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WHITE HALL NURSING & REHAB CENTER	**620 WEST BRIDGEPORT WHITE HALL, IL 62092**

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F 441	Continued From page 27	F 441		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)2) 300.1210b)5) 300.1220b)3) 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: 2) All treatments and procedures shall be administered as ordered by the physician	F9999		

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F9999	Continued From page 28 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 300.1220 Supervision of Nursing Services 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. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. 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. The plan shall be reviewed at least every three months. 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 Requirements were not met as evidenced	F9999		

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F9999	Continued From page 29 by: Based on observation, interview and record review, the facility failed to assess, monitor, treat and implement the comprehensive plan of care for pressure sores for 3 of 4 sampled residents, R1, R2, R15. These failures resulted in R1 developing a stage 2 pressure sore with Methicillin Resistant Staff Aureus. R2 developed a stage 2 pressure sore which the facility failed to identify until it was infected and deteriorated to an unstageable pressure sore, and R2 developed Sepsis. R2 died with cause of death documented as Septicemia, Left Leg Wound, and advanced Debility. Findings include: 1. R2's Minimum Data Set, MDS, of 9-4-09 shows no cognitive impairment. The MDS identifies R2 as requiring extensive assistance of 2 for transfer and bed mobility. R2's INTERDISCIPLINARY CARE PLAN TEAM note of 9-10-09 states R2's Skin Risk Assessment is "Low." ASSESSMENT OF PRESSURE ULCER RISK of 10-9-09 shows R2 is at risk for developing pressure sores. WEEKLY SKIN ASSESSMENTS dated: 5-18-09 and 5-25-09 show a blister on the left foot from shoe and states no pressure sores. 6-1-09 through 6-29-09 show open lesion/sore spot on left heel and No Pressure Ulcer. 7-13-09 through 7-27-09 shows an open lesion/sore spot on the left heel. 9-21-09 and 9-28-09 identify an abrasion on the left heel with note on 9-28 stating heel	F9999		

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F9999	Continued From page 30	F9999		

scabbed over

9-7-09 and 9-14-09 does not mention the left heel

10-5-09 shows under "Open Lesions/Sore Spots" post left calf area nickel size -- yellow moist center. "No" is marked for pressure ulcer.

10-26-09 documents healing left calf and "No" pressure ulcer.

11-2-09 identifies an open lesion/sore spots to left lower outer leg and left heel. and no pressure sores marked.

August 2009 is not in R2's medical record. This was confirmed by E2 on 1-21-10 per faxed statement.

R2 had a Physician order dated 9-30-09 to apply safe gel and dry dressing to left posterior calf daily until healed and to culture drainage from Left calf.

Physician Order Sheet, POS, shows R2 has an order of 10-10-09 to Add Levaquin 500 mg daily for 10 days, Diagnosis: Infection of the left lower leg.

POS of 10-6-09 also shows an order to R2's left outer heel for Santyl and Triple Antibiotic Ointment to left outer heel until healed.

POS shows an order of 10-18-09 to reculture left calf on Monday.

POS shows an order on 10-20-09 to start Vitamin C 500mg twice a day and a multi Vitamin with Mineral daily for wound healing.

POS shows order to give Prostat AW 30 ml three times a day.

