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F 314	Continued From page 7 Santyl ointment is indicated for debriding chronic dermal ulcers. Use of the ointment should be terminated when debridement is complete and granulation tissue is well established.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)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 300.1010 Medical Care Policies	F9999		

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h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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

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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.

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.

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.

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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 are not met as evidenced by:

Based on observation, interview and the record review the facility failed to
have a wound care program to monitor residents skin, reduce pressure, protect the skin, identify causes of pressure and evaluate the effectivness of the interventions. These failures resulted in R3 developing an unstageable wound to the left posterior thigh.

This applies to 3 of 4 residents (R1, R3, R4) reviewed for pressure ulcer management in a sample of 4.

The findings include:

1. On 6/20/12 at 1:10 PM, R3 was transferred into bed using a mechanical lift by E11 and E14 (Certified Nursing Assistant - CNA). R3's legs and arms were in a contracted position. During personal care and repositioning, a wound was observed on the back of R3's left leg, in the mid thigh area. Through the center of the wound was a skin crease from the disposable incontinence pad she was wearing. The center of the wound was filled with black scabbed tissue. E11 and E14 both stated they were not aware she had a wound there. E11 stated, "She did have one on the coccyx, but I think it is healed". E11 stated, "We are to report open areas to the nurse", she

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was not aware if the nurse knew of this opening. No barrier cream was applied to R3's buttocks after incontinence care was completed.

On 6/20/12 at 1:50 PM, E2 (Director of Nurses - DON) and E4 (Registered Nurse - RN) observed the wound on the back of R3's leg. E4 (RN) stated there was no treatment order for a wound on the back of R3's left leg. E4 stated she was not aware of the wound, nothing had been reported. E2 and E4 did not know the reason R3 could have developed a pressure sore on the back of her leg. E4 measured the opening 1cm x 0.5 cm and stated, "The black center is eschar, and the wound is unstageable". E4 stated she was not aware of any facility protocols for wound care. E4 stated the physician will give the treatment order.

R3's shower sheets dated 6/8/12 and 6/19/12 do not identify the open area on the posterior left thigh.

R3's pressure ulcer risk score was 12 on 4/2012, (greater than 8 is high risk for development of pressure ulcers).

The treatment record for R3 dated 5/1/2012 shows on 5/8/12 a stage I area of non-blanchable redness was noted and "Skin Prep" treatment was ordered. On 5/17/12 the wound was assessed as healed. The treatment order for daily skin checks was documented on 9 of 31 days in May and 5 of 19 days in June.

The nurses' notes for R3 from 2/29/12 through 6/20/12 do not identify any pressure concerns to R3's posterior thigh. R3's updated care plan

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dated 5/2/12 states R3 is non-ambulatory and dependent on staff for mobility. The care plan states R3 has no pressure areas. The source of pressure to R3's posterior thigh is not identified and no interventions are listed to prevent pressure on the area.

The Physician Order Sheet dated 6/1/12 lists R3's diagnoses as Dementia, Chronic Pain, Multiple Sclerosis, Osteoporosis and Neurogenic Bladder. The physician orders for skin care includes: Daily skin checks for breakdown, Vitamin A and D ointment for buttocks/peri area as needed, Apply skin prep to left posterior thigh daily.

On 6/26/12 at 9:25 AM, Z1 (Physician) stated, "The facility has wound care protocols." Z1 added he could not recall if the facility had notified him of an unstageable area on the left posterior thigh. Z1 stated, "The back of the thigh is an unusual area for pressure to develop, but the care plan should address what to do (to relieve the cause of the pressure)."
R3's Minimum Data Set (MDS) of 4/24/12 shows she is at risk for skin breakdown and does not have any unhealed pressure ulcers.

The (undated) facility policy for Pressure Ulcer Prevention and Care states inspection of the resident's skin should be included in the daily routine. Reporting of new wounds or a change in the resident's skin to the nurse is not included in the policy. E2 (DON)

2. The facility weekly skin report of Non-Pressure areas dated 6/19/12 shows R4 has 2 facility acquired wounds; one on her right lower back and the other on her midline back. The type of

