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	145754	A. BUILDING ______ B. WING ______	03/02/2012

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SNOW VALLEY NRSG & REHAB CTR	**5000 LINCOLN AVENUE** **LISLE, IL 60532**

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F 441	Continued From page 44 E28 and E17. E2 was unable to show that these employees were free of a infectious/communicable disease. The facility's policy read, all newly hired employees will be screened for TB (tuberculosis) and disease after an employment offer has been made but prior to the employees' duty assignment. The initial TB testing will be a two step test (purified protein derivative) PPD intradermally.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.1220b)2)3) 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	F9999		

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F9999	Continued From page 45 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 procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician.	F9999		

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F9999	Continued From page 46 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as	F9999		

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F9999	Continued From page 47	F9999		

are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months

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 observation, interview and record review the facility failed to: (1) Identify the existing acquired pressure ulcer for R 2. (2) Failed to reposition and toilet R 2 for more than two hours. (3) Develop a pressure ulcer plan of care for R 2. (4) Consistently implement the interventions developed for R 1 and to evaluate the effectiveness of their current interventions.
These failures resulted in (1) R 2 ' s development of multiple avoidable facility acquired pressure ulcers (two Stage I ' s and two Stage II ' s) and (2) Avoidable acquired Stage III on R1's right heel.
This applies to two of three residents (R 1 and R 2) reviewed for pressure ulcer in the sample of 13.
Findings include:
1. Review of the facility pressure ulcer report presented on the 1st day of the survey (02-27-12) showed the facility has no acquired pressure ulcers. Two residents (R 1 and R 7) were documented with pressure ulcers that they were admitted with. R 2 was not included in the list with

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F9999	Continued From page 48 pressure ulcers. 2. On 02-27-12 at 6:10 a.m., R 2 was observed in the small dining room sleeping in her high back rest wheelchair. The night nurse/ E 12 stated " she (R 2) was gotten up by the 10 PM to 6 AM - shift (night shift). " At 8:45 AM R 2 was observed feeding herself for breakfast. At 9:00 a.m. R 2 was transferred in the large dining room. At 9:30 AM R 2 was observed sleeping in her wheelchair. At 10:20 AM, R 2 was moved back in the small dining room. At 12:15 PM lunch tray was served. R 2 was not observed being repositioned or toileted by the staff for more than two hours on 02-27-12. Review of R 2 ' s most current Physician Order Report (01-01-12 thru 02-29-12) showed an order to turn and reposition every 2 hours, on each shift and as needed. At 1:30 PM, R 2 was taken to her room (per surveyor ' s request) by the CNA/E 8 and the Restorative Aide/E 19. R 2 had a very strong urine odor. During the incontinence care R 2's disposable incontinence pad was observed saturated with urine and with moderate amount of BM. R 2's right and left ischium was observed with a (Hydrocolloid) dressing. Both E 19 and E 8 stated they can't recall if R 2 was toileted or repositioned while she was up in her wheelchair from 6 AM thru 1:30 PM. At 2:10 PM, the permanent CNA/E 6 stated " these (pressure ulcers on the right and left ischium) started as redness then, it opened up. The nurses are aware; it ' s been there for a while. She ' s (R 2) confused and disoriented, she can't verbalized her needs. She's a mechanical lift transfer, totally dependent on staff with her activities of daily living and can be combative at times. " R 2 was noted to have impaired cognition, when spoken to	F9999		