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F9999	Continued From page 31 POS shows an order of 10-28-09 for Ceftin 500 mg twice a day for 10 days for wound infection and an order for Levaquin 500 mg for 10 days for left leg wound. POS order of 10-29-09 shows a change of treatment to the left posterior calf to Santyl daily. due to 2nd degree wound on leg. The facility's October 2009 TREATMENT RECORD for R2 shows R2's treatment for October 1 thru 6 was Santyl and TAO to the left outer heel and treatment of Safe gel and dry dressing to open area on the left heel from October 7 thru October 31. (This conflicts with the Physician Orders.) The Treatment Record shows a change in treatment to R2's left calf to on 10-29-09 from Safe gel and dry dressing daily to Santyl daily. Treatment records show documentation that the facility continued the Safe Gel treatment through to 10-31-2009 and also did treatment of Santyl on 10-30-09 and twice on 10-31-09. November 2009 Treatment Records show no treatments were documented as being done on 11-1-09. R2's Care Plan of 3-9-09 states R2 has potential for skin breakdown due to decreased mobility. No skin breakdown noted at this time. The following notes were written on R2's Care Plan: 9-30-09 - Safe gel and dressing daily to left calf. Culture drainage of left calf. (There is nothing on the Care Plan identifying any pressure sores or wounds prior to this note.) 10-5-09 - Stage 2 Left posterior calf 2.0 x 1.5 x 0.1. Levaquin 500 mg by mouth for 10 days. Safe gel and dressing to left heel, Multipodus boot to left foot. Float heels.	F9999		

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F9999	Continued From page 32 10-12-09 - Stage 2 Left posterior Calf 1.8 x 0.8 x 0.2, Stage 2 Left heel 1.0 x 1.6 x 0.2. 10-19-09 - Stage 2 Left post calf 2.0 x 1.5 x.0.2 and stage 2 left heel 1.6 x 1.0 x 0.1. 10-26-09 - UP (Unstageable Purple) left posterior calf 3.0 x 2.3 x ?. Stage 2 Left heel 1.5 x 1.6 x 0.2 10-28-09 - Wound infection. Ceftin 500mg twice a day for 10 days. The Care Plan shows a decline in both pressure sores but no change in treatment to the heel or the Left Calf.]Weekly Facility Skin Record shows from 9-30-09 thru 10 -21-09 the treatment for the pressure sores on the heel and calf remained Safe Gel even though the Physician ordered Santyl and TAO on 10-6-09 to the heel and the pressure sore on the calf was increasing in size and deteriorating. The treatment for the pressure sore on the left calf was not changed even though it had declined from a stage 2 pressure sore measuring 2.0 cm x 1.5 cm x 0.1 cm to a "unstageable purple" pressure sore measuring "3.0 x 2.3 x ?." Laboratory Report of Culture of R2's left calf wound of 9-30-09 showed a heavy growth of Morganella Morganii. Laboratory Report of Culture of the wound on 10-19-09 showed a heavy growth of Escherichia coli and heavy growth of Acinetobacter. POS shows an order for Ceftin 500 mg twice a day for 10 days was not ordered until 10-28-09. POS shows the Ceftin was ordered for wound infection. POS shows an order for Levaquin 500 mg daily for 10 days for left leg wound yet both cultures of 10-19-09 show the organism's to be resistant to Levofloxacin.	F9999		

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F9999	Continued From page 33 R2's SKIN CONDITION FORM for 7/1/09 show a Blister on the left heel measuring 2.0 cm x 1.0 cm purple blister soft and intact. Interventions show float heels, skin prep and multipodus boot. The WOUND EVALUATION FORM of 10-7-09 identifies a stage 2 pressure ulcer to the left posterior calf measuring 1.8 x .8 x 0.2 cm depth with moderate purulent drainage. The WOUND EVALUATION FORM of 10-14-09 shows it is bland with no assessment of R2's pressure sore on the calf. The next assessment on the FORM is on 10-21-09 that identifies a stage 3/4 pressure sore that has increased in size to 3.0 x 2.3 x ? depth. Moderate amount of purulent drainage with eschar. No improvement. 10-28-09 WOUND EVALUATION FORM documentation shows pressure sore has increased to 4.0 x 3.4 x ? depth. The space for stage of the pressure sore is left blank. Odor is marked and a note is written "area dark purple tissue with moderate amount of drainage with foul odor and increasing in size. (This conflicts with WEEKLY SKIN ASSESSMENT of 10-26-09 that states, "healing left calf". There is a SKIN CONDITION FORM in R2's medical record with his name on it that is not dated. There is no description as to what type of wound, where it is located or description of the wound. The only documentation on the form is measurements of a wound of 2.0 x 1.5 x 0.1 in depth During a telephone conference with E1, Administrator, E2, Director of Nursing, and E13, Consultant Nurse, on 1-7-10, all three stated the cause of the pressure sore on R2's calf was	F9999		