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F9999	Continued From page 13 wound is listed as blister. On 6/20/12 1:40 PM, E4 (Registered Nurse - RN) stated R4 was receiving wound treatments for 2 blistered areas on her back. E4 stated she did not know how or what caused them. On 6/20/12 at 3:15 PM, E12 (Licensed Practical Nurse - LPN) turned R4 while in bed. Two adhesive dressings were observed across R4's lower back at the waistline area. An adhesive dressing was also observed on R4's right upper thigh. E12 stated the areas were blisters. E12 was not aware what caused R4 to develop the blisters. The nurses' notes dated 6/11/12 for R4 states, "Resident found with blisters to her low back. The right lower back noted to have broken open. Wound bed bright red and moderate amount of serous drainage. The lower left back with an intact fluid filled blister measuring 3.0 cm L x 1.0 cm W x undetermined depth." No assessment was done to determine the potential cause of the friction on her lower back. The wound documentation found on the back of the treatment record dated 6/11/12 for R4 states, "Stage II open blister to lower right back, 4.8 cm L x 7.0 cm W x <0.2 cm depth. (Wound) bed bright red moderate amount serous drainage, surrounding skin normal pink." The second area is described, "Left lower back with intact fluid filled blister 3.0 cm L x 1.0 cm W x undetermined depth, surrounding skin normal pink". A wound treatment order for Silvadene Cream 1% to the affected areas twice a day was obtained for R4. According to the treatment record documentation,	F9999		

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the treatment started on 6/11/12. The treatment was applied twice a day on only 2 of the 9 days between 6/11/12 and 6/18/12. There was no treatment order or wound documentation for the wound on R4's right upper thigh.

The care plan for R4 dated 11/23/11 and updated on 5/24/12 shows R4 is at risk for skin breakdown. The blister wounds on her back and upper right thigh are not included, and no causative factors are identified for R4's development of blisters on her back. R4's care plans also address a decreased ability to ambulate and impaired mobility. R4 requires transfer assistance of 1 or 2 staff using a gait belt. According to her care plan, R4's speech is nonsensical, and she is unable to make her needs known.

The facility's undated wound staging cards state, "Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister".

3. The Physician Order Sheet dated 6/1/12 for R1 lists her diagnoses as Urinary Tract Infection, Diabetes Mellitus, Clostridium Difficile infection, Rhabdomyolysis, Decubitus Ulcers, Foot Wound, Hypertension, and Osteoarthritis. A wound treatment order dated 5/7/12 (date of admission) to cleanse wound (coccyx) with normal saline, apply ointment (debridement agent used to debride and heal wounds) and cover with foam border dressing daily until healed.

The weekly pressure ulcer report dated 5/7/12

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F9999	Continued From page 15 shows R1 was admitted with coccyx wound, with undetermined stage, measuring 1.3 cm L, x 0.4 cm W, no depth, moderate serous drainage and debridement agent initiated. The next pressure ulcer report on 5/12/12 shows the coccyx wound assessment as Stage II, measuring 1.0 cm L x 3.0 cm W, <0.2 cm depth. Comments include the area had declined with an increased size noted. The weekly pressure ulcer report dated 5/21/12 shows R1's coccyx wound as Unstageable, measuring 2.0 cm L x 0.6 cm W x 0.3 cm depth, with moderate serous drainage. Progress note states the wound size increased and was covered with 100% slough. The weekly pressure ulcer report dated 5/30/12 shows R1's coccyx wound again increased in size to 2.0 cm L x 1.0 cm L. No progress note is documented; no change in treatment orders are noted. The weekly pressure ulcer reports on 6/13/12 and 6/19/12 document R1's coccyx wound is unchanged in size and wound healing. The same treatment order since admission(debridement agent) is in place. There was no evaluation and treatment modifications regarding the lack of healing progress of R1's coccyx wound. The physician was not notified of the lack of healing. On 6/20/12 at 1:40 PM, E4 (RN) stated, "Each wing nurse does the weekly measurements and on puts them on the log. I'm not sure how the wound progress is evaluated. We have a (consulting) wound nurse but she does not see R1. We can ask her opinion about something, but the doctor gives the orders for wound care treatments." E4 was not aware if the facility had any standing orders or wound care protocols.	F9999		

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F9999	Continued From page 16 The care plan dated 5/30/12 states R1 was admitted with 3 Stage II pressure areas, 2 pressure areas (heels) that are suspected to be deep tissue injury. Wound care interventions include update the doctor and wound care nurse if regression noted. The treatment record dated 5/7/12 for R1 shows the coccyx treatment was ordered daily. Between 5/7/12 and 5/31/12, the treatment was not provided on 8 of the 25 days in May 2012. On 6/20/12, E3 (RN) confirmed the blank entries on the treatment record for R1. E3 stated, "The blank spaces (on the treatment record) means the nurse forgot to sign off the treatment, it does not validate the treatment was done." The (undated) facility policy for Pressure Ulcer prevention and care does not address the monitoring process and wound healing evaluation procedure. The manufacturer's product information for application of Santyl (debridement agent) states Santyl ointment is indicated for debriding chronic dermal ulcers. Use of the ointment should be terminated when debridement is complete and granulation tissue is well established. (B)	F9999		