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6. On 4/16/13 R3 was positioned on her back from 10:30 AM to 12:40 PM. R3 has a stage II pressure ulcer to her coccyx. According to the Care Plan dated 4/10/13, R3 is to be turned and repositioned every 2 hours. According to Braden Scale 4/2/13, R3's score is 8 indicating very high risk.(total score < or =9)

F9999

FINAL OBSERVATIONS

Licensure Violations

300.610a)
300.610c)1)
300.610c)2)

300.1210a)b)
300.1210d)2)
300.1210d)3)
300.1210d)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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed

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and dated minutes of the meeting.

c) The written policies shall include, at a minimum the following provisions:

1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers;

2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray);

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

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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:

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

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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. (A, B) (Section 2-107 of the Act)

These requirements are not met as evidenced by:
Based on record review, observation and interview, the facility failed to identify the difference between pressure ulcers and vascular wounds; reposition residents; and implement aggressive nutritional care, treatment and change of treatments for 1 of 1 residents (R7), reviewed with wounds in the sample of 9 . This failure resulted in R7 developing gangrene of his foot. R7 was hospitalized for the gangrene and amputation of his foot was recommended. R7's family chose not to have his foot amputated, R7 was placed on Hospice and given only comfort measures.

The findings include:

R7 was admitted to the facility on 2/25/13 with diagnoses, in part, of subdural hematoma, altered mental status, difficulty walking, end stage renal disease with dialysis, dementia, and diabetes mellitus.

Physician's Orders, signed by Z1, R7's physician, and dated 2/25/13, document an order for R7's left heel treatment: "Cleanse deep tissue injury to

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outer left heel with skin integrity, apply hydrogel and bordered gauze, change daily and as needed until healed. The treatment for the right heel documents: "Cleanse deep tissue injury to right heel with skinintegrity, apply hydrogel and bordered gauze, change daily and as needed until healed".

The "Weekly Pressure Ulcer Report's", dated 2/25/13 - 3/14/13, document R7's foot wounds measured 2.0 x 2.0 cm for the left heel, and 2.0 x 4.5 cm for the right heel through 3/14/13. The reports document R7's left heel wound increased to 4.0 x 2.0 cm on 3/21/13, and to 17.2 x 7.5 cm on 3/29/13. This report documented R7's right heel increased to 2.5 x 5.0 cm on 3/21/13 and to 11.0 x 6.0 cm on 3/29/13.

The "Weekly Pressure Ulcer Assessment" for R7 was completed by E5, Restorative/Wound Nurse, on 2/25/13 for the left heel and on 2/28/13 for the right heel. There are no other "Weekly Pressure Ulcer Assessment" completed until 3/29/13 when E7, Registered Nurse, completed the assessments. On 3/29/13 E7 documented the left heel was 17.2 x 7.5 cm and 100% necrotic. E5 documented the right heel was 11.0 x 6.0 cm and 100% necrotic. There was no documentation for the toes.

The "Weekly Pressure Ulcer Report", dated 2/28/13, documented R7 had a 2.0 x 2.0 centimeter (cm) unstageable "E/S (Eschar/Slough)" ulcer on the left heel, and an area on right heel measuring 2.0 x 4.5 cm E/S. Both of R7's heels were documented as 100% necrotic with light exudate and no odor. The report does not identify the heels as "SDTI

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(Suspected Deep Tissue Injury)". There is no documentation on the "Weekly Other Skin Condition Report" regarding R7's toes or the heels.

On 3/1/13, R7's "Physician's Orders" documented "Cleanse unstageable pressure ulcer to L (left) heel (with) skin integrity apply hydrogel (and) border gauze 2 (today) and PRN (as needed) T/H". The same treatment was ordered for the right heel.

R7's Physician's Orders, dated 3/17/13, documented "cleanse inner aspect of L (left) foot 4th toe (between 4th and 5th) (with) Microklenz. Apply Silvasorb gel, cover (with) telfa and tape. (Change) BID (twice a day) and PRN (as needed)" and "skin prep L (left) foot 5th toe every shift".

