STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146071	A. BUILDING _____ B. WING _____	06/10/2013

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GARDENS OF BELVIDERE,THE	1701 WEST 5TH AVENUE BELVIDERE, IL 61008

(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
F 520	Continued From page 36 6/3/13.	F 520		
F9999	. FINAL OBSERVATIONS Licensure Violations: 300.1010h) 300.1210b)4) 300.1210d)1)2)3) 300.1220b)2) 300.1620a) 300.1630a)2 300.3240a) 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	F9999		

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F9999	Continued From page 37 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: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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: 1) Medications, including oral, rectal, hypodermic,	F9999		

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F9999	Continued From page 38 intravenous and intramuscular, shall be properly administered. 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. 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. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or	F9999		

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F9999	Continued From page 39 unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. 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 are not meant as evidenced by: Based on observation, record review, and interview the facility failed to monitor and document the effectiveness of pain medications, administer additional pain medication as ordered, and to notify the physician extended of unrelieved pain.	F9999		

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These failures contributed to R7 experiencing unrelieved pain.

This applies to 3 of 7 residents (R7,R6,R1) reviewed for pain ,vascular ulcers and dialysis in the sample of 13.

The findings include:

1. R7's June, 2013 Physician's Order Sheet documents that R7's diagnoses include Chronic Obstructive Pulmonary Disease, Decubitus Ulcers, Chronic Pain, Arthropathy, and Degenerative Disc Disease.

R7's June, 2013 Medication Administration Record shows an order for Morphine Sulfate/ (Roxanol) 10 mg sublingual every 6 hours around the clock, and Morphine Sulfate 10 mg every one hour as needed for pain or shortness of breath. (4 doses of the prn Roxanol were given from June 1, through June 3, 2013)

R7's May, 2013 Medication Administration Record documents Roxanol (Morphine Sulfate) 10 mg every six hours around the clock was started on 5/21/13. The as needed (prn) hourly Roxanol ordered was 10 mg, every hour. (6 doses of prn Roxanol were given from 5/21 through 5/31) a period of 10 days.

The MAR for May, 2013 documents inconsistently, the effect of the analgesic as "helps a lot, or "relief".
The June, 2013, MAR documents the effectiveness of R7's analgesic rated as effective a 5 out of 10 intensity on two occasions. (pain scale of 0-10)

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On 6/3/13 at 11:30 AM, R7 was observed laying in her bed. R7 had facial grimacing and said "I need pain medication." R7 said she had pain in her hips, knees, thighs, legs and back. R7 requested surveyor to come back at a later time. R7 was positioned on her left side, her pillows were on a chair in her room. R7's breakfast tray was on the over bed table, untouched.

R7's admission Minimum Data Set (MDS) assessment of 5/10/13 documents that R7 has no cognitive impairment, and had a pain intensity of 9/10. (0-10 pain scale) The same assessment shows that R7 has multiple pressure and venous leg ulcers. No resistance to care is documented.

On 6/3/13 at 12:55 PM, E8 (Certified Nursing Assistant) said that R7 drinks good, but she is not interested in eating. E8 said R7 is " in pain all the time, sometimes your not even touching her and she cries out oh my legs." E8 said that R7's legs are contracted and if they get her in the wheel chair she just cries, she does not want to be up. Her (R7's) husband said it would be fine if she stays in bed.

On 6/3/13 at 1:00 PM, E4 (Licensed Practical Nurse) said that R7 is "constantly in pain". R7 is supposed to go home with hospice care this week.

On 6/4/13 at 11:00 AM, E12 (CNA) said that R7 had refused to turn, because she was in pain. E12 said R7 was getting some pain medication and they will wait for it to "kick in." E12 said R7 seemed to be hurting today more than usual.

R7's Nursing Notes were reviewed and showed

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the following ongoing documentation of pain:
5/5/13 (3:31 PM) complains of pain even after being medicated.
Often does not remember that she had her pain medicine and will accuse staff of not giving her any. Complains of severe leg and back pains.

5/7/13 (3:30 AM) Asks for large doses of pain medication. Complains of severe leg and back pain.

5/8/13 (4:31 AM) Patient is hyper-sensitive to touch.
Forgets she had pain medication, and accuses staff of not giving them to her .Yells out when turned or with dressing changes.

5/10/13 (2:50 AM) complains of severe pain in back and extremities with any position changes or care, and dressing changes.

