STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G116	A. BUILDING _____ B. WING _____	C 11/13/2009

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W 340	Continued From page 21 standing position, for a couple minutes 2-3 times per day, but that otherwise she sits in the wheelchair, and requires it for mobility. R2's IHP at the day program site lacked specific objectives or guidelines for direct care staff to follow for pressure ulcer prevention. E4, Facility Trainer / RN, was interviewed on 10/29/09, at 3 PM. She stated she did not train staff re: pressure ulcer prevention for R2 and that it would be the responsibility of the nurses assigned to the home, E4 or E5. E5, Director of Nursing, was interviewed on 10/29/09, at approximately 2:30 PM. She stated that she did not provide direct care staff with pressure ulcer training specific to R2, but that she tells staff to get R2 out of the wheelchair when she comes home from the day program. E4, RN, was interviewed on 10/29/09, at 1:50 PM. He stated that he did not train staff regarding pressure ulcer prevention for R2. He confirmed that there were no ulcer prevention health care objectives for R2. R2 was admitted to the hospital on 10/8/09, with a Stage III (full thickness tissue loss) pressure ulcer to her sacrum and ulceration to her right upper thigh.	W 340		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1210b)6)	W9999		

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W9999	Continued From page 22 350.1210c) 350.1210d)1)2) 350.1420a) 350.3240a) 350.3750 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. 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. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. 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.	W9999		

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W9999	Continued From page 23 2) Basic skills required to meet the health needs and problems of the residents. Section 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time. 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) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse	W9999		

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W9999	Continued From page 24 shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one of one resident (R2) in the sample, who has a history of pressure ulcers and is unable to reposition herself, received adequate health care and monitoring, when they failed to: 1) Implement nursing procedures for the treatment and prevention of skin breakdown, including ongoing review and assessment. 2) Obtain a physician's order for medical treatment, which was recommended by nursing and delivered by direct care staff, to a pressure ulcer on R2's buttocks. 3) Ensure that nursing was notified of R2's right thigh "sore" initially documented by the day training site on 8/13, and for R2's buttocks "sore" initially documented by the home direct care staff on 8/4, 10/5, 10/7 and 10/8/09. 4) Develop and update a nursing plan of care for R2's recurrent pressure ulcers. Findings include: Facility policy titled, "Health Services Coordinator [RN] revised 7/06" requires, "Monitors record of clients to insure that files are current and appropriate follow up being implemented." "Records significant medical updates for all	W9999		

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W9999	Continued From page 25 clients' Individual Habilitation Programs." "Provides consultation to staff on health-related issues." "Monitors and updates...medical treatment plans." "Participates as a member of the Interdisciplinary Team at annual staffing." "Documents review of resident's health record and other pertinent health information in resident records." The facility policy titled "Nurse Notification", not dated, requires, "The Health Services Coordinator (RN) is to be notified by phone for the following: Resident illnesses / injury, both emergency and non-emergency. The Health Services Coordinator will document his or her findings and instructions in the integrated progress notes." 1) According to the Individual Habilitation Plan (IHP), dated 11/7/08; R2 is a 54 yr. old with diagnoses of Profound Mental Retardation, Down Syndrome, Diabetes, and Parkinson's Disease. She requires a wheelchair for mobility and is unable to shift her weight, but can take steps with staff assistance. She requires full assistance for activities of daily living. Physician notes, dated from 6/13/08 to 2/18/09, document that R2 was receiving multiple treatments for a sacral ulcer during that 8 month time period. The physician's progress notes were documented weekly to monthly during this time. A physician note, dated 10/1/08, identified that Z1, the contracted Wound Care Nurse, had started seeing the resident weekly, for wound care. The record lacked documentation from Z1, including her assessments of, and	W9999		

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W9999	Continued From page 26 recommendations for, R2's sacral ulcer. Z1's notes were faxed to this surveyor from Z1's wound care office, on 11/3/09. According to these notes, R2 was first seen by the Z1 on 9/22/08, for 3 ulcers on her sacral area. On 10/3/08, Z1 documented that only 2 ulcers remained, however on 11/3/08 she documented that there were 2 new wounds. On 1/6/09, Z1 documented, "Patient has a new wound present on right coccyx that was not present last visit." On 1/15/09, Z1 documented that, "all pressure ulcers healed. Present facility will continue to monitor." Throughout this 8 month time period there is no evidence that the facility nursing staff assessed and monitored the progress of the treatment being provided weekly by Z1, and daily by the facility's direct care staff. The facility's monthly nursing notes, dated 6/08 through 11/08 and 1/09, mentioned that R2 had a decubitus ulcer, but did not include a description, or progression, of the wound. The 12/08 monthly note lacked documentation that R2 had a wound, even though she was receiving pressure ulcer treatment at that time. The facility's quarterly nurses' notes, dated 7/22/08, 10/30/08 and 1/22/09 lacked documentation of R2's ulcer and under the Integumentary (skin) section of these reviews, stated that there were "no abnormal lesions." This was during the same time that the physician was prescribing treatment for R2's pressure ulcer. The physician's annual history and physical,	W9999		

