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	145364	A. BUILDING _____ B. WING _____	C 03/10/2011

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CHAMPAIGN COUNTY NURSING HOME	**500 SOUTH ART BARTELL DRIVE URBANA, IL 61802**

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F 314	Continued From page 14 * On 2/18/2011 R2 was admitted to the hospital and received care and treatment of the pressure ulcer on her sacrum and buttocks. In addition R2 received treatment for infection of the wounds and septicemia. * On 3/4/2011 the unit managers of each unit conducted a visual inspection of the complete body of all residents at high risk for skin breakdown. * On March 2nd through the sixth staff were educated by the Unit Managers and Shift Supervisors regarding the assessment of residents at risk for the development of pressure ulcers, the development and implementation of a plan to prevent pressure ulcers (including re-education on bedpan protocol), staff responsibilities regarding response to an identified wound and protocol for the ongoing management of wounds.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)5) 300.3240a) 300.3240d) 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility. These written policies shall be followed in operating the facility.	F9999		

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F9999	Continued From page 15 300.1210 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: 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. 300.3240 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) d) A faciltiy administrator, employee, or agent who becomes aware of abuse or neglect of a	F9999		

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resident shall also report the matter to the Department. (Section 3-610 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility neglected to follow the policy for bedpan use for R2, one of six residents sampled for pressure sores in a total sample of nine. As a result, R2 developed a stage III pressure sore on her coccyx and buttocks in the shape of a bedpan. After the bedsore was discovered facility staff neglected to follow the facility pressure sore policy including getting a treatment order for the pressure sore from the doctor, and monitoring the condition of the pressure sore. The pressure sore became infected, progressing to a systemic blood infection that necessitated hospitalization, surgical debridement and intravenous antibiotics. After the pressure sore, was discovered and R2 was hospitalized the facility neglected to notify the State Agency. The facility also failed to begin an investigation into the cause of the pressure sore and the suspected neglect.

Findings include:

Physician's Orders dated 1/16/11 to 2/17/11 documents R2 has diagnoses of Morbid Obesity, Cerebrovascular Accident, and Diabetes Mellitus Type II. The Minimum Data Set (MDS) dated 2/4/11 indicates R2 needs extensive assistance with most activities of daily living, including bed mobility and toilet use. R2 is assessed by the MDS as incontinent of bowel and she has an indwelling urinary catheter. The MDS also documents R2 is at risk for pressure sores but

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currently has no pressure sores at a stage one or higher.

A Nurses Note dated 2/18/2011 at 12:15 PM from the hospital reads: "...PT (patient) RECEIVED TO FLOOR, A DIRECT ADMIT FROM (the facility) . PT ALERT, SPEECH GARBLED. RIGHT EXTREMITIES WEAK. PT INC (incontinent) OF URINE, STOOL...WOUND TO COCCYX..."

Z3, Registered Nurse (hospital nurse) stated on 3/2/11 at 12:50 PM that she helped to admit R2 directly from the facility to the hospital on 2/18/11 at about 12:45 PM. Z3 stated, "...I saw immediately after she was admitted - that she had a pressure sore (in) the shape of a bedpan (on her coccyx and buttocks). I immediately thought it was a bedpan injury. The outline was in a brighter pink, stage II or III. She was a direct admit (from the facility) and she had not been on a bedpan since she was here - also our bedpans are shaped differently..."

An incident report signed by the facility Administrator and dated 3/2/2011 states: "...On the day shift of February 17, 2011 resident (R2) was noticed to have a new decubitus ulcer (pressure ulcer) on her coccyx. An assessment of the surrounding area revealed a U-shaped impression. (R2) was unable to report how the impression or ulcer developed...(R2) is frequently incontinent and would periodically use a bedpan..."

E13, Certified Nursing Assistant (CNA) stated on 3/3/11 at 2:17 PM that she and another CNA assigned to R2 discovered R2 on a bedpan. E13

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stated, "...I took care of (R2). We (E13 and E10 CNA) went to clean (R2) up, and we discovered she was on a bedpan...I am not sure of the time or date but neither me or (E10) put her on the bedpan. She (R2) was out of it (not able to communicate). When we took her off the bedpan we saw the impression of the bedpan. Her (R2's) bottom was broke down. My impression was, somebody left her on the bedpan..."

E6, CNA worked with E13 and E10 the day R2 was found on the bedpan. E6 stated on 3/3/11 at 3:05 PM, "...I have taken care of (R2). Some girls found her on the bedpan. (E10), (E13) and I worked together that day, I'm not sure of the date. The other two (CNAs) found her but I knew about it...It was in February..."

E8, CNA also stated she knew about R2 being found on a bedpan and stated it was reported to the nurse. E8 stated on 3/3/11 at 2:00 PM, "...I would take care of her (R2) every once in a while. I took care of her in February. Me, (E13), and (E10) discovered it. We told the nurse (E5, Registered Nurse)... (E13) and (E10) found her on the bedpan when they got her up that morning, I'm not sure what day or date..."

