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	145942	A. BUILDING _____ B. WING _____	C 08/04/2009

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REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

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F 314	Continued From page 16 sores. 2. All high risk residents were identified, reassessed and their care plans revised. 3. The facility has developed and implemented new tracking tools for wound care. 4. Registered dietitian will evaluated identified residents. 5. The QA committee will meet weekly to discuss wound care. The DON will monitor for compliance.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)5) 300.3240a) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing	F9999		

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F9999	Continued From page 17 and determining care required and the need for further 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. Section 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 Regulations were not met as evidenced by: Based on observations, record review and interviews the facility failed to: 1) Monitor residents at risk for pressure ulcers to ensure that pressure ulcers did not develop or worsen on 4 of 5 residents (R2, R3, R4, R5). 2)Provide devices to prevent the development of pressure ulcers and reposition and turn residents every 2 hours who are dependent for bed mobility (R2, R5). 3) Provide care and services (skin checks) to residents with pressure sores to prevent the spread of infection. This failure resulted in R2, R3, R4, R5 developing	F9999		

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F9999	Continued From page 18 new pressure ulcers, and R2 requiring hospitalization for infected sacral wound which was identified during the survey. Findings include: 1. R5 was admitted to facility on 1/30/09 with diagnosis that included Diabetes Mellitus, and Chronic Renal Failure. R5 is ventilator dependent and requires total assistance from staff. On 6/26/09, R5's most recent readmission, R5 was assessed on the Braden Scale as high risk (11) for pressure sores. At the time of the readmission, R5 was readmitted with a Stage 2 to left lateral leg, stage 2 to right lateral thigh and unstageable boggy area to left heel. Review of nurses notes dated 7/12/09 at 11:35 PM, R5 had been observed with skin breakdown to left hip measuring 3 centimeters x 2 centimeters. Documentation includes the "area red with drainage, area cleansed with wet dry dressing applied and message left for physician." On 7/13/09, at 7:25 AM, an order was obtained from the physician 'to cleanse left hip with normal saline apply DuoDerm every 3 days until healed. Review of facility pressure ulcer report dated 7/17/09 denotes R5 had acquired a Stage 2 that now measured 5.5 cm x 4.3 cm x 0.2 cm. with 100 % granulation. There was no notation indicating the wound had improved or declined, or remained the same. On 7/27/09 at 10:00 AM, surveyor requested to do a wound check on R5 with E4 (treatment nurse) and E5 (staff nurse). R5 is in isolation for Methicillin Resistant Staph Aeuros of the trach. Upon entering R5's room, surveyor observed R5	F9999		

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F9999	Continued From page 19 in bed on an air flow mattress, curled up lying on his left side. There were no heel protectors or heel lifts in place. There was only a flat thin pillow propped up against the left side rail and barely touching the bony prominence of R5's knees. In preparation for the wound treatments, R5 was turned to the right side (towards the door). E5 removed the Tegaderm dressing and started cleansing the left hip pressure ulcer. R5 grimaced in pain and pulled away with his arms. Surveyor asked E4 and E5 if R5 had been medicated for pain, and both responded, "he gets his medications at 6:00 AM." E4 completed the dressing change and then stated she had found a Stage 2 wound to the left medial ankle on 7/24/09. Surveyor again prompted E4 and E5, R5 did not have heel protectors on. At 10:50 AM,12:45 PM, 1:45 PM, 2:45 PM and 3:00 PM, R5 was observed still lying in bed on his right side with no heel protectors on and no cushioning devices in place to off load R5's lower extremities. At 3:45 PM, E1 (administrator) and E2 (Director of Nursing) were observed exiting R5's room after E1 and E2 were informed of surveyor's observation during the daily status meeting. At 3:50 PM, E8 was observed entering R5's room. E8 was asked why she was entering R5's room. E8 stated to reposition R5 who was observed lying in the same position again with no preventive devices in place. Review of R5's record reveals an inconsistent order for daily/weekly skin checks for R5. E5 and E6 were asked where current daily skin checks were kept for R5. E5 and E6 stated there used to be a form in the MAR (Medication Administration	F9999		

