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STERLING PAVILION	**105 EAST 23RD STREET STERLING, IL 61081**

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F 354	Continued From page 17 Based on interview and record review the facility failed to ensure that the facility was staffed with a Registered Nurse for 8 consecutive hours, 7 days a week. This has the potential to affect all 89 residents residing in the facility. The example includes: On 11/26/08 at 10:00AM, E2 said that she had been out-of-state on vacation 11/14, 11/15, 11/17 - 11/19/08. She was not aware of R1's pressure ulcers until she came back to work. E2 was asked how many Registered Nurses (RN) she employs. E2 states she only has 1 part-time RN. E2 said that she does not have RN coverage for 8 consecutive hours, 7 days a week. The facility's census as of 11/25/08 is 89 residents. On 2 of the days that E2 was on vacation , November 14th & November 19th, 2008 there was no RN coverage. On 12/12/08 at 10:30 AM, E2 was asked if there is a RN available to staff when she is not available. E2 said that the corporate nurse is available by telephone for any questions, she lives in the Chicago area. E2 said that she does not post telephone numbers where the corporate nurse can be reached.	F 354		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)5) 300.1220b)3)	F9999		

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F9999	Continued From page 18 300.1220b)7) 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 meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for futher medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat 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	F9999		

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F9999	Continued From page 19 b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. 7) Coordinating the care and services provided to residents in the nursing facility. 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 unfasten a resident's leg brace and inspect a resident's leg, while the brace was worn between 11/3/08 to 11/14/08, failed to have the skin care nurse conduct weekly skin assessments once skin breakdown and drainage was identified on 11/14/08, failed to develop a plan of care showing the current skin condition and treatments for R1, and failed to follow up on a fax transmission sent to the physician on 11/15/08 to assure he was aware of the changes to R1's knee on 11/14/08. These failures resulted in R1 developing MRSA infected medial (Stage IV) and lateral pressure ulcers to the right knee requiring hospitalization on 11/19/08 and a possible amputation to the right	F9999		

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F9999	Continued From page 20 leg. The facility also failed to identify, document and monitor a pressure ulcer resulting in the worsening of a wound for R2. Findings include: 1. R1 is an 87 year old resident whose diagnoses include a Right Femur Fracture, according to the 11/08 Physician Order Sheet (POS). The incident report and nursing notes show that the injury occurred on 8/4/08 in the facility. The fracture was treated with a leg brace due to the resident being a surgical risk. "Family wants brace on at all times" is hand-written (no initials) on the 11/08 Treatment Record. The resident's Minimum Data Sets of 11/21/08 & 8/29/08 shows that the resident is non-ambulatory. The 11/21/08 MDS show that the resident has 1 stage II pressure sore. The 11/08 treatment records show that the resident had right and left heel ulcers. On 11/25/08 at 8:35 AM, E5 (CNA) was interviewed. She said that R1 was in the hospital. She said that the resident wore a short leg brace on her right leg because she had fractured her leg a few months ago. E5 said that while giving the resident a shower on 11/14/08 she noticed 2 open areas on the lateral and medial aspects of her right knee. She said that she notified E9 (LPN) of the wounds. E5 said that the resident's brace was never removed except on shower days, once a week. Interviews were conducted with E4 (CNA) at 11:40 AM, and E6 (CNA) at 9:35 AM on 11/25/08. Each staff member said that the brace was only removed on shower day, and that was	F9999		

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F9999	Continued From page 21 the only time the resident's right leg was washed. E6 said that the family wanted the brace on the resident's leg at all times. On 11/25/08 at 9:05 AM, E2 agreed that the staff were not removing the resident's brace except on her shower day. A hand-written order (author unknown, no date, time, or initials) on the 11/08 Treatment Flow Sheet states, "Knee immobilizer at all times except when leg is being washed." Another hand-written order on the Treatment Flow Sheet dated 11/3/08 states "May remove brace at bedtime, or while being moved." Next to the order is written, "Family wants brace on at all times." The initials on all 3 shifts from 11/3 through 11/18 are all circled, indicating that the brace was not removed. Nursing Notes written by E9 (LPN) on 11/18/08 show that the resident's physician was notified of open areas to her right upper knee. There are no measurements or descriptions of the wound. On 11/25/08 at 9:30AM, E6 said that the aide who gave the resident her shower on 11/14/08 reported to her that R1 had 2 open areas. E9 said that the areas looked like abrasions on either side of her right knee. She said that the abrasions are where the knee brace causes pressure. E9 said that she cleansed the areas with soap and water and then applied a Hydrocolloid dressing, per the facility policy. E9 said that the dressings are to be changed every 5 days and as needed so she did not check the wound site. She said that she notified the resident's primary physician by facsimile (fax) transmission. E9's comment on the fax sheet is, "Brace rubbing upper right knee causing	F9999		

