DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145536	A. BUILDING ______ B. WING ______	10/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVENA OUR LADY OF VICTORY	**20 BRIARCLIFF LANE** **BOURBONNAIS, IL 60914**

(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 Annual Licensure and Certification Survey. Complaint 1173063/IL 54748 = F225 Licensure Follow-up of 9/03/11. No Deficiency	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		11/16/11

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews and review of facility records the facility failed to initiate an investigation of abuse as voiced by one of 19 sampled residents (R 12) who stated staff was rude and mean to her and failed to notify the State Survey Agency of an allegation of abuse as made by R 12.

Findings include:

During interview on 10/28/11, R 12 stated there was two staff persons on the night shift who are mean to her; the persons "jerks" the pillow from under her head and throws bed covers back abruptly. R 12 also stated the staff persons are mean and rude to her "They always tell me what I do and don't need. When both work together, they are hell on wheels". When asked for the staff person's names and or a description. R 12 was unable to give specifics. R 12 stated she had "told someone". R 12 requested the administrator not be informed of R 12's name; that her family was taking care of the incident.

When interviewed, 10/28/11 , about abuse and any residents having complained of staff being rough with them, both E 1 (Administrator) and E 2 (Director of Nurses) admitted they had been

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F 225	Continued From page 2 informed of a staff person having been rough with R 12 and of the resident's pillow having been removed from under her head, but had not conducted a written investigation of the allegation, nor had they notified the Illinois Department of Public Health (IDPH) of the allegation because they had not considered the allegation as abuse. E 2 stated she had ultimately terminated the staff E13 person because there had been other concerns regarding the quality of her care of residents. Review of the facility's abuse investigations verified there had not been any investigation conducted regarding R 12's allegations.	F 225		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a medication was given at the proper time for one resident in the sample of 18 (R7). The facility also failed to ensure a nurse locked her medication cart when the cart was not in her view. The findings include: 1. On 10/25/11 at 12:45 p.m. E6 (LPN) was observed administering medication to R7 during	F 282		11/16/11

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the noon medication pass observation. R7 was observed with a gastric feeding tube (G/T). E6 was observed administering Carafate (medication for treatment of ulcers) 1 gram (10 ml) to R7 per G/T at 12:45 p.m. E6 stated at this time, "I need to give this medication 1/2 hour before I give R7 her tube feeding. I give R7 her tube feeding at 1:00 p.m. Review of R7's physician's orders showed R7 did have a physician's order for Carafate to be given at 12:00 noon.

At 1:10 p.m. E6 was observed giving R7 a bolus tube feeding. This was 25 minutes after E6 administered the Carafate to R7. Per review of The Nursing Drug Handbook 2008 and Nursing Drug Handbook 2010, Carafate is to be given one hour before meals.

Follow up interview with E 2 (Director of Nurses) on 10/26/11 at 2:40 p.m. noted E 2 to say, "Carafate should be given one hour before meals/feedings. E6 should have given R7 her Carafate at 12:00 to give the tube feeding at 1:00 p.m.

2. On 10/26/11 E5 (LPN) was observed passing medications during the noon medication pass observation. E5's medication cart was parked against the wall at the hallway entrance to the facility's main dining room. At 12:30 p.m. E5 prepared medications for R21 and took the medications to R21 who was sitting in the main dining room. E5 left the medication cart unlocked and not monitored when she went to give R21 her medications. The medication cart was not in view of E5. Many residents, visitors, and staff were passing the medication cart while it remained unlocked.

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F 282	Continued From page 4 Review of the facility's policy on Oral Medication Administration showed documentation the "Medication cart is to be kept locked at all times unless in use and within nurse's sight." Interview with E5 on 10/26/11 at 1:00 p.m. noted E5 to say, "Oh, I should have locked my cart when I walked away from it."	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to administer anti-seizure medication (Keppra) as prescribed by the physician to one resident outside of the sample of 19 (R24). This failure resulted in R24 being hospitalized with diagnosis of active seizure activity. The finding includes: Review of the facility's incident reports showed an incident for R24 dated 1/01/11 with incident type documented as "medication omission." Review of R24's closed record, the incident	F 309		11/16/11

