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	14G263	A. BUILDING _____ B. WING _____	02/03/2009

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HICKORY STREET PLACE	3905 EAST HICKORY STREET DECATUR, IL 62521

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W 382	Continued From page 22 On 01/20/09, the p.m. medication administration beginning at 4:05 p.m., was monitored by E1 (Housekeeper/Cook). R's 1 through 6 received physician prescribed medications at this medication administration. R3 was the last individual to receive her medications, having completed the process at 4:40 p.m., and left the medication administration area. E1 was then observed to leave the medication administration area, cross the dining room area to the living room area. E1's back was to the medication administration area and E1 could not visually monitor the unsecured medications. R's 1, 2 and 4 have medication boxes secured by a lock. Medication bubble packs for R's 3, 5 and 6 remained in a basket in the medication administration room. E1 did not close the door or secure the medications prior to leaving the medication administration room. Individuals of the facility were observed to be up and about at will. E1 was observed to return to the medication administration area approximately 1 and 1/2 minutes later to put medications away. During the daily status meeting on 1/21/09 at 3:00 p.m., E2 (Residential Services Director/Qualified Mental Retardation Professional - RSD/QMRP) stated that she also had observed that E1 left the medications unsecured at the same time as described above.	W 382		
W9999	FINAL OBSERVATIONS	W9999		

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W9999	Continued From page 23 LICENSURE VIOLATIONS 350.620a) 350.1070 350.1210 350.1210b) 350.1230b)6)7) 350.1230d)1)2) 350.1230e) 350.1230g) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate	W9999		

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W9999	Continued From page 24 supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. Section 350.3240 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)	W9999		

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W9999	Continued From page 25 These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility has failed to provide health care according to resident needs for 1 of 1 individual of the facility who continues to require deep open wound care treatment since her 7/16/08 surgery (R1). The facility failed to: 1) Provide on-going assessment and a plan of care in accordance with R1's Lipoma diagnosis, subsequent surgery and continuing deep open wound treatment. 2) Ensure an interdisciplinary approach with the dietician, including assessment of R1's nutritional status/needs to assist in the healing process of R1's deep open wound. 3) Ensure all staff have received training regarding R1's deep open wound care and infection control procedures. 4) Implement measures to prevent contamination of R1's deep open wound with regard to R1's incontinence. 5) Ensure that recommended infection control procedures and nursing recommendations regarding R1's deep open wound, were implemented at the facility. 6) Provide instructions to R1's day training site regarding infection control procedures; prevention of contamination of the wound site relative to R1's incontinence; and pressure relief	W9999		

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W9999	Continued From page 26 relative to the deep open wound. 7) Develop and implement policies and procedures regarding health care for individuals of the facility with chronic open wounds. Findings include: 1) In review of an undated facility document that validates level of functioning, R1 functions in the moderate range of mental retardation. Her current physician's orders of 1/6/09 validate that R1 is 72 years of age. Additional medical diagnoses include Osteoporosis, Schizo-Affective Disorder, Status Post Knee Replacement and Status Post Hip Replacement. Review of R1's monthly medical history, the nursing consult report and nursing notes further document incontinence issues since 1/10/08. R1's Inventory for Client Agency Planning (ICAP) of 8/20/08 validates an overall age level of 9 years/9 months. Her WAIS-III of 8/23/08 documents an intelligence quotient (IQ) of 53. R1 utilizes a rolling walker for mobility assistance (observations at the facility on 1/21/09 at 3:30 p.m.). A 1/12/08 facility incident report documents that at 5:45 p.m., E4 (Unit Aide/Activity Aide - UA/AA), observed a knot on R1's left buttocks. Facility log notes document that E5 (former consulting nurse), examined R1 on 1/14/08. E5 documented the mass as golf ball size, located on the bottom of the gluteus next to the gluteal fold. E5 recommended a physician consult for R1.	W9999		

