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	145792	A. BUILDING _____ B. WING _____	C 04/01/2009

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WOODBRIDGE NURSING PAVILION	**2242 NORTH KEDZIE CHICAGO, IL 60647**

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F 314	Continued From page 13 policies and procedures on decubitus prevention and treatment. On 03/06/09 and 03/16/09, inservices were conducted with facility staff. Inservices included review of the alleged deficiency, review of the Facility's policies and procedures, as revised, on decubitus prevention and treatment, review of the proper assessment of pressure sores, review of the requirement that proper preventive measures are implemented, and review of requirement that physicians' orders be followed as written. Additional inservices will be conducted by an Outside Consultant beginning 04/01/09. The Director of Nursing and/or her designee will monitor for overall compliance by rounds, general supervision, and reports from nurses on a daily basis. The Director of Nursing has initiated a Quality Assurance program to monitor nurses for completion for all required documentation and measurement/treatment for skin conditions. Director of Nursing will report results of this program to the Quality Assurance Committee. Additional inservices will be conducted as necessary.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)2) 300.1210b)5)	F9999		

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F9999	Continued From page 14 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who	F9999		

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F9999	Continued From page 15 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. These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility: 1. Failed to accurately assess pressure ulcers. 2. Failed to identify, assess, and treat newly developed pressure ulcers. 3. Failed to notify physician of newly developed pressure ulcers. 4. Failed to obtain physician orders for treatment. 5. Failed to follow physician orders for treatment. 6. Failed to follow facility protocol for on-going assessment of existing wounds for 4 of 7 sampled residents (R1, R4, R5, & R7). Findings Include: 1. R4's diagnoses include dementia, resolving pneumonia, coronary artery disease, ischemic heart disease, anemia, climate arthritis, and osteoporosis. Nurses notes of 02/11/09 at 2:30p.m. state a message was left for Z5 (Physician) that an open	F9999		

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F9999	Continued From page 16 sore to R4's left fifth toe was found. At 8:30p.m. Z5 was again paged about open sore on left toe. On 02/12/09 Z5 was again notified of R4's open area to left toe Orders were obtained and carried out. Z5 ordered venous doppler to both lower extremities, normal saline cleanse, and application of Ultec every three days to left fifth toe until healed. On 02/16/09 Pressure sore and skin care weekly flow sheet was completed which shows R4 to have a discolored fifth toe (foot not specified), Stage II wounds to left outer metatarsal, blister to right inner metatarsal, something to right distal toe, and a blister to right inner foot. Assessment of 02/23/09 indicates right fifth toe now necrotic. There is no evidence physician was notified of pressure ulcers assessed on 02/16/09. There were no orders for any treatment to these areas. On 03/05/09 at 11:00a.m. R4 was observed in her room seated in a reclining chair with oxygen per nasal canula. R4 was observed to have dressings to both feet. A nurse aide stated R4 did not have socks on because her dressings needed to be changed. Surveyor requested to observe E3 provide treatment to R4. At approximately 11:15a.m. E3 began removing pillows from around R4. R4 cried out like she was in pain. E3 proceeded to remove the dressing from R4's right foot. On observation R4 had a dime size necrotic area to bunion and a small red raised area to the inner aspect of top of foot.	F9999		

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F9999	Continued From page 17 During removal of dressing R4 was crying out in pain. E3 proceeded with treatment even though R4 cried out in pain. At this point Surveyor informed E3 she must stop treatment and assess R4 for pain prior to proceeding. E2 (Director of Nurses) was also informed that R4 appeared to be in pain. On 03/05/09 a physician order was obtained to medicate R4 with Acetaminophen 650mg. rectal suppository, for pain, 30 minutes prior to treatment. At 12:30p.m. Surveyor observed E3 provide treatment to R4's left foot. During this treatment it was confirmed with E3 that she had removed this dressing earlier and re-dressed the foot. Dressing was removed and area between fourth and fifth toe was a small necrotic area. On the outer aspect of left foot were two ulcers. One measured 3cm. X 2cm. It appeared to have some necrotic areas and sloughing. E3 stated this wound was a Stage IV ulcer. The other area measured 1.5cm. X 1.5 cm. E3 stated this was a Stage III wound. E3 was asked if there had been any treatment ordered for these wounds. E3 did not respond to the question. On 03/05/09 treatment record was reviewed. The only treatment recorded as administered to R4 was cleanse left 5th toe with normal saline and apply Ultec Pro every three days until healed. R4's treatment record runs from 02/20/09 to 03/18/09. On 03/05/09 treatment was already signed as completed every three days up to 03/18/09.	F9999		