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F9999	Continued From page 22	F9999		

ulceration, 2 on each side of knee. Hydrocolloid applied per protocol, can we have a regular order"? The facsimile Transmittal Sheet shows that the fax was sent to the physician's office on Saturday, 11/15/08. A response was not sent back to the facility until Monday, 11/17/08 at 5:51 PM. The physician's response told the facility to, "Notify the doctor who ordered the brace." E9 said that a call was placed to the orthopedic surgeon's office and an appointment was made for the resident to be seen on 11/19/08. She said that the resident was admitted to the hospital from the doctor's office. E9 said that she changed the resident's dressing prior to going to the doctor's office and she observed that the resident had a large amount of drainage that had some pus in it.

On 11/25/08 at 10:00 AM, E3 (Wound Nurse - LPN) said that she had not been made aware of the resident's pressure wounds on her right knee, she was only aware of the the ankle wound. E3 said, "I am supposed to do wound checks when I'm given that capacity. I am not always given time every week to do wound care, so the floor nurses are to pick up the slack. The nurses are to assess and measure all wounds and document their findings. They are to initiate the wound protocol and notify the family and doctor. The measurements and assessment should be placed on the back of the Treatment Administration record. When wound protocol is initiated, the original findings should be documented in the Nurses Notes."

Review of the treatment records show that the initial hydrocolloid dressing was applied on 11/14/08. The next dressing was done on 11/17/08 by E7 (LPN). On 11/25/08 at 1:45 PM,

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F9999	Continued From page 23 E7 said that on 11/17/08, she was told by family members that the resident's dressing had come off. She said that there was a stockinette under the brace, it was wet with drainage. E7 said "It (the wound)looked bad! She said that there was a lot of brown colored drainage. She said she did not note pus in the drainage." When asked how the wound looked and how large it was, E7 said that she "did not see an open area or any redness." When asked where all of the drainage was coming from, she said that "the resident often has a large amount of drainage when she has a skin tear." E7 said she did not notify the resident's physician because she knew that E2 (LPN) was going to make an appointment the next day for the resident to be seen by her Orthopedic surgeon. E7 said that up until 11/17/08, the resident was still wearing the leg brace at all times. On 11/25/08 E2 said that E7 should have called the Orthopedic Surgeon to inform him of the wound drainage. The facility's policy on Change in Condition / Importance of Communication policy states, "Nursing will notify the residents family, physicians, and the Director of Nursing of any accident, injury, or significant change of residents conditions, such as; development or deterioration of pressure ulcers....Each resident will have a comprehensive assessment and plan of care developed to meet the total nursing and personal care needs of the resident....All observations related to the resident's change in condition will be documented in the medical record. This includes physical, mental, emotional changes, and any identified need for further medical evaluation....Physician/Family notification and	F9999		

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F9999	Continued From page 24 corresponding treatment will be documented in the medical record along with resident's responses...." On 11/19/08, Z2 wrote, "I received a phone call from the nursing home yesterday regarding the brace that was rubbing and causing some open wound. I asked her to come in today. She has a large obvious open draining abscess of the medial femoral condyle with probable bony involvement and the medial fragment (bone) is very close to the skin edge on that portion. She also had some lateral skin breakdown. Recommend that the patient be admitted for IV antibiotics and further recommendations. This is explained thoroughly to the patient's family including the risks involved and the seriousness of this infection...cultures done, Gram's stain showed +2-3 gram-positive Cocci with clusters, and also she had a fever of 100.4. White count on admission was elevated to 24,000 (Normal white count 10,000)." Hospital laboratory cultures (collected on 11/19/08) of the right medial knee wound show that the wound contains 4+ Staphylococcus Aureus and 3+ Escherichia Coli. The blood culture and sensitivity collected on 11/19/08 states "Presumptive Methicillin Resistant Staphylococcus Aureus." On 11/25/08 at 9:05 AM, Z2 stated "(R1) was Septic when she came to the office. She looked sick. She was running a temperature of 100.4. I saw her 2 weeks ago and she had no open areas on her knee. Z2 said that on 11/3/08 he gave orders that the resident's brace could come off at night. Z2 said that the resident's skin under the brace should have been inspected at least daily.	F9999		

