STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DANVILLE CARE CENTER	**1701 NORTH BOWMAN DANVILLE, IL 61832**

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F 465	Continued From page 11 On 8/1/12 E16 provided a listing of 41 residents who resided on the New Focus Unit. These included R8, R9, R11, R12, R13, R14, R15, R16, R17, and R21 through R52.	F 465		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)5) 300.1220b)2)3)7) 300.3240a) Section 300.1010 Medical Care Policies 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	F9999		

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F9999	Continued From page 12 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. 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,	F9999		

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F9999	Continued From page 13 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 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.	F9999		

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F9999	Continued From page 14	F9999		

7) Coordinating the care and services provided to residents in the nursing facility.

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 regulations were not met as evidenced by the following:

Based on observation, interview and record review the facility failed to identify and accurately assess pressure ulcers, failed to obtain treatment orders and follow facility policies regarding pressure ulcer care, and failed to reassess and modify the treatment plan as needed for one of three residents(R3) reviewed for pressure ulcers in the sample of seventeen. R3 developed unstageable pressure ulcers of the left medial calf, left heel and two toes and a Stage II pressure ulcer of the left medial foot.

Findings include:

On 7/25/12 at 9:15 a.m. E2, Director of Nurses (DON), provided a listing of residents with current pressure ulcers. R3 was included on the listing as having an unstageable pressure ulcer on the left "shin" and a stage II pressure ulcer on each buttock.

R3's Physician's Order Sheet (POS) dated 7/1 - 7/31/12 lists diagnoses of Insulin Dependent Diabetes, Peripheral Vascular Disease and Dementia. R3's Minimum Data Set(MDS)

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F9999	Continued From page 15 assessment dated 7/16/12 documents R3 requires extensive assistance of two plus staff for bed mobility and total assist of two plus staff for transfers, has cognitive impairment, is always incontinent of bowel and bladder and is dependent on staff for personal hygiene. This assessment documents R3 had two stage II pressure ulcers and one unstageable pressure ulcer with necrotic eschar at the time of the assessment. R3's Wound/Skin Healing Records, as reviewed on 7/25/12, document the following: An unstageable area on the right fourth toe described as 0.4 centimeters (cm) x 0.3cm with "purple" eschar. This site is noted to first be identified on 6/7/12 and is documented as healed on 6/20/12. A stage II pressure ulcer of the left buttock measured as 0.9cm x 0.5cm x depth of less than 0.1cm with a date of onset of 7/4/12. A stage II pressure ulcer of the right buttock measured as 3.5cm x 1.2cm and less than 0.1cm in depth, with an onset of 7/4/12. The most recent assessment date for the two ulcers of the buttock are dated 7/11/12. An unstageable pressure ulcer of the left "shin", date of onset 5/31/12, with the most recent assessment (dated 7/11/12) documenting the site as 7.2 cm x 4.6cm x less than 0.1cm depth, serosanquinous exudate, slight odor and brown eschar. The Wound/Skin Healing Record shows the treatment for this site was changed from Silvasorb to Santyl with Normal Saline gauze on 6/13/12, at which time the wound measured 3.0cm x 1.9 cm with less that 0.1cm with black eschar. R3's POS dated 7/1 - 7/31/12 lists the current treatment to the left shin as Santyl with a Normal Saline gauze dressing. R3's pressure ulcer assessments are	F9999		

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F9999	Continued From page 16 signed as completed by E4, Licensed Practical Nurse (LPN). On 7/26/12 at 8:35 a.m. E4 (LPN) stated she had been filling in as the wound nurse for only a couple of months, since the former wound nurse resigned. E4 stated R3 had gone to the hospital on 6/21/12 and she thought R3's Physician would have seen R3's pressure ulcers then, but was not sure. E4 stated R3 had not been to the wound clinic, to her knowledge. E4 confirmed that R3 had a dried area on her toe that had healed. Nurses Notes dated 7/19/12 at 5:00a.m. document a new "open area" to the left foot "anterior side." The entry states the Physician was notified via fax for treatment orders. The entry was signed by E5, LPN. There is no documented assessment of this site on the Wound/Skin Healing Record or in the Nurse's Notes. R3's Treatment Record dated 7/4 - 7/31/12 does not document a treatment to the "anterior foot." On 7/25/12 at 12:20 p.m. E5 indicated that as of 7/25/12 she had been given the responsibility of wound nurse for the facility. E5 confirmed she had not received a treatment order for R3's "anterior" foot ulcer until 7/25/12 and that 7/25/12 would be the first day for a treatment to the ulcer. On 7/25/12 at 12:30 p.m. E5 stated she did not measure the "anterior" foot on 7/19/12 and no measurements of the site had been documented. On 7/25/12 at 2:30 p.m. E2, DON confirmed that the last pressure ulcer assessments for R3 had been completed on 7/11/12. E2 stated she was unable to find documentation of an assessment of the left "shin" pressure ulcer when first	F9999		