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F9999	Continued From page 49 she will blow kisses and say " I love you! " On 02-28-12 at 10:20 AM, R 2 was observed in the small dining room sleeping in her high back rest wheelchair. At 11:30 AM, R 2 was observed at the back of the dining room still sleeping until the tray was served at 12:30 PM. R 2 was not observed to be repositioned by the staff. At 1:15 PM, a skin assessment was requested of the Nurse in Charge (E 18). At 1:30 PM, R 2 was transferred from her wheelchair to her bed by using a mechanical full lift. At 1:35 PM, a skin assessment was requested. The Nurse in Charge (E 18) identified/Stage and described the following pressure ulcers: (a) Non Blanching area - Stage I on the sacrum, measured at 4.3 cm X 9.0 cm. (b) Open area -Stage II on the right ischium, measured at 2.6 cm X 1.4 cm. (c) Open area -Stage II on the left ischium, measured at 0.9 cm X 1.0 cm. (d) Non Blanching area - Stage I on the right buttocks, measured at 0.5 X 0.6 cm. E 18 stated " it starts as redness then, it gets better then, it opens up. " On 03-02-12 at 12:55 PM, the CNA/ E 7 stated " it started as redness then it opens up. It ' s been (wound) for about 2 months now. The nurses are aware it ' s open and it ' s not getting better. We get her up in the morning (6:00 AM) and we put her back to bed after lunch around 1:00 1:30 PM. No she doesn't ' go back to bed after breakfast. " On 02-28-12 at 2:40 PM, the Director of Nursing / E 2 was informed about R 2 ' s pressure ulcer. E 2 claimed " I didn't ' know about that (R 2 ' s pressure ulcers). " E 2 asked " who staged that? The nurses are not allowed to stage a pressure ulcer. Yes! They can measure, document, do the treatment, call the doctor regarding the ulcer; they	F9999		

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F9999	Continued From page 50 can do everything except to Stage. I ' Im the only one that can stage it. " During the facility presentation on 02-19-12 at 10:00 AM, when the facility Administrative staffs (Administrator (E 1), Director of Nursing (E 2) and the Nurse Consultant (Z 1) was asked why the nurses are not allowed to stage and yet could do anything with the pressure ulcer care, Z 1 stated " the nurses are not allowed to stage because it's a corporate policy, until they are trained. " On 02-29-12 at 10:00 AM E 18 stated " I had my wound training provided by the company. " Copies of all R 2's care plans were requested and found no pressure ulcer care plan was developed for R 2 and this was confirmed by E 2 on 02-28-12 at 2:30 PM. Review of R 2 ' s treatment flow sheet dated 02-25-12-thru 03-26-12 showed an order dated 02-25-12 for Hydrocolloid dressing to both buttocks, change every three days until healed. A review of the wound care clinical guide 5 th edition showed the indications for Hydrocolloid: may be used as primary or secondary dressings to manage select pressure ulcers, partial and full thickness wounds, wounds with necrosis or slough, and wound with light to moderate exudates. 3. On 02-27-12 at 6:10 AM, R 1 was observed in bed waiting for help to go to the bathroom. R 1's right foot was wrapped with a bandage. No pressure relieving device was noted. R 1's heels are directly resting on the mattress. R 1 stated " I have a pressure ulcer on my heel. It developed here. " On 02-28-12 at 1:00 PM, R 1 was observed sitting on her motorized wheelchair, right foot was noted with bandage, no pressure relieving device was noted. R 1 also stated " they're (staff) suppose to put something to elevate my feet when I'm in bed, but they don't	F9999		

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F9999	Continued From page 51 put it regularly. " The facility was requested to update the pressure ulcer report sheet on 02-27-12 during the daily status meeting; on 02-28-12 at 10:45 AM during the facility presentation, the facility presented the same list of residents with pressure ulcer and R 1 is one of the two residents listed with pressure ulcer that was admitted with pressure ulcer. On 02-28-12 at 11:10 AM E 2 stated " there was no comprehensive assessment. R 2's pressure sore developed from the hospital. " At 12:15 PM, E 2 stated " I don't classify that as a pressure sore. " Review of R 1's resident progress note dated (a) 03-21-11 reads: Resident (R 1) also complaint bilateral heels " hurting ...Noted blood blisters measuring about 3.0 cm X 4.0 cm on the right heel and 7.0 cm X 5.0 cm on the left heel. Resident (R 1) only footwear is a pair of tennis shoes which appears to be tight. (b)On 04-04-11 -Upon developing blister on bilateral heels, resident (R 1) was discharged to hospital. Upon return blister broke. " Review of the facility pressure ulcer report showed R 1 was admitted with Stage III pressure ulcer on the right heel. Review of R 1's Minimum Data Set section M dated 02-11-11 showed R 1 has no skin alteration. Minimum Data Set dated 02-02-12 showed R 1 has one Stage I pressure ulcer measured documented at 2.0 cm X 1.1 cm X 0.1 cm. On 02-29-12 at 10:00 AM, treatment observation was requested. The Nurse in Charge/ E 6 identified and stated " right heel pressure ulcer, if I have to stage it, it will be Stage III. There's yellow slough at the base of the wound, with scant amount of drainage (serosanguineous). The measurements are 4.2 cm X 2.5 cm X 0.4 cm. The treatment is Santyl	F9999		

