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	145995	A. BUILDING _____ B. WING _____	C 02/24/2012

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RENAISSANCE AT MIDWAY, THE	**4437 SOUTH CICERO CHICAGO, IL 60632**

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F 323	Continued From page 19 be reported to physician there should be an assessment for joint deformity. If it is not documented that is a big problem, we can all learn from this."	F 323		
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	F9999		

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F9999	Continued From page 20 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. 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 requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to perform skin assessments, for areas of skin breakdown, provide nutritional interventions, provide nursing interventions, and provide treatment for 5 of 5 residents (R1,R2,R3,R4,R7) reviewed for pressure sores in the sample of 10. This failure of delay in care resulted in the progression and worsening of the wounds.	F9999		

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Findings include:

1.On2/21/12, at 12:05pm, R1 was up in the wheelchair with the mechanical lift sling underneath him. R1 stated that he stays sitting up in the wheelchair with the sling underneath him from breakfast until after dinner.

On 2/22/12, at 9:50am, during wound treatment, a thick layer of dried white cream covering a large area of R1's right gluteal area was noted. The white cream was washed off by E8 Certified Nursing Assistant,CNA). An open, reddened area was noted in the right gluteal fold. E4 (Treatment Nurse) was asked about the open area. E4 responded that she was not aware of the open wound and that the white barrier cream should not be put on skin that is not intact. E4 stated that other staff should report skin changes to her. E4 measured the open area to the right gluteal fold as 0.8cmx2.4cmx0cm.

On 2/22/12, at 10:30am, E7(Nurse) stated that she performed R1's wound care to the right thigh blisters. E7 stated that a skin assessment is done daily during wound care and new areas of breakdown are reported to E4. E7 stated there is no new skin breakdown on R1's body and she did not apply any white barrier cream to R1's right gluteal area.

On 2/24/12, at 12:10pm, by phone interview, E9 (Nurse) stated that in the AM on 2/21/12, Z8 (Family) notified her that R1 had excoriation, redness, and bleeding in the gluteal folds. E9 stated she assessed R1 and found redness on the gluteal folds and applied barrier cream. When

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F9999	Continued From page 22 asked if she did anything else, E9 replied, "That was it." When asked if she notified the physician, E9 replied, "I did not call the doctor." Review of R1's clinical chart through 2/22/12: nurse's notes do not document any open area of skin in the right gluteal fold, Physician Orders do not reflect orders for wound treatment, Treatment Record does not document treatment for the open area in the right gluteal fold. Review of R1 ' s clinical chart documents the following: R1 was re-admitted to the facility on 10/5/11. Nurse ' s Note dated 10/5/11 documents bilateral heel redness. The 24 Hour Post Incident Report dated 10/29/11 documents a right heel deep tissue injury, 24 days later. Pressure Sore Risk Assessment dated 10/6/11 gives R1 a score of 11, which is high risk for developing pressure sores. Nurse's Notes do not document that the physician was notified on 10/5/11 of the bilateral heel redness. From 10/5/11 through 10/29/11, 24 days, there is no documentation that interventions of pressure relief, such as elevating the heels, were implemented, or that there was monitoring of the bilateral heel redness. There are no orders for wound care on the physician order sheet.There are no weekly wound notes or assessments. On 2/23/12, at 2pm, by phone interview, Z6 (Physician) stated that he expects to be notified by the nursing staff of any changes in resident conditions, including new areas of skin breakdown or worsening wounds. Z6 stated that when a resident has skin breakdown, the wound care nurse is immediately consulted for	F9999		

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assessment and treatment recommendations. Z6 stated that he does not recall being notified of R1's bilateral heel redness. Z6 stated that for bilateral heel redness, he would have ordered to elevate the heels to relieve pressure, turn the resident every 2 hours, monitor closely, notify him of any changes in the skin condition, and possibly a barrier cream.

2.On 2/22/12, at 9:30am during wound treatment with E4 (Treatment Nurse), a new open area to R2's upper right lateral calf was noted. The gauze dressing was partially folded down, the wound was partially exposed, and the gauze was soiled with red drainage. E4 (Treatment Nurse) was asked about the open area. E4 responded that it was a closed, purple, discolored area since admission. E4 stated that she did not change the dressing this morning and that it must have just opened up this morning because she was not aware that it was now open. E4 stated that she has not documented or measured the wound because it has been a closed area since admission.

On 2/22/12, at 10:35am, E7 (Nurse) stated that she changed R2's dressing at about 8:30am that morning and had nothing new with the wounds to report to the treatment nurse.

On 2/23/12, at 3:25pm, by phone interview, Z7 (Physician) stated that this new wound to R2's upper right lateral calf is from pressure. Z7 stated that they were not treating this area, not measuring it, and missed documenting on it.