R7's nurses notes, dated 3/17/13, documented that R7's family was at the facility and notified staff that there was "drainage coming from between his toes". R7's Nurses Notes document a 1.8 by 0.2 by 0.6, Stage 3 open area on his left foot. The nurses note documented the area was "at left foot inner aspect between 4th and 5th toe. Small amt (amount) of clear with very slight red tinged drainage, slight purple color also around wound bed. Left foot 5th toe purple and very mushy".

On 3/18/13 the order was changed to "Cleanse L ft (foot) 4th and 5th toe stasis ulcer with skin integrity, apply maxsorb extra AG (aquagel) rope, secure with telfa tape". There is no documentation on the "Weekly Pressure Ulcer Report" or the "Weekly Pressure Ulcer

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Assessment" report regarding R7's toes.

A telephone order, dated 4/1/13, documents an order for "medihoney" to both heels and cover with isosorb gauze with the surrounding tissue receiving skin prep.

E2, Director of Nursing, stated in an interview on 4/18/13 at 1:05 PM that E5, Wound Nurse, was supposed to do the weekly pressure ulcer assessments but didn't do them as required. E2 stated E5 quit on 3/28/13 but had not done what was required with the pressure sores for a few weeks prior to that. E2 stated E5 was not following the pressure sores in the facility. E2 stated as the wound nurse, E5 was supposed to implement the policies of the facility regarding pressure sores, monitor and educate the staff. E2 said that the Facility staff nurses now assess and document pressure sores.

E2 stated R7 had a regular mattress but all the mattresses in the facility were pressure redistributing mattresses. E2 also stated R7 went to dialysis three times per week for 6 hours each time. E2 stated the dialysis staff would not allow R7 to be turned and repositioned even though they sent a staff from the facility to dialysis with him. E2 stated they had sent a special cushion with R7 when he went to dialysis. E2 stated R7 did wear pressure relieving boots on both of his feet.

R7's Care Plan, dated 2/26/13, documents: "Focus - The resident has multiple pressure ulcer and potential for pressure ulcer development r/t (related to) Disease process". There is no documentation where the pressure sores are

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F9999	Continued From page 31 located on R7's body. "Interventions" include, in part, "Administer treatments as ordered and monitor for effectiveness; assess/record/monitor wound healing weekly, monitor nutritional status. Monitor/document report to MD (Medical Doctor) PRN (as needed) changes in skin status. Pressure reduction mattress on bed". There was no documentation regarding R7's pressure relief boots. R7's Care Plan, dated 3/7/13, documents: "Focus - The resident has potential for pressure ulcer development r/t immobility and incontinence". There are no pressure ulcers identified. The "Interventions" included, in part, "Nurses to complete weekly skin assessment" and "Turn and reposition every 2 hours and more often if needed". R7's "Weekly Skin Assessments" document the following: On 3/5/13 and 3/12/13, "Mild Risk" is documented in the area on the form which states "B" or "Bruise noted - describe color and size, and if there is induration noted. Indicate if this is a new finding or existing by checking the "N" box for New and "E" box for existing bruise". The "Findings/Initial Assessment" section is not completed and there are no descriptions of the bruise or where the bruise was located. On 3/19/13 and 3/26/13, "Mild Risk" is documented in the area on the form which states "existing B and O". The "O" code is defined as "Open areas noted. Indicate if this is a new finding or existing by checking the "N" box for New, "E" box for existing wound". Both the B and O are checked as an existing wound. There is no description under the "Findings/Initial	F9999		

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Assessment" section. There is no documentation where the bruise or open area is located.

On 4/2/13, "Mild Risk" is documented on the form. An X is written in. X is defined as "Other noted skin issue: rash, etc. Indicate if this is a new finding or existing by checking the "N" box for new, "E" box for Existing skin condition." The form does not designate if the area is new or existing. Under the "Findings/Initial Assessment" section states "new tx (treatment) for heels and coccyx (4-1-13)".

R7's "Weekly Pressure Ulcer Assessments" document the following:

2/25/13, left heel wound measures 2.0 x 2.0 cm "unstageable P/U (pressure ulcer)". The wound was described as 100% necrotic with "slough/eschar" and "clear". There was a small amount of pink/yellow exudate. There was no documentation of any wounds with the toes.

