STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145718	A. BUILDING ______ B. WING ______	C 06/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CRESTWOOD	14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445

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F 441	Continued From page 23 In an interview on 5/29/13 at 11:00 am, E25 stated she should have washed her hands before stepping out of (R2's) room. 5. On 5/29/13 at 11:10 am, E24, Licensed Practical Nurse, provided wound care on R2's Stage 3 pressure ulcer of the sacrum. E24 washed hands and donned gloves. E24 used the same pair of contaminated gloves from start to end of treatment. E24 failed to perform hand hygiene and change the contaminated gloves prior to handling the clean dressing on a wound area that has just been cleaned. In an interview on 5/29/13 at 12:10 pm, E24 stated she washed her hands and gloved before the treatment and thought she changed gloves after taking off the dressing. E24 admitted she did not perform hand hygiene nor changed gloves prior to applying the dressing. The facility policy and procedure on Accucheck revised 10/06 reads, " The machine will be cleaned with a disinfectant wipe between residents. If the machine is dedicated to the resident, then it is not necessary to disinfect between uses. " The facility policy and procedure on Handwashing revised 10/03 reads, "Proper handwashing is necessary for the prevention and transmission of infectious disease. Procedure #1. Handwashing is done before and after any procedure, after using a (tissue) or the restroom, before eating or handling food, when hands are obviously soiled and regardless of glove use.	F 441		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 24	F9999		

LICENSURE VIOLATIONS

300.610a)
300.1210a)
300.1210b)
300.1210d)3)5)
300.1220b)2)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 300.1210 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

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F9999	Continued From page 25	F9999		

Continued From page 25

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. Restorative measures shall include, at a minimum, the following procedures:

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, 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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F9999	Continued From page 26 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 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 requirements were not met as evidence by: Based on record review and interview, the Facility failed to develop a Plan of Care with effective interventions to prevent pressure ulcers for 1 of 7 (R8) residents reviewed for skin breakdown in the	F9999		

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F9999	Continued From page 27 sample of 26. This failure resulted in R8 developing Pressure Ulcers/Deep-Tissue Injuries to his left buttock and left heel. Findings include: R8 was originally admitted to the Facility on 2/2/13 with diagnoses, in part, of End-Stage Renal Disease, Diabetes Mellitus and Cerebrovascular Accident. R8's Admission Minimum Data Set (MDS), dated 2/8/13, documents that he had disorganized thinking; was dependent on the extensive assistance of two or more persons for physical assistance during transfers; required the extensive assistance of one person for ambulation, dressing and personal care; had functional limitations in range of motion on one side for both his upper and lower extremities; and was occasionally incontinent of urine and bowel. The Facility "Patient Risk Profile, Risk Assessment History", dated 2/4/12, documents that R8 was assessed as having a Braden Score of 16. The form documents that a score of 15-18 puts and individual "At Risk" of developing a pressure ulcer. This form includes the following documented "Preventive Interventions-Recommendations: Turning Schedule, observe and assess regularly, use commercial moisture barrier and consult dietitian". R8's plan of care documents no interventions for prevention of skin breakdown until he developed a pressure sore on his left heel on 2/22/13. On 2/22/13, the Facility implemented a care plan for "Deep Tissue Injury" for R8 which documents a	F9999		

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F9999	Continued From page 28 Problem of "Impaired skin integrity related to; deep tissue injury; Goal-promote healing and prevent further deterioration; Approach-Completely relieve pressure, assess and observe every shift, Do Not massage, rinse and pat dry, Apply protective dressing is necessary using sponge dressing, change every 3 days and as needed, heel protectors as tolerated. The following documentation is handwritten onto the Care Plan: "Problem: 3/21/13, Left Buttock". There are undated Approaches documented on the bottom of the Care Plan which state: Low Air Loss Mattress, Turn and Reposition every 1.5-2 hours while in bed, Overlay for Dialysis Chair". Facility nurses notes document "3/20/13, 10:30 AM, Certified Nurses Aide (CNA) made writer aware that resident had an open area on buttock. Writer called wound care nurse to assess. Resident denies pain or discomfort at this time". R8's "Wound Assessment Details Reports" document the following for the pressure ulcer on his left buttock: "3/21/13-Size: 10 x 2 x unknown (LxWxD), Area: 20 centimeters squared (cm2), Volume: unknown, Undermining: None, Tunneling: None. Facility acquired Suspected Deep Tissue Injury. Current Plan: Resident was noted with a Deep Tissue Injury (DTI) to the buttock irregular shaped. He is incontinent of bowel and bladder and requires assistance with turning and repositioning. He is currently on turning and repositioning program and has a low air loss mattress and heel protectors in place. 3/29/13-Size: 11 x 3.3 x unknown (LxWxD), Area; 36.3 cm2, Volume: unknown, Undermining:	F9999		