5/11/13 (7:37 AM) refusing repositioning and dressing changes.

5/12/13 (6:43 AM) does not like to be turned or repositioned. Resident is tolerating dressing changes fair.

5/13/13 (3:25 AM) continues to complain of pain with turning and dressing changes,on scheduled pain meds.

5/18/13 (7:39 AM) dressing changed under "painful protest."
(8:45 PM) Has generalized chronic pain. It appears that resident is in so much discomfort/pain when she is repositioned.

5/19/13 (2:45 AM) Complains of pain with any

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F9999	Continued From page 43 movement or touching of skin. 5/20/13 (2:47 AM) Complains of pain with any movement, repositioning, dressing changes or even just touching her, on scheduled pain meds. Additional nursing notes document R7's pain 7 on other days. (5/21, 5/24, 5/25, 5/31, 6/1, 6/3) An incident report investigation dated 5/18/13 documented that R7 reported that E19 (LPN) was doing R7's treatments and R7 yelled out because of pain. E19 told her (R7) "she disagreed with her about the pain she was experiencing." E2 Director of Nursing said on 6/5/13 at 10:15 AM, that when they realized (on 6/4/13) that R7 would be staying another week, they thought they should get her pain medication increased. E2 said that R7 had been there since May 3rd, and always had pain at a 7-9 intensity. (0-10 pain scale) Z2 said on 6/6/13 at 2:30 PM, that she was not aware that R7's pain was not being relieved. Z2 said she had ordered Roxanol scheduled dose with a prn. Z2 said " I could have titrated her up, or added a long acting analgesic, if I would have known she wasn't getting relief." R7's Pain Care Plan dated through 8/3/13 documents the goal that R7 will require less pain medication. The facility policy and procedure for pain management documents on page 1) item 4 The resident has the right to expect a rapid and effective response to a complaint of pain. Treat	F9999		

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F9999	Continued From page 44 the pain, reassess and continue to treat the pain until the resident is comfortable or side effects prevent further treatment. Notify the physician if pain relief can not be obtained. (B) 300.1010h) 300.1210b)5) 300.1210c) 300.1210d)2)3)5) 300.1220b)2)3) 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 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	F9999		

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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:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

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

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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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or

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F9999	Continued From page 47 agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on observation, record review and interview the facility failed to ensure pressure sore prevention measures were implemented for a resident at high risk. These failures contributed to R5 developing a blister to her left heel that progressed to an unstagable wound. R10 and R13 had pressure ulcers without monitoring or assessments. The findings include: 1. R5's June 2013, Physician's Order Sheet documents that R5's diagnoses include Left Femur Fracture, Mild Mental Retardation, and Dementia. R5's admission Minimum Data Set (MDS) assessment of 4/26/13 (admit 4/15/13) shows that R5 is dependent on two or more for transfer. R5 requires extensive assistance of one person for bed mobility. R5 is incontinent of bowel and bladder. The same assessment shows that R5 had no pressure ulcers present. R5's Nursing Note (admission) on 4/16/13 documents that R5 had a surgical site with 5 incision areas on the outer lower thigh areas with a total of 65 staples and a small reddened area under the left breast "other wise skin is intact." The Nursing Notes for 5/2/13 documents a left heel blister with a blackish base.	F9999		

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A Braden Scale for Predicting Pressure Sore Risk dated 4/15/13 documents a score of 15.
(15-16 = low risk) No other skin risk assessments were documented.

R5's Treatment Record for May, 2013 shows that R5 developed a fluid filled blister to her left heel. R5's left foot was edematous and red. The same document shows that R5 wears a hinge knee brace to the left leg. R5 is at high risk for skin breakdown and has orders to have a skin check daily and to document the results on the back of the sheet. R1 is to wear bilateral heel protectors at all times. The back of R5's Treatment Record showed only one entry for her left foot dated 5/4/13.
On 5/8/13 Nursing Notes show the blister was broken and sloughing and a skin flap was present. The Site was draining sero sanguineous drainage.
On 5/22/13 black eschar was present to left heel. The documentation did not show any other wound characteristics. (size, odor, periwound skin, signs of infection, wound pain)

E2 (Director of Nursing) said on 6/4/13 that the majority skin assessments and treatments are done on the night shift. E2 said the schedule varies. The skin assessments and wound descriptions are documented on the back of the Treatment Administration Records.