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F9999	Continued From page 17 identified on 5/31/12. The first available measurements on the Wound/Skin Healing Record for the "shin"are dated 6/6/12. E2 stated that the correct anatomical location for the left "shin" site was left medial calf and the site referred to as the "anterior" foot was the medial aspect of the left foot. On 7/25/12 from 9:30 a.m. until 12:30 p.m.(based on observation of 15 minute or less intervals) R3 was seated in a wheelchair without benefit of repositioning. During these observations R3 was wearing only white socks and her feet were resting directly on the floor. The wheelchair was not equipped with footrests and R3 did not have any pressure relieving device on her feet or between her knees. At 12:30 p.m. E14, Certified Nurse Assistant (CNA) and E6, Restorative Aide transferred R3 from her wheelchair to bed. E5 and E3, Assistant Director of Nurses(ADON), were present. R3 was wet with urine through her sweat pants. This was confirmed by E14. R3 had a large amount loose bowel movement coming out both leg openings of her incontinent brief. R3 had indentations on the backs of her thighs which corresponded with the edge of the pressure relieving cushion in the wheelchair. E3 confirmed the areas, stating they were due to pressure from sitting. E6 then told E3 that E6 had come on duty at 7:00 a.m. and R3 was already up in her wheelchair. On 7/25/12 at 1:25 p.m. E6 again stated that she came on duty at 7:00 a.m. and R3 had been up in her wheelchair at that time. E6 continued that R3 had not been out of the wheelchair until 12:30 p.m. E6 stated, "I just shift her in the chair from side to side. I checked her after breakfast and she was dry." E6 confirmed R3 did not have anything positioned	F9999		

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F9999	Continued From page 18 between her knees/legs to prevent pressure. On 7/25/12 at 1:30 p.m. E7 CNA stated she and E6 were the two CNAs assigned to R3 on 7/25/12. E7 stated R3 is gotten up on the night shift and that R3 was already up in her wheelchair when E7 came on duty at 6:00 a.m. E7 stated R3 had not been removed from the wheelchair since at least 6:00 a.m. on 7/25/12. Once in bed on 7/25/12 at 12:30 p.m. the following pressure ulcers were measured by E5. Stage II pressure ulcer of the right buttock measured 0.4cm x 0.5cm. "Pinpoint" opening to left buttock. E5 removed a hydrocolloid dressing from R3's left media foot, which E5 referred to as the "anterior foot" ulcer she identified on 7/19/12. The dressing was undated and lack initials to indicate which staff had applied the dressing. Once removed the ulcer site was described by E5 as "very macerated from the moisture." The wound bed measured 1.5 cm x 1.5 cm with surrounding macerated area from 1.0 to 1.5cm in width. A dressing located on R3's medical calf was visibly soiled with a large amount of serosanquinous drainage. The dressing was not dated or initialed. E5 referred to this ulcer as being on the left "shin." E5 stated the ulcer was a stage III measuring 6.3cm x 4.4cm . The wound bed had yellow slough. . E5 described a "hard....necrotic....unstageable " black pressure ulcer on the left lateral heel which measured 3.0cm x 3.5cm. "Unstageable" dark fluid filled blisters were noted on the top of the third toe on both the right and left foot, measuring 1.3cm x 1.1cm and 1.2cm x 1.3cm respectively. E5 stated that the pressure ulcers on the toes and heel had not been previously identified by staff.	F9999		