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ointment then cover with dressing. I was told were not to stage pressure ulcer. I had my training for wounds provided by the corporate. We can do everything else except to stage. "
R 1 ' s Care Area Assessment # 16 (pressure ulcer) dated 02-02-12 reads: Resident has a pressure ulcer to the right heel ...Resident ((R 1) has diagnosis of DM ... Resident has limited mobility, confined to wheelchair most of the time. Requires assist with activities of daily living ...
R 1's skin care plan dated 02-02-12 was not individualized and specific to promote healing. R 1's approaches includes to insure resident is wearing proper fitting shoes. Keep right foot elevated as ordered, this was not implemented on 02-27-12 and on 02-28-12. Wear appropriate size shoes to prevent rubbing of foot on shoe. Assess resident for presence of risk factors. Treat, reduce, and eliminate risk factors to extent possible.

(B)

300.610a)
300.1210a)
300.1210b)3)4)
300.1210c)
300.1210d)4)A)
300.1220b)2)3)
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

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F9999	Continued From page 53 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 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: 3) All nursing personnel shall assist and	F9999		

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encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.
4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

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Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months

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 observation, record review and interview the facility failed to, obtain a medical

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F9999	See text below	F9999		

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justification for the use of an indwelling catheter to prevent recurrent urinary tract infections , provide incontinence assistance, evaluate causes of incontinence, develop and implement a specific program to maintain and improved bowel and bladder functioning.
These failures resulted in:
(1) R 1 left lying in a bed soaked with her urine. This resulted in R 1's psychosocial and emotional distress. R 1 stated " it's humiliating and depressing. I just need to adjust my self and find a dryer area on the bed. "
This applies to three of nine sampled residents (R1, R9, R10) who require incontinence care and one of two residents (R5) with a urinary catheter in the sample of 13

Findings include:
On 02-27-11 at 6:10 AM, R 1's room was observed with call lights on with very strong odor (combination of urine and BM odor). R 1 was observed lying in bed, alert and oriented, bed sheet noted to be wet and with brown stain. R 1 stated " I need to go to the toilet. I had my light on since 5:00 AM, no one comes. This is every day. " At 6:20 AM, the certified nursing assistant (CNA)/E 7 (6 AM- 2 PM shift) assisted R 1 to sit up at the edge of the bed (from lying down). R 1 ' s bed pad, bed liner and R 1's adult incontinence brief were observed saturated with urine. The bed sheet soaked from R 1's upper back down to the lower extremities and the sheets were noted with brownish discoloration. E 7 was observed to remove urine saturated disposable liner from R 1's bed. E 7 assisted R 1 to the bathroom using her walker; R 1 was ambulated wearing a bra and an adult disposable brief which was noted to be

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	145754	A. BUILDING ______ B. WING ______	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNOW VALLEY NRSG & REHAB CTR	**5000 LINCOLN AVENUE LISLE, IL 60532**

(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
F9999	Continued From page 57 sagging heavily saturated with urine, R 1 stated " Yes this diaper is too heavy, it's very soaked. " E 7 confirmed R 1's statement. E 7 stated " she's right! This is every day. She's (R 1) always wet when we come in the morning. " R 1 stated " It's upsetting when you need help and there is no one to help you.I don' t think anyone likes to lie down on a wet sheet for several hours. It's very uncomfortable. It' s depressing and humiliating. It feels yucky, I just need to adjust myself and find a dryer area on the bed. I felt embarrass and hopeless. Sometimes its worse than this but this is every day. I just need assistance to go to the toilet. " The CNA/E 7 assisting R 1 stated " she's (R 1) alert and oriented, she can verbalize her needs to go to the bathroom and can ambulate with her walker with supervision." Review of the admitting CAA (Care Area Assessment) #6 Urinary incontinence and indwelling catheter dated 02-11-11 presented was blank and this was confirmed by the Director of Nursing/ E 2 on 03-01-12 at 1:00 PM. E 2 stated " they didn't do the CAA for incontinence. " There was no incontinence care plan developed for R 1 and this was confirmed by E 2 on 02-28-12 at 1:00 PM. On 02-27-12 at 2:40 PM the Restorative / Bowel & Bladder Nurse /E 10 stated " she's (R 1) not in the program because she's continent. That is probably why she doesn't have a care plan. " R1's Care Area Assessment 6. Urinary Incontinence and indwelling catheter dated 02-02-12 reads: Other factors that contribute to incontinence or catheter use: Urinary urgency and need assistance in toileting. Type of incontinence: Stress. Analysis of findings: Resident (R 1) has an occasional incontinence episode; usually due	F9999		

