm by 0.4cm Stage IV with macerated edges, and scant serious drainage." "Left Bunion Stage II 1.2cm by 1cm by 0.1cm." Z3 and Z4 confirmed that R9 should have a pressure relieving mattress as well as other pressure relieving devices. R9's wounds were noted to deteriorate. E16 assessed R9 on December 31, 2008 and noted a 20% weight loss and recommended the addition of a protein supplement.</p> <p>The facility failed to provide treatment as ordered to R9, failed to provide preventative measures to R9 and failed to provide care to prevent new ulcers. This caused R9 to show a deterioration in the wound.</p> <p>5. R10 is an 82 year old resident that developed a sacral ulcer in the facility. R10 per her MDS assessment of 11/7/08 is totally dependent upon staff for all care and uses a feeding tube for nutrition and fluid needs. R10 was readmitted to the facility on 12/20/08 and was noted with a pressure sore on the sacral area described as 2-1/2 inches circular. The readmission note does not contain a weight or an evaluation of R10's nutritional status. R10's readmission order states, "heel lift at all times, pressure relieving</p> | F9999 | | | |

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

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| F9999 | <p>Continued From page 32</p> <p>mattress and reposition every two hours." R10 was also placed in contact isolation for the infected pressure sore. The last measurement of R10's wound was dated 12/8/08 and was noted to be "Stage III measuring 5cm by 4cm by 1cm with small amount of drainage."</p> <p>During the observation of 12/30/08, R10 was noted with heels on the bed, and lacking padding to the bony areas. Upon observation with E6 and E7, the wound was noted to be soiled with feces and appeared to be to the bone. The edges of the wound were noted to be unattached with evidence of tunneling. E6 was unaware of how to stage the wound. Both E6 and E7 were noted to need to leave the room which is an isolation room to wash their hands. This room did not have a handwashing sink.</p> <p>Z3 and Z4 measured R10's wounds on 12/31/08 and noted the following: "Sacrum wound Stage IV 5cm by 3.5cm by 1.1cm with a frail wound bed, pale pink and area macerated." Z3 and Z2 agreed with the survey team that R10 required heel protectors and padding between bones. E16 (Dietitian) evaluated R10 on 12/31/08 and documented, "protein status severely depleted." R10 had been evaluated by the Diet Tech in November and at that time recommended weekly weights. This was not done. The increased nutritional needs with the pressure sore were not evaluated by E16 until prompted by the survey team.</p> <p>The facility neglected to monitor the status of R10's wound, obtain a timely nutritional intervention and provide preventative devices to prevent additional pressure ulcers. This failure caused R10's wound to deteriorate to a Stage 4</p> | F9999 | | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145850 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 01/02/2009 |
|--|---|--|---|

NAME OF PROVIDER OR SUPPLIER

WESTSHIRE NURSING & REHAB CTR

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wound.

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