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F 309	Continued From page 5 report, and incident investigation showed R24 was admitted to the facility on 12/23/10 with diagnoses including New Onset Seizure Disorder, Severe Mental Retardation and Down's Syndrome. R24's admission physician's orders included an order for Keppra 500 mg. two times a day. Nursing documentation dated 1/01/11 at 9:30 p.m. showed R24 was discovered having having a seizure in her bed in her room. R24's physician was contacted and orders were received to sent R24 to the hospital. R24 24 was sent to the hospital and admitted with diagnoses including seizures. Review of R24's MAR (medication administration record) and physician's orders for 12/2010 and 1/2011 showed R24's Keppra medication had been accidentally discontinued on the MAR. There was no physician's order found to discontinue the Keppra. Five doses of Keppra had been skipped from 12/30/11 to 1/01/11 due to a transcription error in discontinuing the Keppra. R24 remained in the hospital until 1/07/11 when she was readmitted to the facility. Readmission orders showed R24 was restarted on her anti-seizure medication. Interview with E 2 (Director of Nurses) on 10/26/11 at 3:00 p.m. noted E 2 to say, "Yes, R24 did start having seizures on 1/01/11. She had missed five doses of Keppra. The Keppra was mistakenly d/c'd (discontinued) by one of the nurses and R24 started having seizures after that."	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		11/16/11

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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 observations, interviews and record reviews, the facility failed to ensure four residents (R14, R15 in a sample of 20 residents and R23 and R24 in the supplemental sample), who need help to do activities of daily living (ADL's) are provided with consistent care and assistance to maintain good nutrition.

Findings include:

At the noon meal on 10/27/2011, residents in the small dining room were observed during the noon meal. Staff reported residents in the small dinning room required assistance and and monitoring from staff to eat their meals. E7 was observed standing and feeding R23 . R23 is a resident who is unable to feed himself and requires the assistance of staff to eat. Then, E7 stopped feeding R23 and start feeding R15. When R15 got the assistance and encouragement, R15 was observed to eat her meal. However, E7 stopped feeding R15 after awhile and went to the table behind R15 and fed R14. R14 had just been sitting. When E7 came to assist R14 to eat, she became alert and started to eat her food. A nurse was asked to assist R15 to eat. Then, R15 was observed to start eating again. But, she refused to eat her

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F 312	Continued From page 7 carrots. R15 complained the carrots were too hard. R15 was observed to have broken and missing teeth. The nurse also reported R15 had difficulty chewing because she had no back teeth. R22 was also in the small dining room on 10/27/2011 for the noon meal. R22 was observed calling out for assistance. R22 reported he needed help to cut his meat and feed himself. A nurse passing was asked to assist R22 in feeding himself. This nurse cut R22's meat and was observe feeding R22. Then, R22 was observed to finish eating the food on his tray. The next day at the noon meal on 10/28/2011, E8 was observed feeding residents in the small dining room. E8 first feed R23. But, E8 left his side in the middle of feeding R23. Then, E8 start feeding and encouraging R15. Next, E8 left R15's side to feed R14. R15 and R23 stopped eating without direct assistance and encouragement. -Review of R15's Admission Face Sheet documented R15 is a 84 year old female with diagnosis including: Cardiovascular Accident, Right Hemiparesis, Immobility, and history of weight loss (on 9/15/2011). Review of R15's care plan documented R15 has a potential for weight fluctuation and nutritional risk. The nursing intervention identified to address this care issue were: to set up meals for R15 and assist as needed. However, R15 was observed not receiving the consisted assistance she required to eat her meal. Review of R15's care plan also identified R15 is	F 312		

