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F 465	Continued From page 21 The findings include: On 5/15/13 at 10:00 AM, a tour of the facility was done. R10 ' s bedside table had sticky raised spots on it. R11 ' s bedside table had sticky spots. R12 ' s bedside table was sticky and spotted. R13 ' s bedside table had large sticky spots. Two bedside tables in room F53 had dry smudges and were dirty. At 4:00 PM, R10, R12, and R13 ' s bedside tables had the same sticky spots. On 5/16/13 at 8:10 AM, R10 and R12 ' s bedside tables had the same sticky spots. R13 ' s bedside table had papers placed on top of the sticky spots that were there. At 4:00 PM, a tour with E1 (Administrator) and E3 (Assistant Director of Nursing) showed R12 and R13 ' s bedside tables unclean. E1 said that R13 ' s table appeared to have dried tube feeding solution on it. On 5/15/13 at 8:00 AM, E6 (Housekeeping) said the rooms are cleaned every day. The bedside tables are disinfected daily. The facility ' s 5/10/07 Cleaning Guidelines-Environmental Services policy states, " Surfaces such as table tops, bedside stands ... etc. will be cleaned daily using an EPA approved hospital grade disinfectant-detergent solution. These surfaces will also be cleaned as needed when spills or soiling occur. "	F 465		
F9999	FINAL OBSERVATIONS Licensure Violations:	F9999		

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F9999	Continued From page 22 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)5) 300.1220b)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant	F9999		

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F9999	Continued From page 23 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 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:	F9999		

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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:

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

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F9999	Continued From page 25 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. (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 accurately assess residents' skin and failed to implement preventive interventions and treatments. These failures resulted in R1 & R7 developing pressure ulcers on their heels that were not identified until the ulcers were unstageable with black eschar. This is for 5 of 7 residents (R1, 2, 4, 5, &7) reviewed for pressure ulcers in the sample of 15. The findings include: 1. R1's 2/25/13 Minimum Data Set Assessment (MDS) shows that R1was admitted on 2/15/13. R1 needs extensive assistance of 2 persons for bed mobility and has total dependence on staff for transfers. R1 has severe cognitive impairment and a diagnosis of Dementia. R1's 2/15/13 admission skin check shows that her feet were cool to touch and the skin on both heels was intact.	F9999		

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On 5/15/13 at 1:40 PM, R1 was in bed with her heels resting directly on the mattress. E9 (Wound Care Registered Nurse) removed the dressing on R1's left heel to show hard black eschar (necrotic, dead, or devitalized tissue) on the posterior aspect. E9 took measurements of 1.5 x 1.7 centimeters (cm), cleaned the area with normal saline, painted the wound with betadine, and then covered it with a foam dressing. E9 stated, "I couldn ' t tell you how she got the sore. When I was notified by the nurse there was already necrotic tissue on the heel."

On 5/16/13 at 8:25 AM, R1 was sitting in a wheelchair in the bedroom. R1 had elastic stockings on both lower extremities. R1 was wearing shoes on both feet.
At 10:50 AM, R1 remained in the wheelchair in the room with the elastic stockings and shoes on both feet. E9 said having shoes on does not relieve pressure from the heels. " I've told the nurses she shouldn ' t have the shoe on. "

R1's February, March, April, and May 2013 Physician Order Sheet (POS) shows orders for daily skin assessments and document findings twice a week.

R1's 4/1/13 Nursing Notes states, "Heels are intact, will continue to monitor." 4/4/13 Nursing Notes states, "Heels slightly boggy (underlying soft tissue damage) and intact, will continue to monitor." 4/8/13 Nursing Notes states, "Left heel noted with black discoloration that is intact, right heel is clear, will continue to monitor." 4/11/13 Nursing Notes states, "Left heel noted with black discoloration, betadine applied as ordered, convoluted boots in place, will continue