3. Review of clinical record for R7 includes the following:

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F9999	Continued From page 24 Nurse's Note dated 1/31/12, at 7:00am, documents notation of a closed blister to R7's sacral area, and endorsement to next shift to follow up with treatment nurse notification. There are no nurse's note from 1/31/12, 7:00am, through 2/3/12, 7:30am. On 2/3/12, at 11:30am, the nurse's note documents 2 dark purplish areas. Wound and Skin Note dated 2/3/12, documents a sacral deep tissue injury, purplish in color, measuring 8cmx3cm, with a 1x1cm area of eschar at the lower portion of the larger wound. From 1/31/12, 7:00am, through 2/3/12, 11:30am, there is no documentation of physician notification of sacral blister, no wound or skin assessments, no monitoring of the sacral blister, no documentation of pressure relief or turning of R7. On 2/23/12, at 1:50pm, by phone interview, when informed that R7 had a new sacral blister that was not being treated or monitored, Z5(Physician) stated that R7 should have had monitoring and documentation of the sacral blister to be aware of it getting worse, frequent turning, a special mattress, pressure relief, and barrier cream. 4. On 2-21-2012 at 11:34AM R3 was laying in bed, bilateral side rails up times two, eyes opened, urinary drainage bag on the left side of the bed. R3 had multiple pressure sores. R3's full thickness sacral sore had no dressing. R3 had an adult incontinent brief on that was not fastened and was laying on 3 layers of bedding (A sheet, a folded sheet and an incontinent pad) on a low air loss mattress. E6(Restorative Nurse) and E11(Nurse Manager) were present in the room. E11(Nurse Manager) immediately	F9999		

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responded while in the room, "R3 should not have as many layers on the bed with a low air mattress. The treatment nurse will treat the sacral sore." On 2-21-2012 at 11:45AM, E2 (Restorative Nurse) stated, "We are going to do some inservice and people will be in trouble for putting multiple layers linen on air mattress beds." On 2-21-2012 at 2:51PM, E4 (Treatment Nurse) treated R3's wounds. R3 was still laying on a sheet, a folded sheet and an incontinent pad. The incontinent pad was stained yellow and wet. E4 (Treatment Nurse) responded, "the catheter is leaking." R3 was laying in bed with right leg contracted over the left leg. During treatment 4 pressure sores were noted, right hip, right groin, right medial leg and left lateral leg. E4 (Treatment Nurse) was only able to measure the right hip pressure sore (2.4cm length, 3.5cm width, .7 cm depth) due to resident declining further Treatment. Physician Orders, Dietary Notes and Medication Administration Records were reviewed from 8-2011 until current 2-21-2012. R3 did not receive any juven or prostat supplements for wounds from 12-11-2011 until 1-10-2012. On 2-23-12 at 10:50AM Z3 (Dietician) stated that she was familiar with R3 and had been following her for a while and has ordered supplements juven and prostat for wounds. Z3 (Dietician) could not answer why R3 did not receive those supplements from 12-11-2011 until 1-10-2012. On 2-23-2012 at 3:47PM, E2(Director of Nursing) stated, "usually juven and prostat are dietary referrals, I can not answer why R3 did not receive those wound supplemts from 12-11-2011 until 1-10-2012. The nurses should have ordered it."

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F9999	Continued From page 26 5. On 2-21-2012 at 11:49AM, R4 was laying in bed with 3 layers, 1 sheet, 1 draw sheet folded and 1 incontinent pad. R4 also has 1 full thickness sacral sore with no dressing. The low air loss mattress bed contained a moderate amount of serosanguinous drainage from leaking sacral and leg wound dressings and there was a pungent odor coming from the dressings. On 2-21-2012 at 2:12 PM E4 (Treatment Nurse) treated R4's wounds. R4's continued to lay on a air mattress with heavy serosanguinous drainage on the sheets, mattress and dressing. R4 stated, "I got the wounds while being here, I have been here since 2009,I am paralyzed legs down." R4 has 3 wounds on upper body, A Left Ischium and an ischium and a sacral wound. All of the wounds' dressing were heavily soiled in serosanguinous drainage. The sacral wound had no dressing on it and it was unstageable with a large amount of slough protruding from the center of the wound. Measurements obtained during the dressing were as follow: Left Ischium, 3 cm length, 7 cm width and 2.6 cm depth Right Ischium, 4.5 cm length, 14 cm width, and 2.7 cm depth Sacral 7.2 cm length, 13 cm width and depth undetermined. Treatment nurse stated, "I just started 3 days ago." Weekly wound Assessment documents the 3 wounds progressively getting worse from 11-14-2011. Documentation as follow: Left ischium 2.0 length, 1.0 width and 4.0 depth, Right ischium 1.0 length, 2.0 width and 4.0 depth Sacral- 6.0 length, 1.0 width and .2 depth	F9999		

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F9999	Continued From page 27 On 2-23-2012 at 10:58 while laying in bed R4 stated, "They turn me here, I get turned once a day when they do the dressing change." Care Plan dated 11-14-2011 for pressure sores states, "Skin cleansing after soiling and at routine intervals. Reposition for comfort and pressure reduction avoiding placement on affected areas if possible." (B)	F9999		