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F9999	Continued From page 34 believed to be caused by the multi podis boot he was wearing for heel protection. The pressure sore developed from pressure from the boot. There is nothing in R2's Nurses Notes concerning R2's left calf pressure sore until 9-30-09 stating a new order was received to culture drainage from the left posterior calf and a new order received to apply safegel and dry dressing to area on left posterior calf daily. Nurses Note of 10-7-09 at 10:05AM, states, "Late Entry for Tuesday evening shift resident was co/o (complain of pain) pain @900pm ask me to look at his left foot because that was where it was hurting so i took off his sock and found a 2 cm diameter decub on his left outer heel i called the on call dr for ... and he told me to use whatever in house tx that we usually use and gave me an order for pain vicodin 5/500 two tabs Q 6HRS PRN (as needed) for pain i applied santyl and a TAO, triple antibiotic ointment, and gave him 2 vicodin 5/500 At 9:45pm told the midnight CNA to make sure to float his heel all night and to keep them off the bed." Nurses Note of 10-30-09 at 8:06AM states, "Late Entry:0600...Foul oder from leg wound res remains alert." Nurses Note of 10-31-09 at 10:10PM states R2's leg has very strong odor. Weekly Skin Meeting note of 10-19-09 states: Stage 2 to left posterior calf and left heel. Treatment is safe gel. Areas have not improved. Increase in size. Multipodis boots. Heels floated Treatment will be changed...(POS, shows R2 has an order of 10-10-09 for Santyl and Triple Antibiotic Ointment to R2's left outer heel. POS shows treatment to the left outer calf was not	F9999		

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F9999	Continued From page 35 changed until 10-29-09. Ten days later.) Weekly Skin Meeting note of 11-2-09 states stage 2 of left heel. Safe gel is the treatment. Area has improved. Last pain assessment was 10-13-09. On Morphine Sulfate A 2 hours. Unstageable purple to left posterior calf. Area is not improved. Treatment is Santyl. Panacea Mattress. Turned and repositioned every 2 hours. Is going on Hospice today. Heels floated. Multipodis boots on. Nurses Notes of 11-4-09 at 4:02 PM show that R2 died. Z1, R2's Physician, stated during interview on 1-8-10 at 2:50PM, R2's cause of death was Sepsis of infected wound to the leg. R2's Medical Certificate of Death dated 11-4-09 identified cause of death as Septicemia, Left Leg Wound and Advanced Debility. 2. R1's Physician Order Sheet, POS, of 12/09, shows a diagnosis, in part, Cortical Basal Degenerative Disorder, MRSA of the urine and MRSA of the right ear and a history of Sepsis. R1 has an order of 12-14-09 to cleanse area of right outer ear with normal saline solution and apply TAO, Triple Antibiotic Ointment, daily. R1 has an order of 12-28-09 to obtain culture of the right ear open area and an order on 1-2-10 for Tetracycline 500 mg BID, twice a day, for 10 days for MRSA of the right ear. Laboratory culture of the right ear dated 12-29-09 shows a heavy growth of MRSA and a heavy growth of Enterobacter Cloacae.	F9999		