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F9999	Continued From page 25 He said that the brace did not even have to be removed. The brace could be opened for visualization of the skin. We are considering several different options of treatment. I will be speaking with the family today. The option that is the most radical but curative is an above the knee right leg amputation. I don't think we'd consider amputation if it weren't for the infection." On 11/25/08 at 11:00 AM, Z3 (Orthopedic surgeon) said, "A spike of bone eroded through the skin. When the hole happened, I don't know. She does have a significant infection that has been there for several days if not longer. Anyone who would have looked at it would have seen a problem. If it weren't for the infection and the breach of skin we would not be considering amputation at this point." Nursing Notes from 11/15/08 through 11/19/08 do not have any resident assessments, temperatures, or assessments of the wound including sizes. On 11/15/08 at 1:20 PM, E9 (LPN) said that the resident looked like she always did, her color was normal. E9 said, "When I saw the wound on 11/19/08 before she went to her appointment, I thought oh, this is bad"! On 11/15/08 at 2:30 PM, E2 (Director of Nursing - RN) said that all open areas are to be measured and assessed as soon as they are found. E2 stated that on 11/17/08 when the wound was found to have a large amount of drainage, the physician should have been contacted by telephone. She said that often when things are faxed to the doctor's offices, they may sit on a fax machine for a long period of time before being seen, especially on the weekend.	F9999		

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F9999	Continued From page 26 The resident's 9/20/08 skin assessment score is 18. On 11/25/08 at 2:30 PM, E2 said that the resident should be considered a high risk for skin breakdown because of her 2 heel pressure ulcers and ankle stasis ulcer. E2 said hat the facility has a wound program that consists of corporate orders and policies. She said that the facility does not have any program for weekly skin checks other than the CNAs checking the resident's skin on their shower days. She said that the nurses are to do weekly wound measurements on Mondays and report to her or to E3 if the wounds are not improving. The facility's policy for Pressure Ulcer Prevention and Care states, "Inspection of the resident's skin should be included in the daily routine....Look for irritation and chafing due to bed linen, braces, and clothing....Assessment of Pressure Ulcers should include the location, state, size in centimeters for length and width, presence of undermining, tunneling or sinus tracts, presence of necrotic tissue, presence of granulation tissue.... Drainage in a wound should be assessed for volume, color, consistency, and odor....Contributing factors to pressure ulcers is immobilization....The aim is to prevent, not cure by...daily skin assessment to all bony prominences.... If, based on the determination of the interdisciplinary team, it is deemed that the resident is at risk for skin breakdown (even through the resident does not score as such), the resident will be considered at risk, and the reasons documented in the clinical record.... Nurses should be aware that skin care is one of their responsibilities...." Taber's Medical Encyclopedia, 20th Edition	F9999		

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F9999	Continued From page 27 states, "All nursing home residents are at risk for pressure ulcers. In at risk patients decubiti can be prevented by inspecting the skin regularly for redness, signs of breakdown, documenting findings and instituting any preventative measures or treatment." R1's skin care plan of 10/08 only addresses the resident's left ankle stasis ulcer. The care plan does not mention the resident having bilateral heel pressure ulcers or the brace to the resident's right leg. The care plan was not updated with the resident's right knee wounds. On 12/12/08 at 10:30 AM, E2 (Director of Nursing) said that the resident was sent back to the facility. E2 said that she still has the infection but is not receiving any antibiotic therapy. She said that R1is now receiving Hospice services. E2 also said that the facility has a total of 11 pressure ulcers, only 3 of the residents were admitted with them. E2 said that up until this morning she was only aware of 2 pressure ulcers. She said that she does not think E3 (LPN - Wound Care Nurse) is aware of them either. The hospital Discharge Summary for R1 states the resident's final diagnoses as "Methicillin-resistant Staphylococcus Aureus infected wound of right knee region with possible osteomyelitis, Deforming Rheumatoid Arthritis, Osteoporosis, and Pressure Sores of heels and ankle. " Review of the resident's discharge medications on the Discharge Summary shows that the resident is not going to be treated with any antibiotics and that the resident is going back to the facility on hospice. 2. R2 is a 78 year old female resident with	F9999		

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F9999	Continued From page 28 diagnoses including Dementia, Parkinson's Disease, Hypertension, Diabetes Mellitus Type 2, Chronic Kidney Disease, and Osteoporosis according to the Physician Order Sheet (POS) dated 11/08. On 11/25/08, E2 said the only residents in the facility with decubitus ulcers were hospital acquired wounds. E2 said R2 had acquired a Stage II decubitus ulcer while hospitalized between 9/30/08 and 10/3/08. A hospital consultation report dated 9/26/08 documents R2 ". . .now having decubitus ulcers so I was consulted . . . the center (of wound) is not able to be staged because of dark discoloration." These hospital notes show R2 had the decubitus ulcer prior to hospitalization on 9/30/08. In a consultation report dated 9/27/08, Z5 (Hospital Surgeon) documents over the past couple of months (R2) has developed a sore on her gluteal area (high). "I am asked to evaluate for possibility of debridement." On 9/29/08, Z6 (Hospital Registered Nurse) documents R2 with a "severe decubitus ulcer" to "left buttock with wet to dry dressings TID (three times a day)." Facility treatment sheets dated 8/08 show only orders for support stockings and oxygen usage. There is no September 2008 treatment sheet. October 2008 treatment sheet is the first documentation of decubitus care. None of the care plans for R2 address her having pressure ulcers or any interventions in place for them. On 9/29/08 (non-legible time) PM, E10 (LPN) documents R2 with a Stage II Decubitus Ulcer (5	F9999		

