STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. BUILDING _____ B. WING _____	C 10/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW REHAB & HCC	**500 NORTH JACKSON STREET MORRISON, IL 61270**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #1112907/ IL54573-F221, F312, F314 Complaint Investigation # 1113139/ IL 54832-F312, F314	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess, document, and show attempts to reduce a restraint for a resident wearing a seatbelt when in the wheelchair. The facility also failed to remove the restraint when the resident was under direct supervision of the staff in the dining room. This applies to 1 of 3 residents reviewed for restraint use (R3) in a sample of 5. The findings include: The Physician's Order Sheet (POS) dated 10/2011 shows that R3 has diagnoses including Alzheimer's Disease and Depression. The POS also states, "May use wheelchair with self releasing seatbelt, release every 2 hours for 15 minutes." This order is dated 9/22/10. The Minimum Data Set of 7/7/11 shows that R3	F 221		10/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1 has a trunk restraint. The MDS of 9/29/11 shows that R3 does not have a trunk restraint. On 10/20/11, E2 (DON) stated, "(The seatbelt) is for positioning. We did consider it a restraint but then decided it was for positioning." On 10/20/11 at 12:30 PM, R3 was observed in the hallway outside of the dining room. R3 was slumped down in her wheelchair with her buttocks about 6 inches from the back of the chair and the seatbelt was stretched tightly around her lower abdomen. E6 (Restorative Nurse) stated, "She used to be able/try to get up but she is not anymore. So now the seatbelt is to keep her up in the chair. " E6 was asked what is the difference between keeping her in the chair when she can stand versus keeping her in the chair because she slides forward? E6 stated, "I see what you are saying. We used to consider it a restraint but then we decided it was more for positioning. I thought they had to be able to get up for it to be considered a restraint." According to the facility policy entitled Physical Restraint/Enabler Policy dated 7/12/10 states, "Physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." The policy also states, "Place physical restraint problem on the resident's care plan. The care plan must address the duration, type, and circumstances under which the restraint can be used., After the initial documentation, all physical restraints require quarterly documentation regarding the type of	F 221		

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F 221	Continued From page 2 physical restraint used, resident's response to the physical restraint, and if any reduction plan has been attempted., and All physical restraint assessments must be completed and updated as least every 90 days thereafter." R3's Fall Care Plan dated 10/3/11 states, "Seatbelt on when in chair. Resident no longer attempts to rise. Seatbelt to prevent resident from sliding down in the chair related to poor trunk control." There is no care plan directly related to use of the restraint. The facility could not provide documentation of any kind of restraint reduction plan since the restraint was applied in September 2010. On 10/20/11 at 11:45 AM, R3 was observed in the dining room with being fed lunch by E4(CNA). R3's seatbelt remained buckled through the meal, even under direct supervision.	F 221		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that dependent residents were toileted every 2 hours and received care following episodes of incontinence.	F 312		10/29/11

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F 312	Continued From page 3 This applies to 2 of 4 residents (R3,R5) reviewed for incontinence in a sample of 5. The findings include: 1. The Physician's Order Sheet dated 10/2011 shows that R3 has diagnoses including Alzheimer's Disease with Agitation and Depression. R3's Minimum Data Set of 9/29/11 shows that R3 requires total assist of 1 staff member for toilet use. On 10/19/11 at 1:30 PM, E4 and E5 (CNAs) were observed as they transferred R3 from the wheelchair to the bed. During the transfer E5 stated, "(R3) you smell like you have a mess." E4 and E5 laid R3 down in the bed and removed her incontinence brief. R3's brief was heavy and saturated with urine. R3 had not been incontinent of stool at this time. R3's buttocks area was pink and moist with deep creases left from the brief. E4 and E5 finished proving care for R3 and left her in a comfortable condition. E4 was asked how long R3 had been up in her wheelchair. E4 stated, "She usually lays down right after lunch, sometimes after breakfast if something is going on with her. I'm not going to lie to you, she has been up since before breakfast." R3's careplan dated 10/6/11 states, "Resident is incontinent of bowel and bladder. Provide proper peri-care after each incontinent episode and Check and change every 2 hours. Resident is unable to sit on toilet safely and is unaware of	F 312		