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W9999	Continued From page 27 R1 saw her physician on 1/18/08, with referral to a dermatologist. Per this same document, R1 was seen by dermatology on 1/23/08. The area was diagnosed as a Lipoma, requiring no treatment at that time. Nursing quarterly assessments, nursing notes, monthly medical history, RN consultant reports and the facility log were reviewed from 1/14/08 through 1/6/09. There is no evidence of further nursing assessment (from the initial 1/14/08 date), until the 3/18/08 quarterly nursing assessment - area noted to be, "pink, warm, soft to touch and dry at this time. Appears the size of golf ball." In a phone interview with E2 on 1/30/09 at 11:02 a.m., E2 confirmed that the facility had supplied surveyor with all nursing notes for this time period. There is no further evidence of nursing assessment from 3/18/08 until the 6/9/08 RN consultant report - lipoma appears larger, red and warm to touch. There is no evidence of recommendations for staff regarding the monitoring of the area. In a phone interview with E2, on 1/30/09 at 11:02 a.m., E2 confirmed that the facility had supplied surveyor with all nursing notes for this time period. 6/16/08 nursing consult report - area has grown to softball size, is red and feels fluid filled. There is a recommendation to staff for covering the area with a 4x4 bandage and to watch for drainage. 6/19/08 dermatology consult note - area has	W9999		

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W9999	Continued From page 28 grown from 5 to 12 centimeters. Diagnosis is Lipoma versus tumor or fluid accumulation. The recommendation is to consult with a general surgeon. 6/25/08 RN consultant report - examined mass - appears less red, same size, cool to touch, denies pain except when underwear rubs, no drainage. 7/16/08 hospital note - excision of the Lipoma on this date after 7/1/08 surgeon consult. 8/12/08 monthly medical history - saw surgeon this date. R1 is still having drainage since surgery. Surgeon packed the area and recommended daily packing. Nursing notes of 8/13/08 document an approximate one inch opening at the distal end of the incision. In an interview with E2 on 1/23/09 at 12:50 p.m., E2 stated that on 8/18/08, R1 began receiving outpatient wound care at a local hospital once daily, to have the wound packed. 9/9/08 nursing notes - "examined (L) gluteal site...wound size decreasing per client & (and) staff." There is no evidence that nursing assessed the size of the wound at this exam, and no evidence of assessing the size of the wound since the 8/14/08 nursing note, when there was a one inch opening at the distal end of the incision. A 9/10/08 memo to staff from E2 - R1 will now have to go to the hospital wound center twice daily, starting this day.	W9999		

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W9999	Continued From page 29 10/14/08 surgeon consult - "Chronic Fistula non healing...deep Fistula & (and) small opening." Under 'Treatment/Recommendation" - "Excision of (R) {right} gluteal fistula." - with surgery to be completed on 10/20/08. After the nursing assessment of 9/25/08, there is no evidence of a facility nursing assessment until 10/21/08. This was confirmed in a phone interview with E2 on 1/30/09 at 1:30 p.m. 10/22/08 nurses consult note - new physician's order for wound care BID, and wound vac three times a week. 11/5/08 nurses consult note - R1 admitted to a local nursing home on 10/31/08 for wound vac treatments. Nurses notes from 10/21/08 through 10/26/08 do not provide evidence of nursing assessing the size of the wound. 11/22/08 nurses notes - R1 was discharged from the nursing home back to the facility on 11/21/08 with orders to resume out patient wound care once daily. Nursing documents no draining noted. There is no evidence of nursing assessing the size of the wound. Additionally, in review of R1's chart, no evidence was found regarding R1's wound healing progress from the outpatient wound clinic or the nursing home stay. In an interview with E2 on 1/21/09 at 10:55 a.m., E2 confirmed that the facility had not obtained wound healing information relative to the size and depth of the wound from the wound clinic or the nursing home. It was not until after the surveyor	W9999		

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W9999	Continued From page 30 interview that the facility obtained wound clinic information relative to the size and depth of the wound (10/27/08 from the clinic; and 10/31/07, 11/3/08, 11/10/08 and 11/18/08 from the nursing home). Nursing notes were reviewed from 11/26/08 to 1/15/09. Nursing notes of 12/2/08 state that the depth of the wound has decreased since the previous assessment, but there is no documentation of the size of the wound. 1/15/09 nursing notes document that the wound is approximately two inches deep, with no further information as to whether this is an increase or decrease in depth of the wound. On 1/21/09, at 11:00 a.m., R1's gluteal wound was observed. E12 (consulting nurse) was present. The wound was located at the left gluteal fold, where the thigh and buttock meet. The outer edge was approximately half-dollar size. E12 utilized a long cotton covered wooden swab to check the depth of the wound. E12 stated the wound appeared to be tunneling and was approximately 1 and 1/2 inches deep. On 1/21/09 at 11:10 a.m., E12 stated that she does not routinely measure the wound at the facility. R1's 8/21/08 Individual Program Plan (IPP) was reviewed. R1's health summary checks "yes" regarding continence. Under the health recommendations portion it states, "Medical and nursing services as needed; labs as ordered by physician; annual dental and vision assessments. Continue current diet orders; maintain stable weight; skin integrity, and lab values."	W9999		

