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F 516	Continued From page 19 The undated facility policy titled, Medical Records Policy and Procedure, states, "Discharged records ... are to be boxed and stored in the Medical Records cabinet in the Store Room." The facility did not provide a policy related to the safeguarding of medical records.	F 516		
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	F9999		

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F9999	Continued From page 20 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: 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. (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on Observation, Interview and Record Review the facility failed to identify pressure ulcers for R107 at a stage I before progressing to stage I. This failure resulted in R107 having two	F9999		

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F9999		F9999		

Continued From page 21
pressure ulcers that were not identified until 5/11/11 when they were at a stage III. R107 developed a pressure ulcer to her right heel that was not identified until 10/28/11 at a stage II.

This applies to 1 of 6 residents (R107) reviewed for pressure ulcers in a sample of 24.

The findings include:

The Wound Care Skin Integrity Evaluation form for R107 dated 5/11/11 showed, "Page 1: Wound 1 - Right 5th toe (lateral).; Onset date - 5/11/11.; Assessment date - 5/11/11.; Exudate: Minimum.; Thickness: Full thickness.; Etiology - Pressure ulcer stage III.; Size - 0.40 x 0.40.; Depth - 0.2.; Push score - 4.; Tunneling - none.; Undermining - none.; Drainage consistency - serous.; Acquisition - facility acquired.; Wound bed - 100% beefy red granulation tissue.; Periwound - Inflammatory phase erythema. Some tannish crusts. Painful.; Evaluation comments: Social services obtaining new shoes. Social Services to get new shoes."

The Wound Care Skin Integrity Evaluation form for R107 dated 5/11/11 showed, "Page 2: Wound 2 - Right 4th toe (lateral).; Onset date - 5/9/11.; Assessment date - 5/11/11.; Exudate - minimal.; Thickness - Full thickness.; Etiology - Pressure ulcer stage III.; Tunneling - none.; Undermining - none.; Drainage consistency - serous.; Size - 1.20 x 0.50.; Depth - 0.2.; Acquisition - Facility acquired.; Wound bed - 100% beefy red granulation tissue noted.; Periwound - Inflammatory phase erythema; slight edema; painful.; Evaluation comments: Social service obtaining new shoes. Social services to

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F9999	Continued From page 22	F9999		

get new shoes."

The Podiatrist Note for R107 dated 5/23/11 showed, "We advise staff to regularly monitor shoewear, or pressure reducing devices and transfer appliances such as wheelchairs, for signs of wear and increased pressure to bony prominences."

On 1/26/12 at 12:50 PM, E12 (Registered Nurse - RN) stated, "I know after that (Pressure ulcers to R107's toes on 5/11/11.) R107 got a bigger pair of shoes." E12 stated R107's shoes had caused the pressure ulcers to her toes.

On 1/26/12 at 12:10 PM, E11 (Certified Nursing Assistant - CNA) stated, "We do skin checks every day to check for skin breakdown. Today R107 had a shower and we make sure her heels are clean and then let the wound nurse know so she can put a dressing on her right heel."

The Wound Care Assessment form for R107 dated 10/28/11 showed, "Size - 4.8 x 5.1.; Depth - unable to determine.; Color - pink/white.; Progress - new.; Moved to pressure sheet."

The Weekly Pressure Ulcer Healing Assessment for R107 showed, "10/28/11 - Stage II.; Size - 3.5 x 7.0 x 0.2.; Drainage - serosanguinous.; Drainage amount - scant.; Drainage color - red.; Ulcer margins - open edge.; Surrounding skin - minimal peripheral tissue edema.; Wound bed - 100% red.; Pain - "Only when it hits the air it stings."

The Weekly Pressure Ulcer Healing Assessment for R107 dated 1/11/12 showed, "Stage II.; Size -