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F 312	Continued From page 4 toileting needs." On 10/19/11, during confidential interview it was stated, "Many times I have to clean (resident) up when I come in.. (Resident) gets to the point of disgusting. (Resident) stinks to high heaven and if that doesn't kill one's appetite I don't know what will. I clean (resident) up and tell them that I did - like hint, hint. I have complained once or twice but I just get tired of telling them." 2. The Physician's Order Sheet dated 10/2011 shows that R5 has diagnoses including Multiple Sclerosis, Morbid Obesity and Dementia. R5's care plan dated 4/14/11 states, "Toilet resident every 2 hours or offer bedpan and Encourage resident to use call light and inform staff of need to go to the bathroom or that she has been incontinent." On 10/19/11 at 1:00 PM, E4 and E5 (CNAs) were observed as they assisted R5 to the bathroom. R5 requires the use of a mechanical stand lift to transfer from one surface to the next. As R5 was assisted to stand with the lift R5 began to urinate on her reclining wheelchair and the floor. (R5 was wearing an incontinence brief) . R5 was transferred to the bathroom, her pants were pulled down and a fully saturated brief was removed. E5 was asked what time R5 had gotten up in the wheelchair. E5 stated, "I'm not sure, I think nights got her up- so before 6 AM. She usually only lays down after lunch, not after breakfast."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		10/29/11

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F 314	Continued From page 5 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to monitor R4's heels by completing weekly skin checks and failed to identify a pressure ulcer to R4's right heel until it was unstageable. The facility also failed to assess and monitor a low risk resident's (R1) skin, after applying a restraint, to prevent R1 from acquiring multiple pressure sores. These failures resulted in R4 developing a necrotic area to her right heel requiring debridement and specialty wound care beginning on 5/2/11 and R1developing 3 Stage II pressure ulcers to his coccyx and Stage I pressure ulcers to his bilateral elbows. This applies to 2 of 3 residents (R1, R4) reviewed for pressure ulcers in a sample of 5. The findings include: 1. The Physician's Order Sheet dated 10/2011 shows that R4 was admitted to the facility on 3/29/11 with diagnoses including Fractured Right	F 314		

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F 314	Continued From page 6 Femur, History of Falls and Depression. R4's Braden Scale for Predicting Pressure Ulcer Risk shows that R4 scored a 17. (17-20= Moderate Risk) R4's Nursing Admission Assessment dated 3/29/11 shows that R4 had "no open areas or bruises". The facility document entitled, Newly Acquired Skin Conditions, dated 5/2/2011 shows that R4 has an Unstageable pressure ulcer to her right heel measuring 2.4 X 3.0 (unit of measurement not indicated). This form shows that R4 stated, "It hurts." The Weekly Wound Tracking Report dated 5/5/2011 shows that R4's right heel measured 2.4 x 2.4 cm and had a black center with minimal drainage. An untitled document dated 6/9/11 states, " (R4) here for wound treatment to right heel. Reports some pain. Not walking much. No other problems or complaints. Sharp debridement of heel wound done then Santyl (debriding ointment) applied, skin prep and foam dressing. Right heel wound- apply Santyl BID (twice a day) to heel wound, use skin prep around heel wound, cover with foam dressing. Juvan (protein supplement) BID. Return in 1 week. Float heels at all times." On 10/20/11 at 1:15 PM R4 was asked how she got the wound on her right heel. R4 stated, "I have no idea. One day it started hurting and they looked at it and there was a hole. I was walking but I can't now. I can't wear my shoes either."	F 314		

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F 314	Continued From page 7 2. The Minimum Data Set of 8/23/11 shows that R1 has diagnoses including Cirrhosis and Dementia. R1's Braden Scale for Predicting Pressure Ulcer Risk dated 8/12/11 shows that R1 scored a 22 (Greater than 20=low risk). The Nurse's Notes dated 8/19/11 states, "Resident placed in (reclining wheelchair) at this time. (7:30 PM). Resident sitting quietly in (reclining wheelchair) at 10:00 PM. " The NN dated 8/21/11 states, "Attempting to climb out of (reclining wheelchair). Using bilateral arms to lift buttocks off of seat in attempt to get out from under the tray." R1's Treatment Flow Sheet for August 2011 shows that R1 was to receive weekly skin checks by a licensed nurse. The skin checks scheduled to be done on 8/13 & 8/20 were not completed. On 8/28/11 the NN state,"Open area noted to coccyx. Treatment implemented. DuoDerm to wound bed." The Monthly Wound Tracking Report for August 2011 describes R1's coccyx wound as 0.5 x 0.5 x <0.1 cm. The facility document entitled Newly Acquired Skin Conditions dated 9/5/11 shows that R1 developed a Stage I pressure sore to his left elbow (3.7 x 2.5 cm), a Stage I pressure sore to his right elbow (7.8 x 5.2 cm) with a scabbed area (0.5 x 0.6 cm) and 3 pressure sores to his coccyx -1) 0.5 x 0.7 x <0.1, 2) 0.4 x 0.6 x <0.2, 3)	F 314		

