STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145657	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE DOWNERS GROVE	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

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F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210a) 300.1210b) 300.1210d)3)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	F9999		

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F9999	Continued From page 24 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 requirements were not followed as evidence by: Based on observation, record review and interview the facility failed to ensure that care and services required to prevent the development and/or worsening of avoidable pressure sores were provided. This is for 3 of 6 residents	F9999		

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sampled for pressure sores in a total sample of 19. (R7, R14, R6) This failure resulted in the worsening of pressure sores(one to a stage 4) for 3 residents.

Findings include;

1.On 1/24/12 at approximately 1:05 PM E6(wound care nurse) removed R7's coccyx wound dressing. R7's incontinence pad and dressing contained copious amounts of yellow/beige/brown foul smelling drainage. The coccyx wound has a surgical edge and E6 states that the wound was surgically debrided last week. R7's coccyx wound measured 5.7 cm by 4.0 cm. E6 stated that there was a less than .1cm depth, however the depth observed was 1cm. E6 stated that there is tunneling and that the wound is unstageable. The wound observed is a stage 4 pressure sore with yellow slough in the center and a small amount of bone visible in the center of the slough.
On 1/25/12 at approximately 11:15 AM with the wound care physician Z2, E6 removed R7's coccyx wound dressing. . Z2 states that the pressure sore is a stage 4 pressure sore.
The record of R7, an 86 year old female admitted to the facility on 12/26/11 for a fractured vertebrae and hypertension was reviewed. R7's record contains a "Ulcer Wound and Skin Assessment" dated 12/26/11 that denotes a stage 2 coccyx pressure ulcer measuring 2.5 cm by 1.3 cm by .02 cm. R7's record contains a "Ulcer, Wound and Skin Assessment" dated 1/8/12 that denotes the coccyx wound is now much larger and measures 5.5 cm by 4.0 cm and is unstageable. R7's record contains a "Ulcer, Wound and Skin Assessment" dated 1/18/12 that states the

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F9999	Continued From page 26 coccyx wound now measures 5.7 cm by 4.0 cm, another increase in size. R7's record contains a wound physician progress note dated 1/25/12 that denotes a worsening of the coccyx wound that measures 5.2 cm by 3.5 cm by 1 cm, "now down to bone...sacral wound stage 4". In an interview with E6, the wound care nurse, she states that R7 would not stay repositioned and that was how the wound became a stage 4. R7's record lacks documentation in the nurses notes or the care plan that repositioning was a problem. R7's care plan was not updated to include the worsening of her coccyx pressure sore. In an interview with R7 she states that her coccyx wound became worse because the staff scraped her "butt" when they took her on and off the bedpan. R7 states that she now is able to go to the toilet. The increase in size and severity of R7's pressure sore was avoidable. 2. R14's record contains a "Ulcer, Wound and Skin Assessment" dated 3/17/11 that denotes she has an open area to her coccyx, no measurements were documented. R14's "Ulcer, Wound and Skin Assessment" dated 3/18/11 denotes a coccyx wound measuring 2.5 cm by 1.0 cm by .1 cm. R14 wound record on 3/31/11 denotes a significant worsening of the coccyx wound which at that time measured 4.4 cm by 3.5 cm by .2 cm. R14's record lacks documentation that her condition recently deteriorated. R14's record lacks a care plan for pressure sore	F9999		

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prevention.
In an interview with E6 she could not remember the specifics regarding R14's coccyx pressure sore.
According to record review and interview R14's coccyx pressure sore was avoidable.

3. On 1/16/12 at approximately 1:20 PM E6 changed R6's dressing. R6's coccyx measures .7cm by .7 cm by .1 cm. These measurements are the same as the measurements on 1/18/12. R6 states that she has pain in the coccyx when the staff clean her after a bowel movement, she states that the toilet paper is too rough. E6 states she would tell the staff to use a wet washcloth. R6's record contains nursing documentation dated 12/30/11 that states she was admitted to the facility with a reddened coccyx. R6's record contains a Braden Scale for predicting pressure sore risk dated 1/6/12 that denotes a score of 15 which is high risk. R6's record contains a Ulcer, Wound and Skin Assessment' dated 1/18/12 that denotes she now has a stage 2 pressure sore measuring .7 cm by .7 cm. R6's care plan was noted updated to include interventions for the development of a pressure sore.
In an interview on 1/24/12 at 10:30 AM R6 stated that her coccyx pressure sore is getting better. R6 states that she did have pain at first with the pressure sore but that the pain is gone now. R6 states that she does not really know how she developed the pressure.
In an interview with E6, the wound nurse, she states that she does not know how R6 developed a pressure sore.

The facility policy titled "Pressure Ulcer" states

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F9999	Continued From page 28 that, "Avoidable Pressure ulcer is defined as a pressure ulcer that develops related to the facility fail (B) 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	F9999		

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F9999	Continued From page 29 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 practicable level of functioning. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	F9999		

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F9999	Continued From page 30 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 requirements were not met as evidence by: Based on record review and interview the facility failed to ensure that techniques used to transfer residents from one position to another is completed safely. This is for one resident in a sample of 19. This failure resulted in the fracture of one resident's arm.(R14) Findings include; R14's record contains an occurrence log dated 3/8/11 that denotes the following; "Daughter came to nurse and stated that mother was complaining of right arm pain after she had been transferred from the bed to the wheelchair..." R14's occurrence report contains an interview with a certified nurse assistant (CNA) that denotes, "She used the sit-to stand lift to transfer the client (R14) from the bed to the wheelchair...states that while the client was lifted she heard a snap." R14's record contains a an X-Ray report dated 3/8/11 that denoted, "A diagonal displace fracture through the distal shaft of the right humerus is identified. There is significant proximal dislocation of the distal fracture fragment this resulted in for shortening of the humerus." This X-ray report describes a serious twisting fracture. R14's occurrence report lacks a conclusion as to	F9999		

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F9999	Continued From page 31 how this serious fracture occurred. R14's record lacks a plan of care for transfers prior to the fractured arm. R14's record contains a family practioner note dated 3/8/11 that denoted ,"...transferring from bed to wheelchair in lift, complained of acute pain...revealed right humerus fracture." R14's record contains a care plan after the broken arm that states she is a two person transfer. In an interview with the E1 administrator she stated that an abuse investigation was not done on this resident. E1 states that inservice education was provided to the CNA who transferred R14. E1 states that the CNA is no longer employed at the facility. (B)	F9999		