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W9999	Continued From page 31 In review of R1's personal chart and her IPP of 8/21/08, there is no updated care plan in accordance with R1's change in health status, regarding her continuing open wound. In an interview with E12 (consulting nurse), on 1/21/09 at 11:10 a.m., E12 stated that she had not provided the facility with an updated nursing care plan for R1,after her change in health status. On 1/30/09, at 8:53 a.m., E12 was interviewed per phone, regarding the staging of R1's wound. E12 stated that she does not really know wound stages, that she has not been trained in this area. E12 stated she has had experience in packing and dressing changes when employed at a hospital, but that other nursing staff were responsible for measuring and staging wounds. E12 further stated that she has had experience in taking care of patients with wound vacs, but has never applied the wound vac herself. R1 was interviewed on 1/21/09 at 11:35 a.m. R1 stated that sometimes the area "hurts" and "bothers" her when she is sitting. R1 further stated that if it hurts, she "will lay down." The facility's "Nursing Service Policies" was reviewed. Per this document, it states, "The R.N. (Registered Nurse) will participate in the following...Development of a written plan for each resident to provide for health care services as part of the total rehabilitation plan...Modification of the health care plan, in terms of the resident's daily needs...." The facility failed to provide a complete and on-going healing assessment of R1's open deep wound; obtain relevant information from the	W9999		

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W9999	Continued From page 32 wound clinic and nursing home relative to the healing of R1's open deep wound; provide a plan of care regarding R1's change in health status; and, ensure recommended comfort measures were implemented as recommended. 2) Nurses consult notes of 11/5/08 and 11/22/08 document R1's admit to a local nursing home on 10/31/08 for wound vac treatments, with discharge from the nursing home back to the residential facility on 11/21/08. An 11/22/08 note from the consulting nurse to the consulting physician states that R1 received a multivitamin with minerals daily, as well as health shakes twice daily, while in the nursing home. The nurse requested clarification as to continuing these orders. The consulting physician responded on 11/24/08, verifying the need to continue with this order. R1's dietary consult notes of 7/16/08 were reviewed (also R1's Lipoma surgery date). In review of R1's dietary notes of 7/16/08 and 10/9/08, there is no evidence of dietary assessing R1's nutritional needs regarding the surgery and healing of her open gluteal wound, and no further notes until 1/23/09. In an interview with E2 on 1/22/09 at 2:45 p.m., E2 stated that the dietary consultant was aware of R1's open area and was aware that R1 had been in the nursing home for treatment of the wound. In a phone interview with E2 on 1/23/09 at 12:50 p.m., E2 stated that the dietician was in on 1/23/09 and had recommended Vitamin C and	W9999		

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W9999	Continued From page 33 Zinc for R1 (after surveyor had interviewed the facility on 1/22/09, regarding the involvement of the dietary consultant regarding R1's wound). In a 1/23/09 fax from the facility to the Department there are dietary notes dated 1/23/09. The notes reflect that R1 has a wound on her left buttocks. This note further states that R1 would benefit from Vitamin C and Zinc Sulfate for wound healing. On the same date there is also a note to the consulting physician requesting an order for these additional supplements. The facility's "Medical Services Philosophy" was reviewed. Per this document it states, "It is the philosophy of this facility to provide and maintain high standards of medical care for the residents of this facility. In accomplishing this, not only the team approach, but the total resident care format will be the criteria used in obtaining this goal." 3) E2 was interviewed on 1/21/08 at 10:20 a.m., regarding how staff are and/or were trained specific to R1's gluteal mass, open wound care and infection control. E2 stated that there is a staff log. When staff arrive for their work shift, all staff are to read the log. After reading the log, staff are to sign the log to verify that they have done so. In review of a facility staff schedule for 1/12/09-1/19/09, there are seven (7) staff listed who provide direct care. E1 (housekeeper/cook), E7 (UA/AA), E8 (Rehabilitation Aide/AA), E9 (UA/AA), E6 (UA/AA), E10 (UA/AA), and E11 (Activity Director). E2 confirmed on 1/22/09 at 1:30 p.m., that this staff schedule was current regarding employees of the facility.	W9999		