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F9999	Continued From page 18 Nurses note of 03/05/09 at 6:00p.m. state a call was placed to Z5 to verify orders for treatment to R4's wounds. Z5 ordered saline cleanse and Ultec with dressing every three days to wounds. Nurses note of 03/08/09 at 5:00p.m. states Z5 here to see R4. Order to be sent to hospital for direct admission to Med-Surg floor with diagnosis of clostridium difficile, colitis, cellulitis of left foot, and rule out osteomyelitis of left foot ulcer. At 7:20p.m. R4 was transferred to the hospital. Z5 was called on 03/05/09 at 2:07p.m. and 03/19/09 at 2:45p.m. but did not return Surveyor's call. 2. R7's diagnoses includes multiple sclerosis and renal insufficiency. R7 currently spends all time in bed. Care plan indicates that R7 is resistant to re-positioning. On 03/05/09 surveyor requested to observe treatments for R7. E3 (Treatment Nurse) proceeded to remove dressings from R7's right foot. On initial observation R7 was observed to have two areas on the foot/ankle area. The upper ulcer was approximately 1 X 1 inch and appeared superficial but skin loss was observed. The lower ulcer of right foot appeared to be approximately a 2 X 3 inch area, appeared to have full thickness skin loss, and was bleeding. Surveyor asked E3 what Stage the ulcers were. E3 stated the ulcers were Stage II. The lower ulcer appeared to be as least a Stage III to IV ulcer. R7 also had a wound to rt. heel which appeared to be red/pink, dry healing area	F9999		

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F9999	Continued From page 19 approximately 1/2 X 1/2 inch in size. E3 stated this ulcer to be a Stage II. Z4 (Physician) was interviewed on 3/05/09 at 2:40p.m. and stated he recently saw R7 and ulcers appeared almost healed with good granulation. Z4 would not state what Stage the ulcers appeared to be. On 03/19/09 facility provided the following documentation of R7's pressure ulcers: 03/06/09 rt. foot #2 (ankle area) 5.5cm. X 3cm. X 0.2cm., Stage IV. 03/06/09 rt. foot #1 0.5cm. X 0.5cm X superficial depth, Stage II. 03/06/09 rt. heel 0.5cm X 0.5cm. X 0 depth, no Stage, healing. 03/13/09 rt. foot #2 (ankle area) 5.5cm. X 5.0cm. X 0.2cm., Stage IV with drainage. 03/13/09 rt. foot #1 and rt. heel same as 03/06/09. On 03/16/09 R7's wounds were again assessed, and four wounds were identified. Assessment showed: Rt. foot, inner aspect of ankle, 4.5cm. X 4cm. X 0.2cm., Stage IV, drainage and slough. Rt. foot, below ankle, 5.5cm. X 3.5cm., Stage II. Rt. upper ankle, 5cm. X 3cm. X superficial depth, Stage II, color as beefy red.	F9999		