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F 312	Continued From page 8 at risk due to inability to swallow and chew food. The intervention identified to address this care concern was to provide food can chew. But, R15 was not observed being given appropriate assistance and food to eat, when she was served food she could not chew. -Review of R23's care plan documented R23 is a 69 year old male with diagnosis including: Cardiovascular Accident with Hemiparesis and Dementia. R23's plan of care documented R23 has a "potential for nutrition risk and weight fluctuations related to possible decreased intake." Review of R23's ADL Functional Assessment dated 10/22/2011, documented R23 was assessed to need extensive assistance to eat his meals. However, this was not provided to R23. -Review of R 14's ADL Functional Assessment, dated 8/27/2011 documented R14 required total assistance from staff to eat. -Review of R22's ADL Functional Assessment, dated 9/28/2011 documented R22 requires encouragement to eat his meals. Review of R15's most recent MDS Assessment documented R22 needed extensive assistance from staff to eat his meals. During the Daily Status Meeting with administrative staff (E1/administrator and E2/director of nursing) on 10/28/2011 and 10/29/2011, E1 and E2 were told of concerns residents did not receive the appropriate assistance they required to eat their meals. E1 presented inservice done with staff and orders to change R15's diet and get a speech assessment.	F 312		

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F 312	Continued From page 9 But, E1 nor E2 provided any evidence to support residents were given appropriate services to ensure residents were given assistance they needed to eat.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 observations, interviews and record review, the facility failed to enure one resident (R15 in a sample of 4 residents identified with pressure sore out of the sample of 20 residents.) received timely assessment and treatment for an unstageable wound on the left heel. This failure resulted in staff identifying R15 had a change in skin condition of the left foot on 9/06/11, but provided no treatment until approximately 14 days later, when R15's left heel developed to an unstageable wound. This has the potential to effect all five residents identified in the facility with decubitus, because four of the resident's wounds were identified as facility acquired.	F 314		11/16/11

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F 314	Continued From page 10 Findings include: On 10/29/2011 at 11:15 AM, R15's wound care to the left heel was observed. R15 was observed to have a unstageable wound to the left heel. E8 reported R15 had acquired this wound (to the left heel) at the facility. When it was initial identified and treated, E8 said it was already unstageable. E8 stated: "When I started it was a black scab, like eschar... I just started in this position (treatment nurse) last month. At first her (R15's) wound was 100% eschar. Now its about 25% eschar, and 75% pale granulation." So, R15's wound improve with treatment. However, E8 could not explain when asked, why staff did not treat R15's pressure sore before it became a blackened and a unstageable wound. E8 said she did not know. E8 was also asked to present her comprehensive assessment of R15's left heel wound. E8 said, "When it developed, I did not have (written) a comprehensive note," or comprehensive assessment done. Review of R15's Admission Face Sheet documented R15 is a 84 year old female with diagnosis including: Cardiovascular Accident, Right Hemiparesis, Immobility, Incontinence and history of Pressure Sores. Review of R15's care plan documented on 9/10/2011 staff identified R15 was at risk for impaired skin integrity. The goal was to prevent R15's skin from breaking down. The interventions identified to achieve this goals were: "Daily skin inspection; report any changes in skin or signs of possible skin breakdown... Report any breakdown to the feet or heels..." However, facility's staff did not implement these	F 314		

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nursing interventions to prevent R15 left heel from developing into an unstageable wound.

Review of R15's shower sheet had documented problems with the skin integrity of her (R15's) left heel several days before being assessed and treated. R15's Shower Sheets documented the following:
"9/16/2011... Description of Skin Issues: Heel of left foot is hard and dark colored. Says her entire back hurts.
9/13/2011... Description of Skin Issues: Heels Dark and Dry.
9/20/2011... Description of Skin Issues: Heel of left foot has black sore..."

But, review of R15's Pressure Ulcer Assessment Form documented R15's left heel wound was not identified until 9/20/2011. R15's Pressure Ulcer Assessment Form documented on 9/20/2011, R15's wound measure "3.5 cm x 1.2 cm", was "100% black eschar" and "unstageable".

Review of R15's Nursing Notes were observed to not have documentation of R15's left heel wound until 9/20/2011 at 3:51 PM. This nursing notes documented R15's left heel wound was reported to R15 primary physician and treatment orders obtained. A comprehensive nursing assessment of R15's skin and general condition was not documented as done until 10/28/2011.