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W9999	Continued From page 34 The log notebook was reviewed. There is a 1/14/08 note from E5 (former consulting nurse) regarding the golf ball sized mass in the left gluteal area. E5 recommended making a physician appointment for R1, observe the area and monitor for change in size, shape, color and pain. E5 was to be called for changes. E5 also recommended a pillow under R1's buttocks when sitting on hard surfaces. This is signed by E5. There are however no signatures from staff to verify that they read these instructions. This was confirmed with E3 (Acting Administrator), on 1/21/09 at 10:45 a.m. There is a 7/16/08 document of "Post-Op Instructions" for R1 from E5 (former consulting nurse), regarding the care of her L (left) gluteal mass/lump excision. These instructions discuss the following: when to remove the initial dressing; what to do if soiling through the dressing occurs; when to remove dressing and keep open to air; bathing instructions; when and how long to complete vital signs; frequency of wound checks; when to call the nurse; what to administer for pain; resuming medications and diet; and when R1 can return to day training. At the top of the page it states, "All read & (and) sign". There are two signatures on the page: E5's (former consulting nurse who prepared the document for staff), and E6's (Unit Aid/Activity Aide - UA/AA). The facility did not present any further documentation to validate that the remaining staff had read this information, or had received specific training in providing care for R1's deep open wound.	W9999		

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W9999	Continued From page 35 Within the log there is another memo to all staff dated 8/14/08. This memo provides instructions to staff regarding R1's still draining wound. Staff are instructed to change the gauze that covers the area; and, to not pack the area or remove any gauze that has been packed in. This memo also states that due to the large amount of draining, R1 will need to wear incontinence briefs again. There are no staff signatures to validate that staff read these instructions. This was confirmed per interview with E3 on 1/21/09 at 10:40 a.m. Within the log there is another memo to all staff dated 8/15/08. Per this memo staff are to place a clean dry gauze over her wound after her bath. The wound clinic recommends using a towel to soak up some drainage. White wash cloths have been purchased to take to the wound clinic daily. Only have the clean gauze on R1 when she goes for her appointment. The new wash cloths are to be used on R1 only. There are no staff signatures to validate that staff read these instructions. This was confirmed per interview with E3 on 1/21/09 at 10:40 a.m. Within the log there is another undated memo. In an interview with E2 on 1/21/09 at 10:20 a.m., E2 stated that this memo was put in the log for staff review in August of 2008, specific date not recalled.This memo instructs staff as follows: R1's laundry is to be washed separate from everyone else, including her towels. R1 is to use the same towels daily, wash them daily and keep them in her room. Ensure that hospital germicide is utilized for R1's laundry. Ensure the washing machine is sterilized after R1's laundry. All of R1's dressings needs to be placed in plastic	W9999		

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	14G263	A. BUILDING _____ B. WING _____	02/03/2009

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W9999	Continued From page 36 bag and in the medical waste container. Staff are to sterilize the toilet seat and tub after R1's use. R1 is to have a pad sitting under her when sitting at the facility, as well as one the van. There are no staff signatures to validate that staff read these instructions. This was confirmed per interview with E3 on 1/21/09 at 10:40 a.m. Facility policies and procedures were reviewed. The "Communication Book Policy" states that the purpose of the communication book is to allow staff on all shifts access to pertinent information enabling them to complete their jobs and be alert to specific potential situations during their shift. Information which should be recorded in the log includes: "...instructions for a specific individual." "All staff should read the Communication book immediately upon their arrival to work. All staff should sign and date that they have read the log." Inservice training logs were requested from E2 for one year. Inservice logs were presented from 01/08 through 01/14/09. The most frequent in service presented to staff regarding, "Hand Washing/Infection Control" and "Biohazard Waste" was presented on 2/22/08. Signatures for this inservice include E4, E8 and E7. There is no evidence that E1, E6, E8, E10 and E11 have received training in these areas since 1/2/08. Additionally, there is no evidence of staff having received specific training regarding care of R1's open deep wound. On 1/30/09, at 8:53 a.m., E12 was interviewed per phone regarding the staging of R1's wound.	W9999		