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F9999	Continued From page 27 to monitor." R1's Condition Report/Concern fax communication dated 4/10/13 states, "Resident has been noted with a pressure ulcer to the left heel area Stage VI, area noted to be black. Hospice is requesting for betadine to be painted at the heel daily." The response dated 4/11/13 states, "Agree." R1's April 2013 Treatment Administration Record (TAR) shows that no treatment was started until 4/11/13. R1's 4/17/13 POS shows an order to apply foam heel cup to left lower extremity ankle and change weekly. On 5/15/13 at 12:10 PM, E9 stated, "The floor nurses do skin checks twice a week, usually on evening and night shift. They (the floor nurses) email E10 (treatment nurse) and I with new concerns. The initial treatment is started by the floor nurses." Treatments are changed as needed after assessments are completed. R1's Wound Assessment Reports show the following: 4/9/13- 2.0 x 1.9 cm, wound bed has 100% eschar; 5/2/13- 1.9 x 1.7 cm, 100% eschar. Eschar is stable in nature at current time; 5/15/13- 1.5 x 1.7 cm, 100% eschar. R1's Wound Assessment Reports dated 4/8, 4/9, 4/17, 4/25, 5/2, 5/9, & 5/15/13 state, "Date Physician notified- 4/8/13." On 5/16/13 at 1:00 PM, E9 stated, "CNA ' s (Certified Nursing Assistant ' s) are to notify the	F9999		

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F9999	Continued From page 28 floor nurse of any redness before the skin opens." On 5/16/13 at 2:05 PM, E8 (CNA) stated, "If I see a residents heels are red, I elevate the heels and notify the nurse." R1's Risk for Impaired Skin Integrity Care Plan initiated on admission (but dated 2/1/13) states, "Daily skin inspection; report any changes in skin or signs of possible skin breakdown or redness ... Turn at least every two hours when in bed ... Float heels off bed surface with pillows or specialty devices ..." R1's 4/8/13 unstageable pressure ulcer of the left lower extremity posterior heel Care Plan show approaches including: reposition every two hours; place pressure-reducing device on the wheelchair to decrease the pressure under bilateral ischial tuberosities (boney prominences on either side of the tailbone); encourage to shift weight while sitting up in the chair; develop turning/repositioning plan with R1's input; teach R1 the risk factors for development of pressure ulcers; weekly evaluation of wound healing; float heels on pillow; monitor for changes in skin status that may indicate worsening of pressure ulcer and notify the physician. The facility's 11/11/10 Pressure Ulcer Prevention policy states, "Individualized interventions will be implemented for at risk residents based on risk assessment findings ... Interventions will be documented in the resident care plan and revised based upon on-going assessment and evaluation." "The effectiveness of preventative interventions will be evaluated and changes to care plan made as appropriate ... The Care Plan will be updated to reflect discontinued	F9999		

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F9999	Continued From page 29 interventions and the addition of new interventions based on this evaluation." The facility's 11/11/10 Pressure Ulcer Treatment policy states, "The attending physician is notified when a skin ulceration/wound is identified ... Orders for treatment of a pressure ulcer are obtained from the physician and processed according to facility policy." "Residents with pressure ulcers will have an individualized care plan developed ... The interventions are designed to decrease the magnitude of tissue loads and to provide levels of moisture and temperature that support tissue health and growth ... Avoid positioning residents on a pressure ulcer. Use positioning devices to raise a pressure ulcer off the support surface ... Use devices such as pillows and foam wedges that totally relieve pressure on the heels, most commonly by raising the heels off the bed." "Re-assessment of treatment plan, and residents overall clinical condition should be completed if no improvement in pressure ulcer is evident after 2 weeks of treatment based on PUSH Tool graphing. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Documentation will include the rationale for continuing or changing the current treatment plan ... Communication with the physician related to wound progress will be documented at least every 2 weeks ..." 2. R7's 2/14/13 MDS Assessment shows R7 was admitted on10/18/06. R7 has total dependence on 2 persons for bed mobility and transfers. R7 has severe cognitive impairment. R7's 10/18/06 admission skin check shows	F9999		

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callous areas by the right and left great toes. The right heel is noted to be pink, skin intact, and "not mushy" (underlying soft tissue damage).

On 5/16/13 at 9:25 AM, E10 (Treatment Nurse) cleansed and treated R7's left heel. The open area was deep and pale pink. E10 stated, "Wounds need to be protected by making sure the heels are off loaded."

R7's 2/4 & 2/7/13 Nursing Notes Skin checks show no new red or open areas. The 2/9/13 Nursing Note states, "Resident has 2 x 1.5 cm black area on left heel. Nurse Practitioner here and received the following orders: 1. Apply skin prep to area on left foot twice a day. 2. Apply [foam] cup to heel. Change [foam] cup every 7 days and as needed. Convoluted boot to left foot at all times."