Review of the facility's Pressure Ulcer Assessment/Evaluation and Treatment documents the following:
"...that patients/residents with pressure ulcers will have appropriate assessment, intervention and evaluation of treatment implemented. Physicians

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F 314	Continued From page 12 will be notified of pressure ulcers. A physician order is required for all pressure ulcer treatments." "When a pressure sore is present daily monitoring will be documented." However, staff failed to implement this policy for R15 until her pressure sore had developed to an unstageable wound. During the Daily Status Meeting on 11/29/2011 with the administrative staff (E1/administrator and E2/director of nursing), the survey team expressed concerns that R15's pressure sore was not assessed and treated in a timely manner. E1 reported that R15's shower sheet documented that a CNA (certified nurses aide) observed a change in R15's left heel. But, E1 said that nurse and treatment nurse given R15's shower sheet did not assess and treat the change in R15's skin condition on 9/16/2011. E1 also told surveyor that the nurse and treatment nurse no longer worked at the facility and were not available for interview. But, R15's shower sheet, physician orders and nursing notes documented that her left heel wound was not treated until it became unstageable.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		11/14/11

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(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
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in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, policy review and interview the facility failed to ensure nursing staff washed their hands after instillation of eye drops to one resident (R20) outside of the sample of 19.

The finding includes:

On 10/25/11 at 12:20 p.m. E4 (LPN) was observed administering medications to R20

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	145536	A. BUILDING ______ B. WING ______	10/28/2011

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F 441	Continued From page 14 during the noon medication pass observation. R20's noon medications included a physician's order for Liquitears one drop to be instilled in each eye. E4 took R20 from the dining room to her room, put on a pair of clean gloves, and instilled one drop of Liquitears into each of R20's eyes. After instilling the eye drops in R20's eyes, E4 removed the gloves and took R20 back to the dining room. E4 then returned to his medication cart and was starting to prepare medications for the next resident. E4 did not wash his hand after removing his gloves and before exiting R20's room. Before E4 started preparing medications for the next resident E4 was stopped and asked about washing his hands. E4 stated, "Oh yeah. I should have washed my hands after giving the eye drops." Review of the facility's policy on Hand Hygiene notes, "Hand washing will be done before and after patient care, between tasks, and as appropriate for the work area. This policy also notes, "Hand hygiene will be done after removing gloves and other personal protective equipment." Interview with E 2 (Director of Nurses) on 10/25/11 at 3:30 p.m. noted E 2 to say, "The nurses are supposed to wash their hands after removing their gloves and after administering eye drops."	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210b) 300.3220f)	F9999		

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F9999	Continued From page 15 300.3240a) 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 shall include, at a minimum, the following procedures: Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. 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 record review and interview the facility	F9999		

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failed to administer anti-seizure medication (Keppra) as prescribed by the physician to one resident outside of the sample of 19 (R24).

This failure resulted in R24 being hospitalized with diagnosis of active seizure activity.

The finding includes:

Review of the facility's incident reports showed an incident for R24 dated 1/01/11 with incident type documented as "medication omission."

Review of R24's closed record, the incident report, and incident investigation showed R24 was admitted to the facility on 12/23/10 with diagnoses including New Onset Seizure Disorder, Severe Mental Retardation and Down's Syndrome. R24's admission physician's orders included an order for Keppra 500 mg. two times a day.

Nursing documentation dated 1/01/11 at 9:30 p.m. showed R24 was discovered having having a seizure in her bed in her room. R24's physician was contacted and orders were received to sent R24 to the hospital. R24 24 was sent to the hospital and admitted with diagnoses including seizures.

Review of R24's MAR (medication administration record) and physician's orders for 12/2010 and 1/2011 showed R24's Keppra medication had been accidentally discontinued on the MAR. There was no physician's order found to discontinue the Keppra. Five doses of Keppra had been skipped from 12/30/11 to 1/01/11 due to a transcription error in discontinuing the

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Keppra. R24 remained in the hospital until 1/07/11 when she was readmitted to the facility. Readmission orders showed R24 was restarted on her anti-seizure medication.

Interview with E 2 (Director of Nurses) on 10/26/11 at 3:00 p.m. noted E 2 to say, "Yes, R24 did start having seizures on 1/01/11. She had missed five doses of Keppra. The Keppra was mistakenly d/c'd (discontinued) by one of the nurses and R24 started having seizures after that."

(B)

300.1210b)5
300.3240a)

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 shall include, at a minimum, the following procedures:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest

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practicable level of functioning.