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W9999	Continued From page 27 dated 4/2/09, lacked documentation of R2's pressure sore. The record lacked a RN's initial and final assessment of the wound, along with continued monitoring including detailed descriptions such as measurements, from the time the wound was identified by the physician on 6/13/08, to the date the physician documented the wound was healed on 2/18/09. The record lacked nursing's follow up monitoring of the affected area. E4 (RN) was interviewed on 11/3/09, at 9:50 AM. He confirmed the above findings and stated that he started working at this facility 11/08. He stated that the doctor was monitoring the wound and had arranged for Z1 to treat and monitor R2's sacral pressure sore on a weekly basis. E4 stated that the direct care staff were administering the treatments as suggested by the doctor, but that the facility nursing staff was not involved in the care nor the monitoring of R2's wound. 2) A progress note, dated 8/4/09 and written by E3 (Residential Service Director) (RSD) states, "The morning staff had documented that R2 has a sore on her buttocks. When R2 returned from workshop, I checked the area but I didn't see a sore. I asked the staff did they see a sore on R2's buttocks, but no one did. Therefore, the nurse and doctor didn't have to be notified at this time." E3's note, dated 8/7/09, stated that she followed up with staff and they stated they did not see a sore, however the direct care staff's documentation on the daily observation sheet,	W9999		

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W9999	Continued From page 28 dated 8/4/09, stated, "R2 has a sore on buttocks." 3) Another progress note, written and dated 8/13/09 by E3, stated, "At workshop the case manager pulled down R2's underpants and [illegible] the skin off her upper right thigh area." "The sore on R2's upper right thigh is a very small sore." The record lacked further documentation of the thigh wound. The record lacked evidence that either nursing, or the physician, was notified. E3 was interviewed on 11/3/09, at 10:00 AM. She confirmed the above findings for 8/4 and 8/13/09. She stated that she did not call the nurse or physician for the "sore" documented by direct care staff on 8/4/09 because she did not see a wound when she examined the resident. E3 stated that she could not remember if the nurse was called for the thigh wound seen on 8/14/09. The direct staffs' daily observation sheets, dated 10/5, 10/7 and 10/8 documented that R2 "still has a sore on her buttocks." The record lacked documentation that either E3, or the nurse, was notified. E6, Program Aid, who had documented the "sore observation" on a sheet dated 10/8/09, was interviewed on 11/3/09, at 9:15 AM. She said that she did not notify anyone because ointment was still being applied as directed by the nurse on 9/1/09, and that the nurse had already been notified at that time. E3 was interviewed on 11/3/09, at 10:00 AM, and confirmed the above observation sheet findings.	W9999		

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W9999	Continued From page 29 She stated that the staff did not notify her of the sore on 10/5, 10/7 or 10/8/09. The nurses' monthly reviews, dated 8/09, 9/21/09 and 10/2/09 lacked documentation of the status of R2's skin. The quarterly nurse's physical examination report, dated 10/2/09, lacked documentation of any pressure sore problems for R2 and stated under "Integumentary [Skin]: abnormal lesions - none." E4, RN, was interviewed on 10/29/09, at 1:50 PM. He stated that the nurse is responsible for reviewing the progress notes when assessing a resident and when writing monthly or quarterly notes. He said he was aware of R2's history of pressure sores, but that on 10/2/09, 6 days before she was hospitalized with pressure sores, her skin was clear. 4) E3 was asked if measures had been put into place to prevent and monitor R2 for the development of any future pressure sores, since she was at risk. She provided a physician's progress note, written on 6/13/08, which stated, "Right buttocks wound. Size quarter. Erythematous (red surrounding area). Some drainage - Pus. Decubitus ulcer: Apply dressings twice per day. Change sitting position every 30 minutes. Keep area clean. No nylon panties or diapers on for now. Keflex (antibiotics) x 7 days". The physicians's order that R2's sitting position be changed every 30 minutes, was noted on the monthly physicians's order sheets, dated 7/08 through 10/09. E3 documented the physician's instructions in	W9999		