R7's 2/9/13 Wound Assessment Report shows R7 has a left heel pressure ulcer. The wound bed has 100% eschar and measures 2 x 1.5 x 0 cm.
R7's 5/15/13 Wound Assessment Report shows R7 ' s left heel pressure ulcer has scant serous drainage. The wound bed is 80% granulation tissue and 20% slough. The wound measures 0.9 x 1 cm. The depth is not measured. The treatment is Hydrogel and foam dressing.

R7's Risk for impaired skin integrity Care Plan is dated 2/1/13. R7's 2/13/13 Care Plan for an unstageable pressure ulcer to the left heel includes the following approaches: Reposition every 2 hours and as needed; Teach the risk factors for development of pressure ulcers; Weekly evaluation of wound healing; daily

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F9999	Continued From page 31 observation of skin with routine care; and float heels on a pillow. 3. R2's 9/7/12 MDS Assessment shows R2 was admitted 8/31/12. R2 needs extensive assistance of 2 persons for bed mobility, transfers, and toilet use. R2 has cognitive impairment related to a CVA (Cardiovascular Accident). R2's 8/31/12 admission skin check shows R2 had a dark discoloration on the right great toe and a dark circle and callous on the right foot. Both right and left ankles were clear with skin intact. R2's Nurses Notes Skin Assessments show the following: 9/6/12- "Bilateral Lower Extremities (BLE) skin dry, intact. No discolorations. Heels firm, dry and intact" ; 9/12/12- "BLE are clear and intact. Feet clear with pedal pulses present" ; 9/15/12- "BLE skin dry, intact. No discolorations/bruises noted. Heels firm, dry and intact" ; 9/19/12- "BLE skin dry. Left lateral outer ankle with bruise and it opened. Site cleansed with normal saline and Calazyme applied with foam dressing. Wound nurse notified by email. Will continue to monitor. Heels soft, intact" . R2's 9/21/12 POS shows a physician order to cleanse the left outer ankle gently with saline; pat dry; do not rub; NO Calazyme to area; apply foam dressing; change daily and as needed. Wound specialist is to see patient. R2's September 2012 TAR shows a wound treatment was started on 9/21/12. R2's 9/26/12 Wound Care Specialist Initial Evaluation shows a pressure ulcer of the left,	F9999		

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lateral ankle. The ulcer is unstageable due to necrosis. The wound size is 6 x 5 cm. The skin around the wound is macerated. The wound is draining light serous exudate. The wound is 50% thick adherent devitalized necrotic tissue and 50% granulation tissue. Recommendations are to apply Santyl and cover with foam dressing daily. Sponge cradle boot is to be worn in bed to off-load pressure to the wound.

R2 had no Care Plan for the left lateral ankle pressure ulcer.
R2's 9/7/12 at Risk for Pressure Ulcers Care Plan shows approaches including: reposition every hour and turn every 2 hours; encourage to shift weight while sitting up in the chair; teach risk factors for development of pressure ulcers; R2 needs assistance with repositioning to avoid skin friction/shearing; R2 needs 2 persons to assist with repositioning to avoid skin friction/shearing; daily observation of skin with routine care; float heels off the bed; use pillows or other supportive/protective devices to assist with positioning.

On 5/6/13 at 2:00 PM, E8 (Certified Nursing Assistant- CNA) stated, "Resident skin is checked anytime care is given. Anything out of the normal, red or purple spots, anything that could be a problem is reported to the nurse for additional treatment." Residents are positioned off of the red spots.

4. R4's 5/3/13 MDS Assessment shows R4 was admitted on 4/26/13. R4 needs limited assistance of 1 person for bed mobility, transfers, and toilet use. R4 has moderate cognitive

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impairment.
R4's 4/26/13 admission skin check shows the coccyx/sacral area to be dark toned and skin intact.

R4's Nursing Notes Skin Assessments show: 5/9/13- Buttock/peri area has no redness or open area noted; 5/13/13- Buttock/peri area has two small open areas. NP (Nurse Practitioner) notified.

On 5/16/13 at 10:35 AM, E9 (Wound Nurse) removed the dressing from R4's sacral area to show one pale open area surrounded by reddened skin. E9 said that there is not much tissue covering the sacral area and that is why the staging progressed so rapidly.