2/28/13, right heel wound measures 2.0 x 4.5 cm "Unstageable pressure ulcer". The wound was described as clear with slough/eschar. The tissue was 100% necrotic with a small amount of pink/yellow exudate. There was no odor.

3/29/13, left heel wound measures 17.2 x 7.5 cm with 100% necrotic tissue and "slough/eschar". The wound was described as erythematous with a moderate yellow, pink color exudate and a mild odor. There was no documentation of the toes.

3/29/13, right heel wound measures 11 x 6 cm "unstageable pressure ulcer". The wound was described as 100% necrotic tissue with slough/eschar. The wound was macerated with a small amount of pink/yellow exudate and a mild odor. There was no documentation of any toe wounds.

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E7, Registered Nurse (RN), stated in an interview on 4/18/13 that E5 had been the Wound Nurse but had quit on 3/24 or 3/25/13. E7 stated she had been filling in for E5. E7 stated she could not find any measurements for R7's wounds from 2/25 and 2/29/13 until she did the measurements on 3/29/13 on the "Weekly Pressure Ulcer Assessment".

The Braden Scale For Predicting Pressure Sore Risk dated 2/25/13 assessed R7 as a 16 or "Mild Risk". On 3/4/13 and 3/11/13, R7 was assessed as a 13 or "Moderate Risk" for the development of pressure sores. On 3/18/13, R7 was assessed as a 9 or "Very High Risk".

On 3/8/13 the "Dietitian's Progress Record" documented a recommendation by Z3, Registered Dietitian (RD), of Nephro Vites or renal multivitamins and to obtain labs to better evaluate nutritional status. The record documents the areas on R7's right and left heel. There is no mention of the wounds on R7's toes. The Nephro Vites were not started until 3/13/13. There is no further documentation by the Registered Dietitian. There was no nutritional assessment of R7's albumin level.

The "Nutrition Report" from the dialysis center dated 3/7/13, documents R7's Albumin at 3.1 g/dl (grams/decaliter) with the requirement at 4.0 or higher. The report documented R7's protein was "VERY LOW". The report documented "It is important for you to increase your protein intake to help with healing and feeling well". Past values of R7's Albumin level was 3.4 g/dl on 2/28/13.

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F9999	Continued From page 34 The nurses notes written by E5, LPN, and dated 3/21/13, document "Called placed to dietician to notify of new wounds. Awaiting call return." On 3/22/13 the nurses notes document "RD returned call-notified of new stage 2 pressure ulcers to coccyx. Recommendations made to start Novasource Renal 1 can PO (passing orally) BID (twice a day) and to consult dialysis unit to see if starting Prostat AWC would be contraindicated". R7's coccyx pressure ulcer was identified on 3/15/13. The Physicians' Orders document an order, dated 3/22/13, for the spplement Novasource Renal 1 can twice a day and Prostat 30 cc (cubic centimeters) twice a day for wound healing. The "Medication Record" documented the Novasource Renal and Prostat were not started until 3/23/13. When R7 was admitted to the hospital on 4/5/13, his Albumin level was 1.6 g/dl. The "Dietitian's Progress Note" documented on admission R7's diet order was regular, low concentrated sweets. E20, Food Service Supervisor, documented on 3/18/13 R7's diet was changed to mechanical soft. On 3/26/13, R7's diet was changed to puree. There was no documentation of the Nepro Vite recommendation or any other supplements. R7's "Physician's Orders", dated 3/4/13, document to change the diet from regular texture to mechanical soft, low concentrated sweets. On 3/13/13 the Nephro Vites were ordered. On 3/15/13 the physician ordered a divided plate for R7. On 3/18/13 the physician ordered a pureed, low concentrated sweets diet for R7.	F9999		

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R7's Physician Progress, written by Z1 and dated 3/28/13, did not document any information regarding the area on R7's bottom, coccyx or heels. E4, Licensed Practical Nurse, stated in an interview on 4/23/13 at 1:50 PM that Z1 did not see R7's wounds that day because R7 was going to dialysis. E4 stated there were no treatment changes to R7's heels or toes on 3/28/13.