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F9999	Continued From page 36 R1's WEEKLY SKIN ASSESSMENT dated 12-11-09 identifies R1 as having an open small sore spot on the right outer ear. On 1-20-10 at 12:40PM, E13 stated she had talked to the nurse who originally identified the sore on R1's ear. The nurse, E16, told E13 the sore on R1's ear appeared to be a pressure sore and that E16 had incorrectly dated the skin check as 12/11/09, it should have been 12/14/09. There is nothing in R1's Nurses Notes addressing the open sore/pressure sore on R1's right ear until 12-29-09 stating, "...noticed draining from area on right ear...got order for culture of area. R1's SKIN CONDITION FORM does not identify the pressure sore on R1's right ear until 12-16-09. The assessment identifies R1 as having a scratch to the right outer ear measuring 0.4 cm in length x 0.2cm in width x 0.1 cm in depth with small amount of serosanguinous drainage, with no redness noted. Note of 12-23-09 shows an increase in size to 1.0 cm in length, 0.4 cm in width and 0.1 cm in depth. "Area remains scratched with some scabbing noted." There is no description of the periwound. Note of 12-30-09 shows length of 1.2 cm x 0.4 cm and depth - (line marked for depth). "Area is increased in size, has small amount of serous drng." Again there is no assessment of the Periwound in the space provided on the form. Facility SKIN RECORD tracking forms for Wounds and Pressure Sores for the week of 12-14-09, 12-23-09, and 12-30-09 does not identify R1 as having any wounds or pressure sores.	F9999		

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F9999	Continued From page 37 During tour of the facility on 1-5-09 at 10:55AM, E11, Licensed Practical Nurse, LPN, identified R1 as having MRSA of the right ear. R1 was observed on 1-5-10 at 11:15AM, to be up in a reclining geriatric chair in the Dining Room/Activity Area in the back hall of the facility. R1's head was turned to the right and his ear was lying directly on the back of the geriatric recliner. R1 stated he had been up since 5:30AM. He stated he had a sore on his ear. R1 was asked to turn his head to the left and he stated he was unable. E5, Certified Nurse Aide, CNA, was asked to turn R1's head and when she turned his head to the left, it was noted that R1 did not have a dressing on his wound to the right ear and his hair was matted into the wound and his entire ear was reddish purple. E5, CNA, confirmed the matted hair into the wound and stated she did not want to take it out and would tell the nurse. At 12:00PM, E1, Administrator, and E15, Company Vice President, were informed of concerns that R1 had been up in the reclining geriatric chair, his head was turned to the right and lying against the back of the reclining geriatric chair, with hair matted in the wound and there was no dressing. E6, E7 and E14, CNA's were interviewed on 1-5-10 between 12:30 and 12:40PM. All three CNA's stated they were the CNA's on R1's hall. E6 stated that she and E14 got R1 up sometime after 6:00AM and she had not repositioned him since. E7 stated she had not given any care to R1 that day. E14 confirmed she helped get R1 up stating it was almost 7:00AM. E14 stated R1 had not been moved or repositioned since then. (This would indicate R1 had been up in the geriatric reclining chair for over 4 hours without being repositioned.) At	F9999		

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F9999	Continued From page 38 1:18PM, R1 was observed to be in bed but still did not have a treatment to his right ear. At 12:50PM on 1-5-10, E4, Licensed Practical Nurse/Treatment Nurse, stated she got a treatment order on 12-14-09 for a scratch on R1's right ear. (SKIN CONDITION FORM shows no assessment until 12-16-09.) E4 stated on some days R1 is capable of moving his head and some days he cannot. He gets stiff. E4 stated R1's hair also was matted to the wound the day before. E4 stated it concerned her that R1 was up so long in his geriatric reclining chair and stated he should be repositioned every 2 hours. E4 agreed the sore on the right ear had declined. E4 confirmed the facility was not providing any type of pressure relieving device for R1's ear. E4 stated it concerned her that R1 has MRSA of the sore on the right ear and it is not covered and pressing directly against the back of the reclining geriatric chair. E4 stated she got a Physician Order for a dry dressing to the ear but could not find the order. At 1:18PM, R1 was observed to still have no dressing on his ear and E4 confirmed she had not yet treated R1's ear. R1 was in bed and the back of his geriatric chair was soiled with dried debris where his head would lay. At 1:30PM, E4 brought in supplies to do the treatment on R1's ear. E8, CNA assisted with the treatment. R1 had dried brownish drainage on his pillow case by his right ear approximately 3 inches by 5 inches. E4 confirmed the drainage. E4 measured R1 sore at 1.1 cm x .4 cm x .2cm depth. On 1-7-10, E1, Director of Nursing, stated E13, Consultant Nurse, had assessed R1's ear and identified the sore to be a stage 2 pressure sore.	F9999		