E10, CNA stated on 3/4/11 at 11:15 AM that she discovered R2 on the bedpan and that she knows the day was 2/11/11. She stated she told the nurse E5. E10 stated, "...I have taken care of (R2). I have used the bedpan with her. I went in with (E13), but this was approximately a week or more before (2/18/11), the day the facility stated the pressure sore was discovered. We found (R2) on the bedpan on 2/11/2011. I know because it was a day when we all worked

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together, (E6), (E13), (E8) and (E5). I looked at her backside and it was split open. When I saw it I said, 'Oh my God' because I saw pink meat. I went and got the nurse. (E13) was still in the room. We asked her (R2) who put her on the bedpan and she did not know. I said to the nurse (E5), 'Do you see this (E5's first name), and she said yes, just put some EPC cream (a protective ointment) on it?' The nurse said it looked like the resident had been on there (on the bedpan) for quite some time."

A facility document titled, "Daily Nursing Schedule" shows that (E5), (E6), (E8), (E10), and (E13) all worked together on Unit Two on day shift on 2/11/2011. The schedule shows the five employees did not work together on Unit Two, on day shift, on any other day in February of 2011.

E5, RN stated on 3/3/11 at 1:20 PM that the pressure area was not pointed out to her on 2/11/2011. E5 stated, "...I don't remember anyone pointing out anything to me on the 11th (2/11/11). If I did not chart it, I did not see it..." E5 also stated R2 could not be depended on to use her call light. E5 said, "...The CNAs used a bedpan to toilet. She (R2) would have good days and bad days. She was very inconsistent cognitively. You really could not trust her to do what she was supposed to do..."

A document titled "BEDPAN/URINAL, OFFERING/REMOVING" and submitted by the Administrator on 3/4/11 as the facility policy on bedpan use reads as follows: "...General Guidelines... 5. Do not allow the resident to sit on a bedpan for extended periods. (Note : This is not only uncomfortable to the resident, it also

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F9999	Continued From page 20 causes skin breakdown.)..." R2's clinical record including skin report sheets and Nurses Notes does not document a pressure sore as being found on 2/11/2011. Z1, R2's Primary Care Physician stated on 3/4/2011 at 3:30 PM, "...The facility did not notify me of the buttocks wound of (R2) until 2/17/2011. I was not notified on 2/11/11 of any pressure areas." The "Prevention of Pressure Ulcers" policy states, "...The facility should have a system /procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family and addressed..." A "Report of Operation" dated 2/20/11 reads as follows: "Indications: A 61 -year-old, evidently in (the nursing home), had been on a bedpan 6 hours. Pressure necrosis with decubitus right buttocks measuring 15 cm (centimeters) x 4 cm and then subsequently 3 cm deep about in the deepest. She is for debridement...Description of Procedure:...She had a circumferential area of necrosis both on right and left buttocks cheek, including the sacrum. Superficially necrotic really left side and the area of the sacrum. She had obvious necrosis with tracking by her right buttocks cheek with necrosis as above. Using the cautery only, we removed the necrotic tissue down to the deep subcutaneous tissue..." Z4, Surgeon stated on 3/2/11 at 2:30 PM that the wound was a "pressure necrosis" consistent with someone who was on a bedpan for hours. The surgeon described the wound as a "circular ridge	F9999		

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from one side of the buttocks to the other and down the thigh. The wound was infected and it would have taken days for the infection to develop not hours."

A report titled "Consultation" dated 2/19/11 and signed by Z2, Infectious Disease Specialist documents: "...She has a horseshoe shaped decubitus extending from the left to the right gluteal area across the top of the sacrum. On the right side, it is approximately 24 cm. It is 1 to 1.5 cm in width. it is undermined. there is frank purulent drainage..."

Z2, Infectious Disease Specialist stated on 3/4/11 at 10:45 AM "...I think blood poisoning (septicemia) was caused by the infection the resident had of the pressure ulcer on (her) backside. I had cultures that verified this..."

A Progress Note dated 2/23/11 and signed by Z5, Attending Physician states, "...Assessment and Plan: 1. Septic Shock: Probably secondary to decubitus ulcer. Patient is improved status post debridement and now on a combination of Zosyn and Vancomycin (intravenous antibiotics)..."

A document titled "...(Facility Name) Abuse Prevention Program Facility Policy..." and confirmed by the Administrator as the facility abuse/neglect policy states: "...NEGLECT is the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or in the deterioration of a resident's physical or mental condition...IV. Internal Reporting Requirements and Identification of Allegations... Employees are required to report

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F9999	Continued From page 22 any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator. VI. Internal Investigation of Allegations and Response 1. Initiating an Investigation. Once an allegation of abuse, mistreatment, misappropriation or neglect has been made, the Administrator or designee will initiate a comprehensive investigation...VII. External Reporting of Potential Abuse 1. Initial Reporting of Allegations. Within twenty-four hours of an allegation of abuse , mistreatment, misappropriation (or) neglect, a written report shall be sent to the Department ..." E1, Administrator stated on 3/2/2011 at 2:30 PM that facility staff had full knowledge of the bedpan incident on 2/11/11 and R2 was re-examined by supervisors on 2/18/11 and was sent to the hospital. E1 acknowledged an investigation into the neglect of R2 had not yet (as of 3/2/2011) been initiated and the Department had not been notified of the potential neglect. (A)	F9999		