R7's Physician Progress Note, written by Z1, dated 4/5/13, documents "(R7) is often at dialysis during the times we come to visit the nursing home patients however I made arrangements to come out today to see him. We note that he has black eschars on both heels which is a new finding. He also has some necrotic appearing lesions on the lateral toes on the left foot which are somewhat foul smelling. He is otherwise not much changed. Pressure sores of the heels, Possible Gangrene Left Foot. We will set him up with wound clinic and see about getting him evaluated". There is no mention of the pressure ulcer on R7's coccyx.

Z1 stated in an interview on 4/22/13 at 1:35 PM that he had seen R7's wounds one time when there was eschar and gangrene in his foot. Z1 stated the heel ulcers were due to pressure and vascular insufficiency. Z1 stated the area on the coccyx was due to pressure, but R7 wouldn't stay off his back. Z1 stated "beats me" when asked if using a air overlay mattress sooner than 3/27/13 would have helped. Z1 stated R7 had end stage renal disease and severe arteriosclerotic disease.

On 4/24/13, the facility submitted a written statement by Z1. Z1 documented that R7 had a diagnosis of Peripheral Vascular Disease. Z1

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documented R7 "had "0" toe pressure. It is my conclusion that the area to (R7's) feet were unavoidable and due to his condition and diagnosis of peripheral vascular disease and were not pressure related."

E4, Licensed Practical Nurse (LPN), stated in an interview on 4/23/13 at 1:50 PM that Z1 did not see R7's foot wounds on 3/28/13. E4 stated R7 was on his way to dialysis at that time. E4 stated that on 4/5/13, R7's left foot "was nasty". E4 stated it had a necrotic smell - "like dead tissue".

R7's 4/5/13 nurses notes, written by E4, documents that Z1 was at the facility and examined R7's feet. Z1 wrote an order for R7 to be seen by the wound specialist. An appointment with the wound specialist was made for 4/12/13 and R7's family was notified. The nurses notes document That R7's family was upset and requested R7 be sent to the emergency room. According to the nurses notes, R7 was sent to the local emergency room on 4/5/13.

The local emergency room "Emergency Department Record" documented "Positive for redness and wounds. Coccyx decubitus approx. (approximately) 10 cm; also significant pressure sores on both heels; ?necrotic looking left 4 th toe". R7's albumin level was 1.6 G/L (grams/Liter) normal (3.4-5.0). The emergency department record documented "Multiple Decubitus, renal failure and IDDM (insulin dependent diabetes mellitus). The emergency room record documented R7 was transported to a large metropolitan hospital.

The History and Physical from the large

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145454	A. BUILDING ______ B. WING ______	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLINVILLE REHAB & HCC	751 NORTH OAK STREET CARLINVILLE, IL 62626

(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 37 metropolitan hospital, dated 4/5/13, documents "early decubitus on the sacrum". On 4/6/13 a "Wound Consult" documents R7 was admitted to the hospital with "multiple BLE (bilateral leg extremities) vascular ulcers which are currently managed by Vascular team...". The hospital "MD Progress Note" dated 4/6/13 document "left 4th and 5th toes necrotic and foul smelling. Both heels with ulcers about 6 cm in diameter, skin necrotic, previous ABI noncompressible and 0 toe pressure". The physician recommended a left below knee amputation. On 4/8/13 the "MD (Medical Doctor) Progress Notes" documented the plan was for comfort measures and to not have the amputation. The Facility Policy and Procedure titled "Pressure Ulcer Prevention and Healing Program" documents the following requirement: "The facility has a designated Wound Care Nurse, who completes weekly assessment and documentation. Nutritional support is used as needed for those at risk or those who have wounds or nutritional deficits. The physician and family are notified timely when wounds are identified and with any significant change in status. Care Plans and MDS (Minimum Data Set) reflect the current wound status, risk factors and individualized approaches. Support Surfaces according to resident's risk level and specialty beds appropriate for existing wounds". (B)	F9999		