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F9999	Continued From page 19 On 7/25/12 at 12:30 p.m. as R3 was positioned in bed on her left side for E5 to do the assessments and treatments, R3 assumed a fetal position, with her right knee resting directly on the dressing covering the stage III pressure ulcer of left medial leg. E5 had to hold R3's right knee up off the left calf in order to change the dressing, measure and do the treatment to the left calf ulcer. Once the treatment was complete E5 allowed the right knee to rest directly on the fresh dressing over the stage III ulcer and E5 and E3(ADON) left the room. R3 remained positioned on her left side with her right knee resting directly on the Stage III pressure ulcer dressing of the left medial calf at 1:30p.m. and 2:00p.m. A document dated 7/25/12 sent to R3's Physician and signed by E5 states R3 had several areas of concern during skin check, identifying the new sites of the toes and heel and requesting an order for skin prep daily to these areas. It does not address the stage III pressure ulcer of the left medial calf or the left medial foot. The document includes a request to discontinue the hydrocolloid dressing to the buttock as the areas are "pinpoint" at this time. Telephone orders dated 7/25/12 include orders for skin prep to the toes and left heel, discontinuation of the hydrocolloid dressings to the buttocks and "heel protectors while in bed." On 7/26/12 at 9:40 a.m. E5 was questioned about her assessment of R3's right hip stage II pressure ulcer on 7/25/12 which was later referred to as "pinpoint" to the Physician. E5 explained that she had thought it was open but it wasn't. E5 continued that she has not had much experience assessing dark skinned residents and was still learning.	F9999		

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F9999	Continued From page 20 On 7/26/12 from 8:30 a.m. until 9:00a.m. (based on observation of 15 minute intervals or less) R3 was seated in her wheelchair with only white socks on and her left foot resting on the hard floor surface. R3 did not have any intervention in place to prevent pressure to the unstageable left heel pressure ulcer. On 7/26/12 at 9:00 a.m. E9 and E10, CNAs stated they were the two CNAs assigned to R3, and that R3 was already up in her wheelchair when they arrived at 6:00 a.m. E9 and E10 stated they had not gotten R3 out of the wheelchair to reposition her since they arrived. E2, Director of Nurses, then arrived in the room and E9 and E10 told E2 that R3 had been up in the wheelchair since at least 6:00 a.m. On 7/26/12 at 10:05 a.m. E9 stated R3 did not have heel protectors on when up in the wheelchair as staff only put them on when they lay a resident down in bed. E9 explained that R3 was to be repositioned every hour but it didn't happen because R3 needed a shower after breakfast. R3's Care Plan as reviewed on 7/25/12 listed the unstageable pressure ulcer of the left "shin" but did not address any pressure relieving interventions specific to the site. The Care Plan did not address the pressure ulcer of the left "anterior" foot identified on 7/19/12. On 7/25/12 at 2:15p.m. E8, Care Plan Coordinator confirmed that the left "anterior" foot was not addressed on R3's Care Plan. E8 stated that she receives knowledge of pressure ulcers via the Skin Condition Report. E8 showed a Skin Condition Report dated 7/11/12, stating it was the most recent report she had received. R3's Care Plan as reviewed on 7//26/12 included the newly identified pressure areas of the left heel, toes,	F9999		

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F9999	Continued From page 21 and medial left foot. The Care Plan listed a new approach dated 7/25/12 for "Heel protectors while in bed." On 7/26/12 E8 stated R3's Care Plan at that time did not address pressure relieving interventions for the left medical calf and only directed the use of heel protectors while in bed. The Care Plan was void of interventions to prevent pressure to R3's heel ulcer while in the wheelchair. E8 explained that the CNAs have care instructions on the "pocket worksheet" which they are to keep on them. On 7/26/12 at 10:15 a.m. E8 asked E9 and E9 if they had their pocket worksheet for R3. E8 and E9 both stated they had not received a pocket worksheet. The Pressure Ulcer Prevention, Identification & Treatment policy (last revised on 5/20/11)directs the following: It is the responsibility of the D.O.N./Designee to monitor for healing progress, and ensure appropriate treatments are in use. It is recommended that D.O.N./Designee make frequent pressure ulcer rounds with the Charge Nurses....It is the responsibility of the CNA to report any skin conditions to the Charge Nurse immediately upon identification. When a pressure ulcer is identified, whether in house or upon a resident's admission, the area will be assessed and initial treatment started per physician orders... Documentation of the pressure ulcer must occur upon identification and at least once a week until healed. " On 7/25/12 at 4:30 p.m. E2, DON, stated she had not seen R3's Stage III pressure ulcer of the left medial calf. E2 stated her expectation was if the wound/pressure ulcer has not responding positive after 14 days of treatment, the treatment should	F9999		

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F9999	Continued From page 22 be changed. E2 stated she was informed that R3's treatment to the stage III pressure ulcer of the left medical calf had not been changed since 6/13/12. B	F9999		