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F9999	Continued From page 20 Record) but thry have not seen the form for awhile. E4 (treatment nurse) stated she does the weekly checks and the staff nurses are to do the daily skin checks. On 7/30/09, during the morning daily status with E1 and E2, the surveyors were informed the treatment nurse (E4) resigned on 7/28/09 and E2 would be doing the wound treatments. After the daily status meeting, E2 and surveyor went to R5's room to check on R5's positioning and preventive devices. R5 was observed lying on his right side, no heel protectors in place and again the thin pillow against the right rail barely touch between his knees. Surveyor asked to see R5's left hip wound, E2 pulled back the blanket and the left hip wound was soiled with stool. E2 stated R5 needs to be cleaned and E2 would do the dressing change. 2. R2's diagnoses includes Diabetes Mellitus and Respiratory Failure. R2 is in isolation for MRSA of the sputum. R2 is vent dependent. R2's current Minimum Data Set reveals R2 is totally dependent on staff for all activities of daily living. R2's last Braden assessment scored R2 as mild risk for pressure sores. Review of facility 7/3/09 pressure ulcer report documents R2 had acquired a Stage 2 wound to the right and left buttocks on 5/29/09. Nurses notes dated 5/29/09 denote right buttock wound as a Stage 3 measuring 6.5 cm x 9.0 cm x 0.4 cm, left buttock as Stage 2 measuring 1 .5 cm. x 1. 0 cm x 0.2 cm. R2 was admitted to facility with ischemic wounds to both heels. On 7/27/09 at 10:50 AM, prior to wound	F9999		

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treatments with E4 (treatment nurse) and E9 (CNA), surveyor observed R2 lying on her back and not wearing heel protectors. R2 is alert and able to mouth her needs and concerns. E9 was asked whether he had done AM care on R2. E9 stated he did her care at 8:00 AM. R2 was turned on her right side by E9 and E4 and surveyor observed R2's underpad and buttocks soiled with feces. The DuoDerm was dated 7/24/09. R2 has an order to cleanse sacral wound with normal saline then apply DuoDerm every 3 days. When E4 removed the Tegaderm from R2's sacral area, a very foul odor was noted. Large amount of yellow slough was noted to the sacral wound. Surveyor observed an open area to the left buttock and asked E4 if it was new. E4 stated it looked like a skin tear.

At 12:45 PM, surveyor returned to interview R2. R2 was observed lying on her back. Surveyor asked R2 if she was turned every 2 hours or gotten up out of bed to sit in her chair. R2 responded no, not too often. R2 was asked if she would like to get up and R2 responded yes. R2 was then asked whether the CNA (E9) had given her AM care and R2 shook her head no. R2 was observed at 2:45 PM and 3 :50 PM still on her back.

E6 (LPN) stated on 7/27/09, R2 often refuses to get up out of bed. R2 stated this was documented by her anytime R2 refused. No documentation was provided by E6.

Review of daily skin checks which were ordered for R2 in May 2009, document R2's skin was intact with old wounds on 5/23/09 through 5/28/09. On 5/29/09 documentation denoted the skin was intact with new wounds. The wound

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F9999	Continued From page 22 was assessed in nurses notes on 5/29/09 as a Stage 3 to the right buttock and stage 2 to the left. R2's physician was notified on 7/27/09 by treatment nurse (E4) and R2 was sent to hospital to rule out sacral wound infection. Review of hospital records obtained on 7/30/09 denote R2 was admitted for sepsis, pneumonia, urinary tract infection. Wound culture results dated 7/31/09 reveal R2 was positive for 4 different organisms to the sacral wound that included: proteus mirabilis-heavy, citrobacter amalonaticus-few, escherichia coli-few, and enterococcus raffinosus-moderate. 3. R3 was originally admitted to the facility on 4-23 09 with diagnoses of acute respiratory failure, brain injury, paraplegia, sepsis, gun shot wound and lobectomy. The Wound Care Admission Assessment Worksheet, dated 4-23-09, indicated that R3 had the following pressure sores when admitted: Left foot, great toe----Stage lll Left foot, lateral (prox)--Stage ll Left foot, lateral (distal)--Stage ll Left lateral ankle----Stage lll Lower back---Stage lV Left heel---Stage lV Rt. heel----Stage lV Lt. hip----Stage Stage lV Lt. ear----Stage lll The facility Pressure Ulcer Report showed that R3 acquired the following ulcers on 5-05 and 5-25-09: Left knee---Stage lll Left thigh---Stage lll	F9999		