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W9999	Continued From page 37 E12 stated that she does not really know wound stages, that she has not been trained in this area. E12 stated she has had experience in packing and dressing changes when employed at a hospital, but that other nursing staff were responsible for measuring and staging wounds. E12 further stated that she has had experience in taking care of patients with wound vacs, but has never applied the wound vac herself. The "Nursing Consultant Agreement" policy was reviewed. Per this document, it states, "Direct care staff shall be trained in the following areas...Basic skills required to meet the health needs and problems of the resident." 4) R1's nursing notes of 1/10/08 document recent urinary incontinence. This note states that these episodes occur when R1 is in her bedroom and staff are not able to get there fast enough to assist R1, relative to R1's new protocol with her walker. E5 (former consulting nurse) recommends toileting R1 prior to going to bed and to wake her up one or two times in the night to toilet her. 6/16/08 nursing consult report documents diarrhea. R1's 8/7/08 nursing consult report documents, "Examined surg (surgical) site...area still draining pink clear fluid...diarrhea ceased." (No documentation can be found in nursing notes regarding when this diarrhea began, except for the 6/16/08 note).	W9999		

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W9999	Continued From page 38 R1's 8/19/08 monthly medical history documents that R1's physician ordered hemoccult, stool culture for diarrhea. A 12/5/08 note to the consulting physician from E2 requests an appointment for R1. This note documents that R1 has had several recent occurrences of incontinence during bedtime hours. R1's 12/9/08 quarterly nursing assessment documents that R1 has incontinence at night; that her physician has been notified for an appointment. R1's 12/10/08 monthly medical history documents that R1 saw her physician on this date regarding incontinence issues. A Urinalysis was ordered, followed by an order for Cipro BID X7 days. Will need follow up urinalysis. 12/26/08 nursing consult notes document urine culture positive for E. (Escherichia) Coli - Amoxicillin ordered, but discontinued due to Ampicillin ordered by surgeon for left buttocks wound. In an interview with E1 (housekeeper/cook), on 1/21/09 at 11:33 a.m., E1 confirmed that R1 is sometimes incontinent of urine when she arises in the a.m. E1 stated that this a.m. R1 had urine on her underwear and her pajamas. E1 further stated that on occasion, R1 may have a small amount of bowel movement on her underwear when she arises. E1 further stated that she had transported R1 to the wound clinic this a.m., and that R1 had been incontinent of urine by the time she arrived at the clinic.	W9999		

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W9999	Continued From page 39 R1's personal chart and wing book were reviewed. Per this review, there was no evidence that facility nursing had implemented a procedure regarding R1's incontinence. E2 was interviewed on 1/21/09 at 12:20 p.m. E2 confirmed at this time that the facility has not implemented any procedure or protocol for staff to implement regarding R1's incontinence. In a phone interview with Z3 (Physician), on 1/27/09 at 2:00 p.m., Z3 stated that if urine or feces entered the wound, the chance for infection would be increased. The facility's "Nursing Consultant Agreement" was reviewed. Per this document, under "Responsibilities of the Consultant", it states, Control of...infections through identification and assessment....implementation of appropriate protective and preventive measures." 5) Facility log notes document that E5 (former consulting nurse), examined R1 on 1/14/08. E5 documented a golf ball size mass on R1's bottom left gluteus next to the gluteal fold. E5 recommended a physician consult. Recommendations were also made for staff as follows: observe the area, monitoring for change in size, shape, color and pain - call nurse if any of the above arises; apply pillow under bottom, if sitting on hard surfaces. The note is signed by E5 and further documents that instructions were left for staff. In a phone interview with E2 on 1/20/09 at 11:20	W9999		

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W9999	Continued From page 40 a.m., E2 stated that no documentation could be found regarding the implementation of the above nursing recommendations. A 6/16/08 nursing consult report states that R1's gluteal mass has grown to softball size, is red and feels fluid filled. There is a recommendation to staff for covering the area with a 4x4 bandage and to watch for drainage. In a phone interview with E2 on 1/30/09 at 11:30 a.m., E2 stated that no documentation could be found regarding the implementation of the nursing recommendations. Observations were conducted at the facility on 1/20/09 beginning at 3:30 p.m. R1 arrived from her day training site to the facility at 3:30 p.m. R1 sat in an armed chair at in the dining room at the dining table during leisure time. R1 also sat in the same armed chair at the dining room table during the p.m. meal, which began at 5:00 p.m. Observations at the facility ended at 5:35 p.m. Throughout this observation time, staff did not ensure that a pad was placed under R1, as per the 8/08 memo to staff. 6) A facility log note dated 1/14/08 was reviewed. This note is from E5 (former consulting nurse) to staff of the facility, regarding R1's golf ball size gluteal mass. Recommendations are to: observe the area, monitor for change in size, shape, color and pain and to call the nurse if any of these situations arise. Staff are also to apply a pillow under R1's bottom if sitting on hard surfaces. In a phone interview with E2 on 1/30/09 at 11:20 a.m., E2 confirmed that there is no evidence that R1's day training site had been notified of these	W9999		