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 observations, interviews and record review, the facility failed to enure one resident (R15 in a sample of 4 residents identified with pressure sore out of the sample of 20 residents.) received timely assessment and treatment for an unstageable wound on the left heel.

This failure resulted in staff identifying R15 had a change in skin condition of the left foot on 9/06/11, but provided no treatment until approximately 14 days later, when R15's left heel developed to an unstageable wound.

This has the potential to effect all five residents identified in the facility with decubitus, because four of the resident's wounds were identified as facility acquired.

Findings include:

On 10/29/2011 at 11:15 AM, R15's wound care to the left heel was observed. R15 was observed to have a unstageable wound to the left heel. E8 reported R15 had acquired this wound (to the left heel) at the facility. When it was initial identified and treated, E8 said it was already unstageable.

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F9999	Continued From page 19 E8 stated: "When I started it was a black scab, like eschar... I just started in this position (treatment nurse) last month. At first her (R15's) wound was 100% eschar. Now its about 25% eschar, and 75% pale granulation." So, R15's wound improve with treatment. However, E8 could not explain when asked, why staff did not treat R15's pressure sore before it became a blackened and a unstageable wound. E8 said she did not know. E8 was also asked to present her comprehensive assessment of R15's left heel wound. E8 said, "When it developed, I did not have (written) a comprehensive note," or comprehensive assessment done. Review of R15's Admission Face Sheet documented R15 is a 84 year old female with diagnosis including: Cardiovascular Accident, Right Hemiparesis, Immobility, Incontinence and history of Pressure Sores. Review of R15's care plan documented on 9/10/2011 staff identified R15 was at risk for impaired skin integrity. The goal was to prevent R15's skin from breaking down. The interventions identified to achieve this goals were: "Daily skin inspection; report any changes in skin or signs of possible skin breakdown... Report any breakdown to the feet or heels..." However, facility's staff did not implement these nursing interventions to prevent R15 left heel from developing into an unstageable wound. Review of R15's shower sheet had documented problems with the skin integrity of her (R15's) left heel several days before being assessed and treated. R15's Shower Sheets documented the following:	F9999		

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F9999	Continued From page 20 "9/16/2011... Description of Skin Issues: Heel of left foot is hard and dark colored. Says her entire back hurts. 9/13/2011... Description of Skin Issues: Heels Dark and Dry. 9/20/2011... Description of Skin Issues: Heel of left foot has black sore..." But, review of R15's Pressure Ulcer Assessment Form documented R15's left heel wound was not identified until 9/20/2011. R15's Pressure Ulcer Assessment Form documented on 9/20/2011, R15's wound measure "3.5 cm x 1.2 cm", was "100% black eschar" and "unstageable". Review of R15's Nursing Notes were observed to not have documentation of R15's left heel wound until 9/20/2011 at 3:51 PM. This nursing notes documented R15's left heel wound was reported to R15 primary physician and treatment orders obtained. A comprehensive nursing assessment of R15's skin and general condition was not documented as done until 10/28/2011. Review of the facility's Pressure Ulcer Assessment/Evaluation and Treatment documents the following: "...that patients/residents with pressure ulcers will have appropriate assessment, intervention and evaluation of treatment implemented. Physicians will be notified of pressure ulcers. A physician order is required for all pressure ulcer treatments." "When a pressure sore is present daily monitoring will be documented." However, staff failed to implement this policy for R15 until her pressure sore had developed to an unstageable wound.	F9999		

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F9999	Continued From page 21 During the Daily Status Meeting on 11/29/2011 with the administrative staff (E1/administrator and E2/director of nursing), the survey team expressed concerns that R15's pressure sore was not assessed and treated in a timely manner. E1 reported that R15's shower sheet documented that a CNA (certified nurses aide) observed a change in R15's left heel. But, E1 said that nurse and treatment nurse given R15's shower sheet did not assess and treat the change in R15's skin condition on 9/16/2011. E1 also told surveyor that the nurse and treatment nurse no longer worked at the facility and were not available for interview. But, R15's shower sheet, physician orders and nursing notes documented that her left heel wound was not treated until it became unstageable. (B)	F9999		