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F9999	Continued From page 58 to resident waiting too long to go to the bathroom. E 10 confirmed on 03-01-12 there's no voiding pattern obtained. And no comprehensive assessment done to analyze the cause of R1's incontinence episode and no program was developed or implemented to improve or to prevent further decline. (2) On 02-27-12 at 9:50 AM, R 10 was observed in the dining room asking the staff to take him to the bathroom. R 10 was taken to the hallway and was left there. At 9:55 AM, R 10 continuously is asking staff that's passing by to take him to the bathroom. At 10:10 AM, R 10 was taken to the bathroom by a Direct Care Staff/E 8. R 10 was observed able to follow instructions from E 8, able to stand up while holding the bathroom side rail, removed his disposable incontinence brief and cleans himself, able to instruct E 8 to wash her (E 8) hand and his (R 10) too and reminded E 8 to put cream (barrier) on his buttocks. E 8 stated " he knows what he wants, he's alert and oriented, and he walks with restorative. He's able to transfer from wheelchair to the toilet, he just need supervision and cuing. Sometimes he's incontinent but most of the time he's continent. " At 10:40 AM R 10 stated " I don't like wearing diaper but many times if I asked them to take me to the bathroom they are not ready for me. Here, you wait in a long line, so the diaper will help. They didn' t ask me if I wanted the diaper, they just put it on me when I was admitted. It's very uncomfortable and hot but it catches the feces when no one can assist you to the bathroom. " R5 observed on 2/27/12 to have an indwelling catheter. The tubing is seen touching the floor. The catheter tubing contains a large amount of whitish clumps of sediment. A review of the clinical record documents the use of an indwelling	F9999		

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F9999	Continued From page 59 urinary catheter is due to prostate gland enlargement as identified by the ultrasound report dated 11/20/2011. The report states R5 has urinary tract infection and gross hematuria form pulling out the urinary catheter. The physician's progress note dated 2/28/12 documents R5 has history of chronic urinary tract infections secondary to urinary catheter. During the observation of catheter care for R5 conducted on 2/29/12 at 1:45pm, with (E9) CNA and (E4) RN. E9 said he changed R5's catheter tubing from the leg bag to the drainage bag. E9 told surveyor he did not wash R5 nor did catheter care. E4 said she would conduct the catheter care for R5. E4 obtained a basin with soap and water, wash clothes and towels. E4 did not use these items. E4 obtained a package of 4x4 gauze and two 10 cc amps of saline. E4 wet the 4x4 gauze with the saline and cleaned the catheter tubing from the insertion site to the end of the catheter. A review of the facility's policy and procedure for urinary catheter care Item # 14 for male: use a washcloth with warm water and soap to clean around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Item # 15: use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. Item # 16 secure catheter utilizing a leg band. These steps were not conducted during the observation.	F9999		

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F9999	Continued From page 60 The 12/10/11 lab culture of urine identifies an infection of Enterobacter Cloacae greater than 100,000 colonies. A review of the facility's current diagnosis list among others dated 11/24/11 Benign prostatic hypertrophy (BPH) without urinary obstruction From interview with E10 restorative nurse and E2 director of nursing, there is no post voiding residual or other testing to determine if R5's catheter could be removed. R9 observed at 6:30am in the cafe dining area in an adult recliner chair. R9 is poorly positioned leaning to the left. R9 observed to be seated in the cafe until 9:00 a.m. and then taken to the main dining room. During the four hours, R9 was not repositioned or toileted. R9 is assessed to require total assistance with ADL's from the 1/4/12 minimal data set. (B)	F9999		