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W9999	Continued From page 41 instructions, regarding the monitoring of R1's mass and sitting comfort. In review of the facility medication administration record (MAR), there is an undated memo from R2 (Residential Services Director/Qualified Mental Retardation Professional) - RSD/QMRP), to all facility staff. E2 was interviewed on 1/20/09 at 2:10 p.m. regarding this memo. R2 stated that the memo was placed in the MAR in August of 2008. Per the memo, R1's laundry is to be washed separately from all other residents. This includes towels. Every morning staff is to complete the facility laundry and then R1's laundry. R1 is to use the same towels daily. The towels are to be washed each morning with R1's laundry and are to be kept in her room. Hospital germicide is to be added to each load of R1's laundry. Staff are to sterilize the washing machine after each washing of R1's laundry. All of R1's removed dressing on her wounded area are to be placed in a plastic bag and placed in the medication closet in the medical waste container. After each toilet use by R1, staff are to sterilize the toilet seat, as well as sterilize the tub after each shower. R1 is to sit with a pad under her when sitting in the facility, as well as on the van. Staff are to follow universal precautions when assisting R1 with baths, room care or dressing waste. In an interview with E2 on 1/20/09 at 2:10 p.m., when asked, E2 stated that R1's day training site was not notified of the above infection precautions regarding R1.	W9999		

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W9999	Continued From page 42 Z1 (day training staff) was interviewed on 1/20/09 at 12:50 p.m. Z1 stated that she has worked at the day training site for three years. The dressing is not changed at this site, but staff keep an eye on the dressing. Z1 stated that the day training site did do her laundry when R1 would have an accident or when there was drainage from the wound on her clothing. The day training site stopped completing any laundry for R1 about mid December 2008. Day training is not sterilizing the toilet after R1's usage. R1 does have leaking from the buttocks wound. R1 carries a pad around to sit on, but does not use it. The facility has not provided any instructions or precautions regarding R1's wound drainage or any specific instructions regarding infection control. Z2 (day training staff), was interviewed on 1/20/09 at 1:05 p.m. Z2 also confirmed that the facility has not communicated information regarding R1's infection control precautions. 7) Facility policies and procedures were reviewed. The policy/procedure entitled "Wounds" was reviewed: "1. To cleanse a wound, wash your hands thoroughly with soap and water. Use ordinary hand soap or mild detergent. 2. Wash in and around the victim's wound to remove bacteria and other foreign matter. 3. Rinse the wound thoroughly by flushing with clean water, preferably running tap water.	W9999		

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W9999	Continued From page 43 4. Blot the wound dry with a sterile gauze pad or a clean cloth. 5. Apply a dry sterile bandage or clean dressing and secure it firmly in place. 6. Caution the victim to see a physician promptly if evidence of infection appears 7. A physician may advise additional home remedies for the care of small wounds." There is also a form, "Staff Instructions for Wound Site Checklist." This form is implemented/completed/discontinued by staff upon direction by the consulting nurse. This checklist includes documentation for the date, time, warmth, swelling, drainage, drainage color, drainage smell, sutures intact and staff initials. In an interview with E3 on 1/22/09 at 10:35 a.m., E3 stated that this was the facility wound policy. E3 further stated that this wound policy was applicable to "minor" wounds, and that the facility does not have a policy/procedure applicable to a chronic open wound as currently experienced by R1. The facility policy for "Resident Protection: Abuse and Neglect Policy" was reviewed. Neglect is defined as any omission by a facility or employee that endangers an individuals's health or safety or fails to respond to an obvious immediate need of an individual regardless of whether or not there is an injury. The facility has failed to provide health care in accordance to R1's open wound care needs. (A)	W9999		