STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
"REPEAT B" VIOLATION(S)
STATEMENT OF VIOLATIONS

MANOR COURT OF MARYVILLE	0050427
Facility Name	I.D. Number
6955 STATE ROUTE 162, MARYVILLE, IL 62062	
Address, City, State, Zip	
29925	10/21/2011
Reviewed By	Date of Survey
LICENSURE FOLLOW-UP VISIT TO LP1 SURVEY OF 5/06/2011	02434, 10877, 10879, 13106, 19842
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"REPEAT B" VIOLATION(S):

300.1210 **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.

The regulation is NOT MET as evidenced by:

Based on observation, record review and interview, the facility failed to provide timely reposition, failed to identify a new pressure ulcer; and failed to measure a pressure ulcer accurately for 3 of 6 residents (R3, R10, R12) reviewed for pressure ulcers in the sample of 19. This failure resulted in a pressure sore decline for R3.

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The facility failed to follow the Plan of Correction submitted to the department of Public Health from the survey completed on May 6, 2011.

Which states:

The Director of Nursing or her designee will monitor all residents for pressure areas and address as appropriate. Those residents with pressure areas will have measurements recorded weekly to monitor healing and progress.

Findings include:

1. The Minimum Data Set (MDS) dated 09/20/11 documents that R3 has short/long term memory deficits, moderate cognitive impairment requires extensive assist of one staff for bed mobility and all transfers and is frequently incontinent of bowel. The Care Plan dated 9/29/11 documents R3 is at risk for skin breakdown due to impaired mobility, has history of skin breakdown with chronic red scarring and is a diabetic. The Care Plan goal is "area to coccyx will decrease in size." The Care Plan interventions include, in part as, air flow mattress, monitor for pain or discomfort, preventative skin care as indicated, turn and position at least every two hours and as needed and weekly skin checks. The Care Plan also documents that R3 has Methicillin Resistant Staph Aureus (MRSA) infection to coccyx wound. On 06/30/11, the Care Plan documents that R3 had an indwelling catheter placed for coccyx wound. Documentation indicates that R3 has a history of multiple Urinary Tract Infections (UTI'S).

On 10/18/11 at 10:00 am, R3 was observed lying on back in bed. At 12:35 pm, E14, CNA, transferred R3 from the bed to her wheelchair. E14 did not check R3's for incontinence at this time. R3 was taken to the dining room for lunch. On 10/19/11 at 9:00 am, R3 was sitting in her wheelchair in her room next to her bed. At 11:30 am, R3 was still in the same position in her wheelchair in her room. At 2:05 pm, R3 was observed sitting in bed on her back with the head of the bed at a 90 degree angle. At 2:43 pm, R3 was sitting up with her feet on the floor attempting to push herself up out of bed unassisted. There was a strong foul smelling odor near R3. When asked about the odor, E10, CNA, stated "That's not urine, it's her wound."

On 10/19/11 at 3:40 pm, it was observed that E10 and E18, both CNA's, transferred R3 from the wheelchair to the bed. E10, CNA, stated that they were going to check R3 for incontinence and the nurse was going to change the dressings. When E10 and E18 removed the incontinent brief, there was a six inch area of brownish drainage on the incontinent brief from the pressure sore. It is noted that the wheelchair cushion is also soiled with the same brownish drainage. The area under the abdominal fold and a 6 cm slit-like open area under the right abdominal fold was observed. E10, CNA stated that she had not seen that before.

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It was also observed that there were two dressings on the buttocks/coccyx area with the coccyx wound was observed to be saturated with brownish drainage. When the dressings were removed, an open wound on the right buttocks, as well as an open wound on the coccyx did exist.

On 01/02/11, a nurse's note documents "S/T (skin tear) to coccyx turned into open ulcer, measures 1.5 X 2.5." Documentation indicates that on 10/18/11, R3 was seen by a Specialized Wound Management (SWM) nurse for an evaluation of the coccyx wound. A SWM note documents the wound assessment as "Length 1.1 cm X Width 1 cm X Depth 0.6 cm, Undermining: 12= 0.4 cm, 3= 0.3 cm, 6= 0.6 cm, 9= 0.5 cm...Stage III pressure ulcer." The diagnoses and care plan of the SWM note documents, in part, "turn patient q (every) 1-2 hours side to side only..." In the most recent Weekly Infection Control Report date ending 10/13/11, R3's coccyx wound measured 1 cm X 1 cm X 0.2 cm with no undermining reported. On 09/27/11, the facility Weekly Infection Control Report documents that R3 has developed a new area to the right buttocks measuring 1.2 cm X 0.8 cm X 0.1 cm. There was no documentation of an assessment identifying an area under the abdominal fold until this surveyor returned on 10/20/11.

The policy and procedure titled, "Protocol for Pressure Ulcer Prevention and Treatment" was reviewed on 10/20/11. It indicates under, "Principles: #7. When a resident is admitted to the facility of develops a pressure ulcer in the facility, the following will occur: A. Assess the pressure ulcer for location, size (L x W x D), wound bed, drainage (amount, color, type), odor, tunneling, undermining, wound edges and pain at site. B. Determine the ulcer's current stage of development..."

During a teleconference interview conducted on 10/21/11 at 10:39 am with Z2, physician, it was reported from Z2 that R3 was a long-time patient with many co-morbidities and multiple (UTI's). Z2 reported that R3 was previously on Hospice due to End Stage Renal Disease, but had rallied and was subsequently removed from Hospice status. Z2 stated that he believes that R3 will be back on Hospice in the near future due to her increased edema and general debility and overall decline in health. When asked if the pressure ulcers were preventable, he stated "Skin fails like any other organ." When asked if turning and repositioning would have prevented the pressure ulcers, he replied, "There's no doubt turning and repositioning would make a difference." Z2 did confirm that R3 "was either incapable or simply doesn't want to move herself" while in bed. Therefore, R3 must be repositioned by staff. Z2 responded with "Yes."

2. R12's Admission Record identifies him to have diagnoses of renal failure, constipation and Septicemia. The MDS dated 10/4/11 identifies R12 as having cognitive impairment and being totally dependent on staff for all aspects of daily living and is occasionally incontinent of bowel and always incontinent of bladder.

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On 10/19/11 at 11:55am, R12 was taken to the bathroom by E13 and E21, CNA's to toilet. R12 was transferred to the toilet and found to be incontinent of stool and his brief was saturated with urine. According to E13 and E21, R12 was last checked/toileted at 9:10am that morning almost 3 hours prior. R12 is at risk for pressure ulcers according to his care plan dated 10/13/11 with interventions to turn and reposition every two hours.

3. R10's Care Plan, goal target date 11-02-11, documented R10 was at increased risk for skin breakdown related to age and skin fragility, impaired cognition with impaired safety awareness. It was also noted, dated 9-20-11; R10 had a deep tissue injury to her coccyx. R10's Treatment Flow sheet, dated 10-1-11 to 10-31-11, documented "Cleanse coccyx, apply Santly, and cover with bordered gauze, change daily and prn (as needed)."

During observation of R10's care, on 10-19-11 at 9:45a.m., R10 did not have a dressing in place on her coccyx. In an interview of E16, Certified Nursing Assistant (CNA), on 10-19-11 at 9:45a.m., E16 stated R10 did not have a dressing on her coccyx when she got R10 up, around 7:00a.m., and that she did not tell anyone R10's coccyx dressing was not in place.

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