R4's 5/13/13 Wound Assessment Report shows a stage II pressure ulcer to the sacrum measuring 0.9 x 0.9 cm. R4 ' s 5/14/13 Report shows a stage III pressure ulcer to the sacrum measuring 1 x 0.8 cm with 100% granulation tissue. Treat with Hydrogel to wound bed and cover with foam dressing daily and as needed. Continue to monitor. The depth measurement was not done on either assessment.

On 5/16/13 at 2:25 PM, E4 (Registered Nurse, Unit Manager of North Unit) stated, "I didn't know anything about [R4 ' s pressure ulcer] until E9 said something today."

R4's 5/13/13 Stage III pressure ulcer to the sacrum Care Plan has approaches including: reposition every 2 hours and as needed; encourage to weight shift while sitting up in the chair; weekly evaluation of wound healing.

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On 5/16/13 at 2:10 PM, E7 (CNA) stated, "When getting the residents undressed for bed, I check the skin for any bruises, sores, redness, and skin tears. I look at the shoulders, buttocks, and heels. Any problems I tell the nurse and get the resident off the area. We use pillows for positioning."

5. R5's 4/16/13 MDS Assessment shows R5 was admitted on 4/9/11. R5 needs extensive assistance of 2 people for bed mobility and has total dependence of 2 people for transfers. R5 has moderate cognitive impairment.
R5's 4/9/11 admission skin check shows intact skin to right and left ankles and feet. There is mention of scabs on bilateral lower extremities, but no location specified.

On 5/16/13 at 9:40 AM, E9 cleansed and treated R5's right outer ankle. R5's right outer ankle had an area of pale skin surrounded by darker skin. In the middle of the pale area was a pin point red area.

R5's 4/9 & 4/16/13 Nursing Notes Weekly skin assessment state, "legs and heels are clear." R5 had no skin assessment for 4/23 & 4/30/13.

On 5/17/13 at 9:00 AM, E3 (Assistant Director of Nursing) said the skin assessments are documented in the computer and had no further skin assessments to present.

R5's 5/2/13 Hospice Nursing Visit Note states, "Facility CNA's returning patient to bed. Hospice CNA report states red area on right ankle bone outer side." Protective boots were put on.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145563	A. BUILDING _____ B. WING _____	C 05/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST ANNE CENTER	4405 HIGHCREST ROAD ROCKFORD, IL 61107

(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 35	F9999		

R5's Wound Assessment Reports for the right outer ankle pressure ulcer show the following: 5/2/13- stage I, 1.5 x 1.5 cm; 5/2/13- stage II, wound bed has 100% epithelial tissue, 0.5 x 0.9 (no depth measurement), "Fax sent to [physician] to ask for an order as follows: Cleanse wound with normal saline, apply Hydrogel to wound area and cover with foam dressing daily and as needed."

R5's 5/2/13 Condition Report/Concern Fax states, Resident has pressure area 1.5 cm to outer right ankle. May we have an order for convoluted boots at all times and foam dressing to area and change every 3-5 days."
The reply of " yes " to the fax was noted on 5/4/13.

R5 ' s May 2013 TAR shows R5 ' s foam dressing treatment was started on 5/6/13.

R5's 5/13/13 Wound Assessment Report shows the right outer ankle pressure ulcer is stage II measuring 0.5 x 0.5 cm (no depth is measured). The wound bed has 100% epithelial tissue.

R5 ' s 5/2/13 stage II pressure ulcer to the right outer ankle Care Plan has approaches including: Reposition every 2 hours and as needed; place pressure-reducing device in the wheelchair seat; encourage to weight shift while sitting up in chair; teach the risk factors for development of pressure ulcers; assist with repositioning to avoid skin friction/shearing; weekly evaluation of wound healing;

On 5/16/13 at 1:00 PM, E9 stated, " I develop the care plans for the MDS Assessments for wounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145563	A. BUILDING _____ B. WING _____	C 05/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST ANNE CENTER	**4405 HIGHCREST ROAD ROCKFORD, IL 61107**

(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 36 Wound documentation is in the computer. " There is no log to track residents with wounds. On 5/17/13 at 9:00 AM, E3 said there is no log of residents with wounds. (B)	F9999		