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W9999	Continued From page 30 the communication log for the direct care staff to follow, on 6/13/08. There was no further evidence of these instructions in R2's record, nor was there documentation that these orders were being carried out. E3 said during the interview on 11/3/09 at 10 AM, that she instructed staff to turn R2 every 2 hours at night, but there is no evidence of the training or that the position changes were being implemented. R2' annual Individual Habilitation Plan (IHP), dated 11/7/08 and the semi-annual plan, dated 5/31/09 lacked an objective, or any type of specific guidelines, for pressure ulcer prevention. This was confirmed by E3 during the interview on 11/3/09, at 10 AM and by the E1, Director of Habilitation Services on 10/29/09, at 3:30 PM. E10, E11 and E12, Training Counselors at R2's day program stated during their interviews on 11/4/09, between 9:00 to 9:45 AM, that they had not received training regarding a repositioning schedule for R2. E12 said she has worked with R2 for approximately 3 years and that R2 is usually repositioned 2-3 times per day. She is assisted from her wheelchair to a standing position for a couple minutes, but otherwise she sits in the wheelchair. E12 said that R2 is at the day program site approximately 5 hours per day, excluding bus transportation time. R2's IHP at the day program lacked specific objectives or guidelines for day training site to follow for pressure ulcer prevention. E9, Facility Trainer / RN, was interviewed on 10/29/09, at 3 PM. She stated she did not train staff re: pressure ulcer prevention for R2 and that it would be the responsibility of the nurses	W9999		

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W9999	Continued From page 31 assigned to the home, E4 or E5. E5, Director of Nursing, was interviewed on 10/29/09, at approximately 2:30 PM. She stated that she did not provide the home or the day training site with pressure ulcer training specific to R2. She said that she tells staff to get R2 out of the wheelchair when she comes home from the day program. E4, RN, was interviewed on 10/29/09, at 1:50 PM. He stated that he did not train staff regarding pressure ulcer prevention for R2. He confirmed that there were no ulcer prevention health care objectives for R2. The facility was unable to produce evidence that nursing monitored R2's skin, focusing on the high risk areas, including ongoing assessments and follow up, along with implementation of preventative measures. On 11/4/09 at 12:00 PM, E3, was asked if the facility had any type of policy or procedure for monitoring alterations in skin integrity, such as pressure sores. She stated there is not. On 11/4/09 at approximately 1 PM, E4 stated that the Director of Nursing is not available for an interview. He said that he is not aware of a policy or procedure specific for the care of skin alterations. 5) On 9/1/09, a progress note written by the E3 (RSD) stated, "Workshop documented on the log-book that the ulcer which was at the top of R2's buttocks, appeared to be re-opened...The nurse, E5, was informed. She instructed staff to	W9999		

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W9999	Continued From page 32 apply triple antibiotic ointment to the area and apply gauze. Continue to monitor." On 9/5/09 E3 documented, "Staff cleaned and applied ointment to the buttock area. The nurse, E5, will be out tomorrow for an assessment..." The record lacked nurses' notes regarding this wound. The record lacked a physician's order for the treatment recommended by E5. The record lacked documentation on the Medication Administration Records of the daily wound treatment being provided by the direct care staff. E3 confirmed the above findings on 11/4/09, at 12:00 PM. E5 (RN / Director of Nursing) was interviewed by phone on 10/29/09, at approximately 2:30 PM. She stated that she did see the resident's wound, but her progress notes were in her office, at another building. These notes were faxed to this surveyor by E5, on 11/3/09. According to the notes, E5 did not see this wound until 9/6/09, 5 days after she was notified, when she wrote, "The sore has healed up. Will continue to monitor." The notes lacked a description of the wound. The record lacked evidence that this affected area was being monitored by nursing. E4 (RN) was interviewed on 11/4/09, at 2:00 PM. He stated that the antibiotic ointment, which E5 had directed the staff to use daily on R2's open sacral wound, is a medication in the First Aid kit and can be used as needed. However, he confirmed that there is not a written standing physician's order, or a protocol, for the use of antibiotic ointment, specifically to treat a sacral pressure ulcer.	W9999		

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W9999	Continued From page 33 E4 called back at 2:30 PM and said the physician had given E5 a verbal order for the use of the ointment for R2's wound, however he had no documentation of this order. E4's progress note, dated 10/8/09, stated that direct care staff reported to him that R2 had a high blood sugar reading of 350, a fever of 100.7 and was "shaking." R2 was sent to the hospital Emergency Room on 10/8/09 at 3:30 PM. The hospital emergency record, dated 10/8/09 at 5:44 PM, documented that R2 was admitted with Pneumonia, Sepsis (infection in the blood) and Decubitus (pressure ulcer). The hospital nurse's note from 10/9/09 at 2:00 AM stated, "Patient placed in Contact Isolation for open wound. Dressing done at sacral area, noted to have Stage III decubitus ulcer. Noted right groin skin tear." The hospital physician's admitting history and physical stated that R2 had an ulcer over the buttocks, along with ulceration on the right upper posterior thigh. (A)	W9999		