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F9999	Continued From page 23 Right medial lower leg---Stage ll The most recent Pressure Ulcer Report dated 7-17-09 showed the stages of R3's pressure ulcers: Sacral -- Stage lV Left hip-Stage lV Left heel-Stage lV Rt. heel- Stage lV Lt. knee-Stage lV Rt. lower leg- Stage lV Lt. thigh- Stage lll Lt. lateral ankle- Stage ll On 7-26-09, R3 was sent to the hospital and was diagnosed with Sepsis and Urinary tract Infection. The hospital Patient Assessment Form dated 7-29-09 identified the following pressure ulcers on R3 when admitted. The list of pressure ulcers had increased from eight to 13 sites and were listed as follows: Lt. leg # 1----Stage lll Lt. leg #2-----Stage lll Lt. leg below knee---Stage lll Lt. foot #1----Stage ll Lt. foot #2----Stage ll Rt. medial leg--Stage lV Rt. leg------Stage ll Lt. heel-----Stage lll Rt. heel---Stage lV Lt. hip-----Stage lV Rt. ankle---Stage ll Sacral, medial----Stage lV Coccyx, medial---Stage lll Review of the POS (Physician Order Sheet) showed the following orders for pressure ulcer management on R3: Turn and reposition every two hours; heel protectors while in bed; air loss	F9999		

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mattress; skin protectant to buttocks; skin check daily (changed to skin check weekly on 7-02-09). Record review showed that there was no records to indicate that daily skin checks were done for the month of July, 2009. Moreover, no heel protectors were applied on R3 while in bed as observed on 7-23-09 at 11:15 A.M.

The increase in the number of pressure ulcers acquired by R3 demonstrated that the facility failed to provide the necessary care, prevention and treatment so that R3 did not develop more pressure ulcers. In just seven days R3 developed five more pressure ulcers as a result of this failure.

4. R4 was admitted to the facility on 5-12-09 with diagnoses of diabetes Type ll, dementia with behavioral disturbance, hypertension, CVA and respiratory dependence. The Wound Care Admission Assessment dated 5-13-09 listed the following sites and stages of the pressure ulcers on R4 when admitted:

Rt. hip---unstageable (length = 0.8 cm., width= 0.8, depth = undermining)
Lower back----Stage lV (4.5 x 3.0 x 1.7 cms.)
Lt. foot, 5th. base---unstageable (2.2 x 1.9 cms. Depth = undermining)
Lt. heel----unstageable (4.0 x 5.5 cms. Depth = undermining)
Rt. heel----unstageable (4.0 x 5.5 cms. Depth = undermining)

On 6-8-09, R4 was observed with a re-opened pressure ulcer, Stage lll on the left hip measuring 6.6 x 2.6 x 0.4 cm.

On 6-22-09, according to facility documentation

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F9999	Continued From page 25 and Patient Transfer Form, R4 was sent to the hospital and was admitted with pneumonia, sepsis and hypertension. On 7-7-09, R4 acquired a new pressure ulcer on the Rt. hip, Stage ll measuring 5.5 x 5.7 x 0.2 cm. This is not the same pressure ulcer with which R4 was admitted on 5-13-09. Review of the POS showed orders for: Weekly skin check to body; elevate bilateral heels while in bed; skin protectant to buttocks per each incontinent episode; turn every two hours. Chart review did not show that a weekly skin check was done for the month of July. R4 is another example of the facility's failure in providing the necessary services to the residents in order to prevent new sores from developing. Review of facility wound care policy requires: - residents admitted with wounds of any origin will be deemed high risk and will have a body check done by staff daily during care and any skin change conditions will be relayed to the nurse for follow up with the wound care nurse. -A resident that scores at high risk will have a skin check performed daily by a licensed nurse and all new sites identified on the daily skin check sheet. -All residents with pressure ulcers who are dependent for bed mobility will be turned and repositioned every 2 hours. -A resident with healed wounds will be deemed at high risk for development of wounds for 6 months after the wounds are healed. (A)	F9999		