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F9999	Continued From page 39 On 1-8-10, at 2:50PM, Z1, R1's Physician, stated he would have expected the staff to cover R1's ear since he had drainage and MRSA. It is standard nursing practice. Z1 stated the facility had called yesterday for an order to cover the ear. Z1 stated R1 had a significant neurological disease but is also manipulative. He had seen R1 move his head and had it in his notes of 12-20-09 that R1 stated he could not voluntarily move his head but when Z1 was in another room he saw R1 move his head. Z1 stated he ordered on 1-6-10 to move R1 across the hall where he has to turn his head to the left to see out of the room. R1 likes to look out the door and hopefully it will encourage him to move his head to the left. On 1-20-10, R1 was in a different room on the other side of the hall where he would have to face left to look out the room. R1 was observed to have his head turned to the right facing the window. When asked if he could turn his head to the left, E5, CNA stated she would have to turn his head for him. He is unable to turn his head. R1 was observed to have a pressure relieving foam ring under his ear and did not have a dressing on the ear. R1's Care Plan of 10-9-09 identifies R1 as having potential for skin breakdown due to decreased mobility. He has no skin breakdown noted upon admission. There was nothing on the Care Plan identifying R1's sore on the right ear or pressure relieving interventions for the ear until 1-5-10, when E4 was observed to add to R1's Care Plan to ensure ear foam pressure device is in place. Encourage resident to turn and reposition every 2 hours. Check for pressure on ear while in geri chair.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145519	A. BUILDING _____ B. WING _____	C 02/05/2010

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F9999	Continued From page 40 3. The Minimum Data Set (MDS) dated 1/5/10 identifies R15 as having short/long term memory deficits with severe cognitive impairment requiring extensive assist of two staff for bed mobility, transfers and ambulation. The MDS also identifies R15 as being totally incontinent of bowel and bladder. R15 is at risk for pressure ulcer development according to the care plan dated 1/13/10 and staff are to reposition as needed. The facility's turn schedule policy indicates staff are to reposition residents at least every two hours for pressure ulcer prevention. On 1/29/10 at 10:30am, R15 was in the television area of the back hall in his wheelchair where he remained until they moved him to the dining table for lunch. At 12:45pm following lunch, R15 was transferred to bed by E17 and E18, Certified Nurses Aides. Interview with E17 and E18 at the time indicated that they had gotten him up prior to 7:00am that morning. On 2/4/10 at 12:45pm, E18 clarified the times stating they had laid him down after breakfast that morning and then gotten him up for church at 9:30am. E18 confirmed that R15 was in his wheelchair without repositioning from at least 9:30am until 12:45pm, 3 hours and 15 minutes. Review of the Activity Calender for January shows church at 9:30am on 1/29/10. (A) 300.1020a) 300.1020c)	F9999		

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F9999	Continued From page 41 Section 300.1020 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). c) All illnesses required to be reported under the Control of Communicable Diseases Code and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693) shall be reported immediately to the local health department and to the Department. The facility shall furnish all pertinent information relating to such occurrences. In addition, the facility shall inform the Department of all incidents of scabies and other skin infestations. These Requirement were not met as evidenced by: Based on record review and interview, the facility failed to call their local County Public Department when there was a cluster of residents and staff who were exhibiting gastrointestinal, GI, symptoms. Findings include: E2, Director of Nursing, stated on 1-5-10 at 9:45AM, the facility had residents with GI symptoms and some staff had also called off sick. E2 stated it had been going on for about 1 week and she had not called her local Public Health Department stating she did not know she was suppose to. E2 was asked for a list of residents who had	F9999		

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F9999	Continued From page 42 exhibited GI symptoms which showed 21 of 85 resident had experienced GI symptoms. (B)	F9999		