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F9999	Continued From page 29 None, Tunneling: None. Was seen on rounds by wound physician. Continue with current treatment orders for the left buttock. Turn and reposition program in place. Noted an open area at the sacral 1.3 x 0.6 with 30% granulated and 70% slough. It was debrided. Left heel remains dry and intact. 4/5/13-Size: 14 x 6.5 x unknown (LxWxD), Area 91 cm2, Volume: unknown, Undermining: None, Tunneling: None. Turning and repositioning program in place. Treatment to include Santyl, cover with dry dressing daily: On 3/29/13 it was also documented, "Noted an open area at the sacral 1.3 x 0/6 with 30% granulated and 70% slough. It was debrided." This was the only documentaion in R8's clinical record or in the wound reports, concerning the open area on R8's Sacrum which was documented on 3/29/13. R8's "Wound Assessment Details Reports" document the following for the pressure ulcer on his left foot: 2/22/13-Size: 2 x 1.6 x 0 (LxWxD), Area: 3.2 cm2, Volume: 0, Undermining: None, Tunneling: None. Facility Acquired Suspected Deep-Tissue Injury. 3/1/13-Size: 2 x 2 x Unknown (LxWxD), Area 4.0 cm2, Volume: Unknown, Undermining: None, Tunneling: None. Treatment appears to be beneficial to the wound. Noted no open areas, wound appears as stable eschar. Pedal pulse palpable. 3/8/13-Size: 2 x 2 x unknown (LxWxD), Area 4.0 cm2, Volume: Unknown, Undermining: None,	F9999		

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F9999	Continued From page 30 Tunneling: None. Skin dry and intact, no drainage, continue dry dressing, offload heels when in bed. 3/15/13-Size: 2 x 2 x unknown (LxWxD), Area 4.0 cm2, Volume: Unknown, Undermining: None, Tunneling: None. Wound at this time appears to be unstageable. Has 80% of hard necrotic tissue with 20% soft necrotic tissue with the periwound having yellow adherent slough. Physician notified and treatment order changed. Resident co-morbidities are Diabetes Mellitus, Left sided Cerebrovascular Accident (CVA), Hemiparesis, Pulmonary Edema. 3/22/13-Size: 1.5 x 1.5 x unknown (LxWxD), Area: 2.25 cm2, Volume: Unknown, Undermining: None, Tunneling: None. Decreasing in size. No drainage. 3/29/13-Size: 2 x 2 x unknown (LxWxD), Area 4.0 cm2, Volume: Unknown, Undermining: None, Tunneling: None. Continue with current treatment plan. Area presents with stable escarp. Unable to palpate pedal pulse at this time. (The box on the bottom of the form indicating "Physician Notified" is not checked). 4/5/13-Size: 2 x 2 x unknown (LxWxD), Area 4.0 cm2, Volume: Unknown, Undermining: None, Tunneling: None. Continue treatment until healed/resolved. Heel protectors in place." In an interview with E2, Director of Nursing, and E12, Clinical Risk Manager, on 5/30/13 at 11:10 AM, it was confirmed that the Facility failed to develop a plan of care to prevent the development of unstageable pressure sores for R8. Both E2 and E12 are unaware when the	F9999		

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Approaches stating "Low Air Loss Mattress, Turn and Reposition every 1.5-2 hours while in bed, Overlay for Dialysis Chair", were added to R8's plan of care however, they think it was after he developed the open area on his left buttock. They could not confirm that R8 had a low air loss mattress or an overlay for his dialysis chair.

R8's clinical record documents that he was sent to the hospital on 4/6/13 for sepsis. R8 expired at the hospital on 4/10/13. The History from the hospital, dated 4/6/13, documents that R8 had "Active Sepsis -there is concern for possible blood stream infection, source uncertain".

During an interview with Z5, Wound Care Physician, on 5/30/12 at 11:45 AM, it was stated that he could not remember R8 without reviewing his clinical record. Z5 went on to state that sometimes residents develop 3:30 Kennedy pressure sores which can develop in a matter of hours however, he was unable to state if this was the case with R8.

The Kennedy Terminal Ulcer website (www.kennedyterminalulcer.com) documents that patients who have the 3:30 Syndrome Kennedy Terminal Ulcer have a history of dying within 8-24 hours after development of the pressure sore.

The Facility "Skin Care Prevention Protocol; documents "All resident's will receive appropriate care to decrease the risk of skin breakdown. The Skin Care Coordinator or person designated by the Director of Nursing will review all new admissions to put a plan in place for prevention based on the resident's activity level, comorbidities, mental status, risk assessment and other pertinent information".

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F9999	Continued From page 32 (B)	F9999		