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F9999	Continued From page 20 Rt. heel 3cm. x 4cm. X superficial depth, Stage II, 30% granulation in center. Treatment was changed to Santyl ointment to slough area for seven days then return to Hydrogel. Weekly assessments of wounds for January 2009 were also reviewed which showed that R7 was being treated for three wounds. This assessment lists all three wounds on 01/07/09, 01/14/09, 01/20/09, & 01/28/09. Only one measurement is listed and it appears to be measurement of heel wound which is listed as a Stage II wound with slough to heel. 3. Weekly pressure sore report for 01/14/09 lists R5 as having a Stage IV pressure ulcer to sacrum. Assessment of this wound size was 2cm. X 1.5cm. X 0.5cm. depth. Tissue pink/red in appearance and no drainage noted. On 02/02/09 wound was assessed by Family Medicine Resident. Pressure ulcer was Stage IV, measured 8cm. X 8cm. with 10% slough. Wound depth was not indicated. Surveyor requested any further assessments of this wound, and none were presented. During interview E3 stated facility policy is to assess wounds weekly. On 03/05/09 Surveyor requested to observe treatment to R5's pressure ulcer. E3 was also requested to measure wound. At 12:00p.m. treatment was observed. E3 measured sacral ulcer which was 5.5cm. X 3.5cm. X 1.5 deep. E3 proceeded to cleanse wound with normal saline and packed wound with saline soaked gauze. E3 stated treatment was for wet to dry saline	F9999		

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F9999	Continued From page 21 dressing. Treatment Administration Record (TAR) was reviewed for February to March 2009 and treatment to sacrum is listed only as a daily dressing change. Physician order for treatment for this wound dated 02/20/09 to 03/19/09 was cleanse wound with normal saline, apply loosely Aquacel Silver dressing, cover and secure with DuoDerm Dressing, change every three days and as needed. E3 could not state why this ordered treatment was not listed on the TAR and was not aware of the physician order for treatment. During record review it was also noted that on 01/08/09 R5 had a physician order for DuoDerm dressing every two to three days to right ischial area. Surveyor requested assessments of this area, and none were presented. During observation on 03/05/09 right ischial area was observed to be healed. 4. R1 was re-admitted to the facility on 06/30/08. Diagnoses include diabetes mellitus, hypertension, mild dementia, and Parkinson's disease. R1 received nutrition by tube feeding only and required staff assistance for re-positioning. Comprehensive skin assessment dated 08/12/08 indicates R1 developed blister to right heel. Assessment does indicate R1 kicks off heel protectors. On 08/12/08 physician ordered Silvadene to right heel daily and as needed after normal saline cleanse. On 08/13/08 wound was assessed to be a Stage II pressure ulcer (fluid	F9999		

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F9999	Continued From page 22 filled blister) and measured 3cm. X 3cm. Treatment Administration Record (TAR) for 07/20/08 to 08/19/08 shows treatment to heel was documented as done only on 08/12/09 and 08/16/08. There is no documentation of treatment on 08/13/08, 08/14/08, 08/15/08, 08/17/08, 08/18/08, or 08/19/08. Pressure Sore and Skin Care Weekly Flow Sheet states on 08/20/08 rt. heel is now an unstageable ulcer and 100% necrotic. By 09/03/08 wound was unstageable, 100%necrotic, and measured 4cm. X 4cm. On 08/20/08 physician ordered to discontinue the Silvadene to right heel, apply dry dressing to heel, no pressure to right heel as much as possible, re-position every two hours, heel protectors daily and off at night, and arterial and venous doppler studies of lower extremities. On the TAR for 08/20/08 treatment was for dry dressing to right heel daily. Written in on this treatment is 'apply Santyl.' There is no physician order for any application of Santyl to heel. E2 was questioned regarding this writing in of a treatment which was not ordered by the physician and she stated she had no idea who would have added that treatment on the TAR. Arterial doppler of lower extremities completed on 08/21/08 showed severe arterial stenosis of both lower extremities. Venous doppler showed dampened flow in common femoral, superficial femora, and popliteal veins of both lower extremities. Nurses notes 08/23/08 state R1 has appointment	F9999		

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F9999	Continued From page 23 for a wound consultation on 08/30/08 and daughter agreed to go with resident. Nurses note of 09/05/08 state daughter, who is Power of Attorney, gave consent for surgery for a right above knee amputation on 09/08/08. Nurses note of 09/07/08 state R1 congested, sweating, skin warm, temperature 100 degrees, Tylenol given. Physician was called and ordered R1 to be transferred to hospital. R1's admission diagnosis was sepsis. (A)	F9999		