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	145879	A. BUILDING _____ B. WING _____	C 01/02/2013

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F 441	Continued From page 17 Policy Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Tests documents 2) after obtaining a physician's order, a qualified nurse or healthcare practitioner will inject 0.1 milliliter of purified protein derivative (PPD) and 3)individuals with less than 10 millimeters of induration will receive a booster of PPD at least 1 week and no more than 3 weeks after the first test is administered.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 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.	F9999		

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F9999	Continued From page 18 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. 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:	F9999		

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F9999	Continued From page 19 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. 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 record review the facility failed to perform skin assessments and provide skin care in a timely manner for 1 of 3 residents (R4) reviewed for	F9999		

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pressure sores in the sample of 14. This failure resulted in a worsening sacral pressure sore and the development of a new area of skin breakdown.

Findings include:

Admission record documents R4 was admitted on 10/24/12. Skin Observation 12/4/12 documents R4 has a sacral pressure sore measuring 0.5x0.5x0.2 centimeters (cm). On 12/5/12 from 10:40am-2pm, in 10-15 minute intervals, R4 was in the dining room sitting in a reclining chair with a lift sling underneath her. R4 was not turned, repositioned, checked for incontinence, or changed during this time frame. At 2pm, R4 was brought back to the room and transferred into bed with the lift. E6 and E7 (Nurse Aides) removed R4's incontinent brief and it was saturated with urine and full of a large loose stool. The dressings to the sacrum and left buttocks were visibly soiled with both moist and dried stool and were falling off R4's skin. There was moist and dried stool to the areas of skin breakdown. E4 (Nurse Aide) stated R4 was last changed at 10am. On 12/5/12 E3 (Treatment Nurse) measured the sacral pressure sore as 3x1.4x0.1cm, an increase in size from 0.5x0.5x0.2 cm on 12/4/12 , a wound to the left upper posterior thigh discovered on 11/27/12 does not have any previous measurements, measured 2x1x0.1cm, and a new area of skin breakdown to the left buttock measures 2x1.5x0.2 cm. Admission Braden scale 10/24/12 scores R4 as mild risk for skin breakdown. The next Braden scale is completed on 12/5/12 now scores R4 as high risk for skin break down. 10/20/12 MDS section G functional status rates R4 as needing extensive assistance

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with personal hygiene and section H bladder and bowel rates R4 as always incontinent of bowel and bladder. The current care plan does not address incontinence. The wound care plan documents "keep the area clean and dry" but does not document turning and repositioning, pressure relief, or other interventions for the care and treatment of the ulcers. Physician Order Report documents an order "turn and reposition every 2 hours, every shift and as needed."

On 12/5/12 at 3:30pm, E2(Director of Nursing) stated the staff should be rounding and checking residents for incontinence and toileting every 2 hours. If residents are wet, change them. If there is already a wound, check the resident more frequently than every 2 hours.

On 12/6/12 at 12:15pm, E3 (Treatment Nurse) stated Braden Assessments are done on admission and then weekly for 4 weeks, or if there is new breakdown or a worsening wound. E3 did not know why there are no weekly Braden Assessments between admit on 10/24/12 and 12/5/12, or why there is no Braden assessment on 11/27/12 with the discovery of a wound to R4's left upper posterior thigh. E3 stated there are no initial measurements for the wound on R4's left upper posterior thigh, "I didn't measure it, I don't know if it is getting worse."

On 12/8/12 at 12:30pm, by phone interview, Z1(Physician) stated that not turning and repositioning R4, not keeping the skin clean and dry, and R4 sitting in urine and stool has contributed to the worsening sacral pressure sore and the new area of breakdown on the left buttock. Z1 stated R4's sacral wound was

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healing. "They should have been watching (R4) closer, more than every 2 hours. If they were doing all the protocols as they should, the stability of the skin would be OK. If the wounds get worse or there is new breakdown, they did not follow the protocols and that cause the skin to get worse."

Policy Pressure Ulcer and Wound Prevention Management Program documents 7.c) care plan interventions ae individualized to the residents condition/situation to prevent the development of an ulcer, or if present, for the care and treatment of the ulcer, 8) Braden Pressure Ulcer Risk Scale will be completed upon admission, readmission, and weekly for four weeks, and updated as needed for a significant change in condition as determined by the interdisciplinary team.

Policy Prevention of Pressure Ulcers documents general preventive measures for a person in a chair is to change position at least every hour. Risk factors include moisture and the resident should be placed on a minimum of an every 2 hour check and change program, chairfast residents that are unable to change own position should have their position changed at least every hour, residents incontinent of bowel and bladder should be check for incontinence at least every 2 hours and clean skin when soiled, and use the Braden Risk Assessment Form and Intervention Preventive Measures (Appendix A) to asses skin and pressure ulcer risk.

Policy Support Surface Guidelines documents to reposition residents who are in a chair at least every hour and for residents who depend on staff for repositioning, change position at least every 2

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F9999	Continued From page 23 hours. Policy Intervention Prevention Measures (Appendix A) documents interventions for residents at high risk for pressure ulcers are toilet/inspect resident at least every 2 hours, residents with an ulcer should not sit up in the chair for more than 1 hour and not more than 2 hours if no ulcer present. (B)	F9999		