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F 314	Continued From page 8 0.7 x 0.4 x <0.1.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. Restorative measures	F9999		

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F9999	Continued From page 9 shall include, at a minimum, the following procedures: Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on interview and record review the facility failed to monitor R4's heels by completing weekly skin checks and failed to identify a pressure ulcer to R4's right heel until it was unstageable. The facility also failed to assess and monitor a low risk resident's (R1) skin, after applying a restraint, to prevent R1 from acquiring multiple pressure sores. These failures resulted in R4 developing a necrotic area to her right heel requiring debridement and specialty wound care beginning	F9999		

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F9999	Continued From page 10 on 5/2/11 and R1developing 3 Stage II pressure ulcers to his coccyx and Stage I pressure ulcers to his bilateral elbows. This applies to 2 of 3 residents (R1, R4) reviewed for pressure ulcers in a sample of 5. The findings include: 1. The Physician's Order Sheet dated 10/2011 shows that R4 was admitted to the facility on 3/29/11 with diagnoses including Fractured Right Femur, History of Falls and Depression. R4's Braden Scale for Predicting Pressure Ulcer Risk shows that R4 scored a 17. (17-20= Moderate Risk) R4's Nursing Admission Assessment dated 3/29/11 shows that R4 had "no open areas or bruises". The facility document entitled, Newly Acquired Skin Conditions, dated 5/2/2011 shows that R4 has an Unstageable pressure ulcer to her right heel measuring 2.4 X 3.0 (unit of measurement not indicated). This form shows that R4 stated, "It hurts." The Weekly Wound Tracking Report dated 5/5/2011 shows that R4's right heel measured 2.4 x 2.4 cm and had a black center with minimal drainage. An untitled document dated 6/9/11 states, " (R4) here for wound treatment to right heel. Reports some pain. Not walking much. No other problems or complaints. Sharp debridement of heel wound	F9999		

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F9999	Continued From page 11	F9999		

done then Santyl (debriding ointment) applied, skin prep and foam dressing. Right heel wound- apply Santyl BID (twice a day) to heel wound, use skin prep around heel wound, cover with foam dressing. Juvan (protein supplement) BID. Return in 1 week. Float heels at all times."

On 10/20/11 at 1:15 PM R4 was asked how she got the wound on her right heel. R4 stated, "I have no idea. One day it started hurting and they looked at it and there was a hole. I was walking but I can't now. I can't wear my shoes either."

2. The Minimum Data Set of 8/23/11 shows that R1 has diagnoses including Cirrhosis and Dementia.

R1's Braden Scale for Predicting Pressure Ulcer Risk dated 8/12/11 shows that R1 scored a 22 (Greater than 20=low risk).

The Nurse's Notes dated 8/19/11 states, "Resident placed in (reclining wheelchair) at this time. (7:30 PM). Resident sitting quietly in (reclining wheelchair) at 10:00 PM. " The NN dated 8/21/11 states, "Attempting to climb out of (reclining wheelchair). Using bilateral arms to lift buttocks off of seat in attempt to get out from under the tray."

R1's Treatment Flow Sheet for August 2011 shows that R1 was to receive weekly skin checks by a licensed nurse. The skin checks scheduled to be done on 8/13 & 8/20 were not completed.

On 8/28/11 the NN state,"Open area noted to coccyx. Treatment implemented. DuoDerm to wound bed."

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F9999	Continued From page 12 The Monthly Wound Tracking Report for August 2011 describes R1's coccyx wound as 0.5 x 0.5 x <0.1 cm. The facility document entitled Newly Acquired Skin Conditions dated 9/5/11 shows that R1 developed a Stage I pressure sore to his left elbow (3.7 x 2.5 cm), a Stage I pressure sore to his right elbow (7.8 x 5.2 cm) with a scabbed area (0.5 x 0.6 cm) and 3 pressure sores to his coccyx -1) 0.5 x 0.7 x <0.1, 2) 0.4 x 0.6 x <0.2, 3) 0.7 x 0.4 x <0.1. (B)	F9999		