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F9999	Continued From page 29 cm long by 3 cm) to left gluteal region. October treatment sheet shows an order was written for wet to dry dressings to "right sacrum TID." Wound is left gluteal region. The treatment sheet shows this order was discontinued on 10/6/08 and a new order was written to apply a "DuoDerm dressing to Right" (wound is on left) "gluteal wound, change every 5 days and as needed." On 11/25/08, at 1:30 PM, E2 stated R2 returned to the facility on 10/3/08 from a hospital stay between 9/29/08 to 10/3/08. E2 said any resident out of the facility for 3 days or longer is to be re-admitted and a complete skin assessment completed. E2 stated E3 "re-admitted" R2, but did not complete a skin assessment sheet. During an interview on 11/25/08 at 10:15 AM, E3 (LPN, Wound Nurse) stated she does not look at existing wounds on a weekly basis because she does not have enough time so the floor nurses are supposed to be looking at them, measuring them, documenting the findings and reporting to the physician and family. On 11/25/08 at 10:10 AM, E2 (DON) stated the floor nurses are to be measuring and documenting on current wounds every Monday and if there is no progress for a week or two, the nurses are to report the findings to E2 or E3 so they can obtain new orders. The facility's Pressure Ulcer Prevention and Care policy states, "Inspection of the resident's skin should be included in the daily routine....Look for irritation and chafing due to bed linen, braces, and clothing....Assessment of Pressure Ulcers	F9999		

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STERLING PAVILION	**105 EAST 23RD STREET STERLING, IL 61081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 30 should include the location, state, size in centimeters for length and width, presence of undermining, tunneling or sinus tracts, presence of necrotic tissue, presence of granulation tissue.... Drainage in a wound should be assessed for volume, color, consistency, and odor....Contributing factors to pressure ulcers is immobilization....The aim is to prevent, not cure by...daily skin assessment to all bony prominences....If, based on the determination of the interdisciplinary team, it is deemed that the resident is at risk for skin breakdown (even through the resident does not score as such), the resident will be considered at risk, and the reasons documented in the clinical record....Nurses should be aware that skin care is one of their responsibilities...." The only assessment on the November wound documentation sheet for R2 was completed on 11/25/08 during this surveyor's observation of care. On 10/14/08, the IDT (Interdisciplinary Team) Plan of Care Review sheet documents "a necrotic ulcer on her buttocks." On 10/20/08, a Wound/Ulcer Assessment sheet shows and un-stageable 5cm X 4 cm pressure ulcer with a large amount of necrotic tissue/eschar. The assessment shows the wound had thick purulent exudate with a foul odor. This assessment documents wound "not healing." A nursing note date 11/1/08 documents sacral wound with two areas of undermining and drainage of "copious amount of malodorous serosanguinous drainage. . ." This note shows	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145278	A. BUILDING _____ B. WING _____	C 12/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PAVILION	**105 EAST 23RD STREET STERLING, IL 61081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 31 the wound was not painful to R2, but due to some eschar tissue on the wound, the entire wound bed was unable to be fully viewed. On 11/4/08, an order was obtained to culture the sacral wound. On 11/11/08, R2 was started on Keflex 500 mg TID (three times a day) for Escherichia coli (E. coli) in the wound. The Physician Progress Note dated 11/19/08 documents "Biggest issue is (the) Pressure Ulcer (to the) left buttock . . . 5 cm deep pressure ulcer . . .some yellow drainage and tunneling . . . extends into the muscle . . . . stage 3." On 11/24/08, E11 (Registered Dietician) documents "Stage IV (4) pressure ulcer on left buttocks." Unabound Medicine 2008 "Diseases and Disorders" defines pressure ulcer staging as follows: Stage 3 = Full thickness skin loss of epidermis and dermis extends into the subcutaneous tissue; appears as crater or covered by black eschar. Wound base usually not painful; indistinct borders; may have sinus tracts or undermining present. Stage 4 = Full thickness skin loss with extensive destruction of tissue, muscle, or bone, and/or supporting structures; appears as a deep crater or is covered by thick eschar; wound base not painful, may have sinus tracts and undermining present. (A)	F9999		