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F9999	Continued From page 23 1.0 x 1.0 x 0.1 open area at 0900.; Undermining/Tunneling - none.; Drainage - serosanguinous.; Drainage amount - small.; Drainage color - red.; Ulcer margins - open edge.; Surrounding skin - hyper and hypo pigmentation.; Wound bed - peri wound with indurated scalp scab = 2.0 x 2.0 x unable to determine." The Nurse Practitioner Progress Note dated 1/12/12 for R107 showed, "Subjective: R107 was seen today for a nonhealing pressure ulcer to the right heel. The wound nurse and I assessed the heel.; Objective: It has a black eschar in the center. The outer edges are pink. It does look like the wound has enlarged. We have been treating this probably for a couple of months. There is slight odor to the wound. This morning the patient had a temperature of 99. She does state that it hurts, especially when it is touched.; Assessment and Plan: Unstagable pressure ulcer to right heel." The Wound Care/Skin Integrity Evaluation form dated 1/18/12 for R107 showed, "Onset date: 10/28/11.; Wound 1 - Right heel.; Thickness - Full thickness.; Etiology - Pressure - unstagable.; Exudate - moderate.; Size - 1.50 x 2.00.; Depth: Unable to determine.; Tunneling - none.; Undermining - none.; Drainage Consistency - Serosanguinous.; Acquisition - Facility acquired.; Wound bed: 100% Tan eschar.; Periwound: Slight erythema indurated.; Treatment intervention: Apply Santyl/Bactroban ointment to eschar. Cover with non-bordered foam dressing. Wrap with stretch gauze and secure with tape every day. On 1/25/12 at 1:30 PM, E7 (Licensed Practical	F9999		

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F9999	Continued From page 24 Nurse - LPN/Wound Care Nurse) stated, "R107's right heel was identified as a blister. A blister is a stage II pressure ulcer. It was healing well and then indurated around the scab and had some drainage around the scab. Her right heel pressure ulcer is a stage II now." E7 was observed giving care to R107's right heel pressure ulcer. E7 removed R107's guaze dressing from R107's right heel. E7 put a mirror under R107's right heel to observe her pressure ulcer. R107 had pressure ulcer to her right heel (medial) that was purple in the center with a white-yellow area around the purple area that appeared to have some drainage. E7 was asked what the caused R107's right heel pressure ulcer? E7 stated, "R107 had a spell when she was unconscious in bed and was moving her feet on her bed and got a blister on her heel." The Nurse Practitioner's Progress Notes dated 11/2/11 showed, "R107 was seen today for unresponsiveness. Staff reports when they tried to get her up this morning she was flaccid. They tried the use of a sit to stand lift. She could not bear weight. Did not open her eyes. Her vital signs have remained stable. She had some involuntary twitching of her bilateral upper extremities and her head. She does have a history of Transient Ischemic Attacks." R107's Pressure Areas Care Plan dated 12/12/11 showed, "Updated on pressure: High risk for skin breakdown as evidence by pressure ulcer scale and some confusion. Occasional incontinence of the bladder.; 10/28/11 - Blister right heel.; Suspend heels when in bed. No shoe until right heel healed."	F9999		

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F9999	Continued From page 25 The facility's Prevention of Decubitus Ulcers Policy and Procedure showed, "Philosophy - Recognizing that residents in long term care facilities have the potential to develop decubitus ulcers, the nursing center believes that this potential can be eradicated with proper preventative measures.; Recognizing the Signs and Symptoms of a Pressure Sore: Usually, the first signs of a bedsore forming on the resident's skin are; heat, reddened areas, tenderness, a feeling of burning at the site and discomfort.; Check the resident's skin condition daily for signs or symptoms of skin irritation or breakdowns.; Use skin protection devices as ordered.; Stages of Decubitus Ulcers: Stage I - A persistent area of skin redness that does not disappear within 30 minutes when pressure is relieved.; Stage 2 - A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.; Stage 3 - A full thickness is lost, exposing the subcutaneous tissue. Presents as a deep cavity with or without undermining adjacent tissue.; Stage 4 - A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone." The facility's policy does not include definitions and/or descriptions of pressure ulcers that are unstagable or deep tissue injury. R107's Pain Care Plan dated 6/25/10 Showed, "Complains of intermittent pain to lower legs and arms. Diagnoses of osteoarthritis, neuropathy, anemia and degenerative joint disease.; 10/20/11 - Continues to have pain and does not communicate pain.; Encourage change of position." R107's Care Plan dated 9/21/11 showed, "Resident prefers in room activities. Potential for	F9999		

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F9999	Continued From page 26 social isolation.; Provide activity calendar in room and invite to activities daily. Provide and offer in room reading material. Respect residents rights and choices regarding activities." R107's Physician Order Sheet (POS) dated 1/1/12 showed Diagnoses including Osteoarthritis, Hypertension, Neuropathy, Anxiety and Depression. (B)	F9999		