R5's Physician Order Sheet for June, 2013 shows to check R5's left heel for off loading every shift. High Risk for skin breakdown, assess skin integrity daily and document weekly on the back of the Treatment Administration Record. Pressure relieving device to bed and wheel chair. Apply

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thigh high antiembolism stocking to the left leg. (order of 4/18/13)

R5's entire care plan dated through 8/3/13 was reviewed and showed no plan for skin breakdown or monitoring. No preventative interventions were documented.

On 6/3/13 at 11:30 AM, R5 was sitting in her wheel chair. R5's left foot was resting on the floor. A hard metal type brace, with adjustment dials, was on the left leg. The brace extended from the knee to the ankle. R5 had one quilted type boot on her left foot. R5's right foot had a slipper sock covering the toes only and the foot was on the foot rest. R5 said she had fallen by her bed and broke her leg.

At 11:45 R5 was in her room, seated in the wheel chair with her right foot swung over the side of the foot rest. R5 was attempting to get out of her chair. R5 said " I can't get out of here."
At 12:20 R5 was in the dining room with both feet resting on the floor (through the middle of the foot rests). R5 had no pressure reducing cushion on her wheel chair. R5 did not have anti-embolism stockings on .

On 6/4/13 at 8:15 AM, R5 was seated in the dining room, her left heel was resting on the foot pedal. Her right foot was resting on the floor. R5 was wearing a slipper sock on the right foot, and a quilted boot on the left.
At 11:30, R5 was in the dining room with both heels resting on the foot rests, R5 was wearing slipper socks on both feet. (No boots)

At 1:25 PM, R5 was sitting in the wheel chair in her room. Both feet were resting on the foot

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(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
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pedals. R5 had no pressure reducing cushion on her wheel chair. R5 was not wearing the anitembolism stockings.

At 1:30 PM, R5 was observed in her room. E5 Certified Nursing Assistant and E12 (CNA) were present. E5 and E6 were made aware of R5's leg positioning. (Heels not off loaded) E5 and E6 were shown that R5 had the imprint of the dials from the left leg brace, on her right inner, lower leg.

On 6/5/13 at 7:15 AM, R5 was seated in the dining room. She was angry and yelled out "I'm sick of this." R5 was wearing a quilted boot to the left foot, and a slipper sock to the right foot. Both of R5's feet were resting on the foot pedals. R5's left foot was edematous and purplish colored on all observations of the survey. R5 did not wear antiembolism stockings throughout the survey observations.

A wound consult note of 6/3/13 documents a recommendation to off-load R5's wound. (heel)

The Policy and Procedure for Treatment and Prevention of Skin Breakdown and Surgical Wounds shows on page 1) B.
Identification of causal factors and clinical conditions which indicate risk for pressure ulcers should be used to implement prevention measures and develop the care plan.

2. On 6/5/13 at 10:49am, R10 was observed sitting in a wheelchair at a balloon activity in the dining room. R10 had a soft blue boot to her right foot that was dangling behind the foot pedal on her wheelchair.

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	146071	A. BUILDING _____ B. WING _____	06/10/2013

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The Nurses Notes for R10 showed, "9/12/12 - Orders received for blister to right heel."
R10's Care Plan dated 9/12/12 showed, "Blister - right heel."
The Treatment Record for R10 showed a treatment order from 9/12/12 through 10/10/12 to cleanse her right heel blister with normal saline and apply skin prep until healed. The Treatment Record for R10 showed "healed" written as of 10/10/12 for R10's right heel.
The Treatment Sheets and Nurses Notes for R10 from 9/12/12 through 10/10/12 showed no monitoring or assessment of the wound to R10's right heel.
The Treatment Record for R10 showed a new treatment to R10's heel on 10/28/13," Cleanse right heel with normal saline. Apply enzymatic debridement ointment and wrap with gauze every day and as needed."
The Treatment Record and Nurses Notes for R10 from 10/28/12 through 11/20/12 showed no monitoring or assessment of the wound to R10's right heel.
On 6/6/13 at 9:30am, E11 (Registered Nurse - Corporate Consultant) stated, "R10's right heel pressure ulcer started on 9/12/12 and healed on 10/10/12. Then it reopened at the end of October 2012 but there is no documentation. The heel reopened on 10/28/12 and then there is no additional documentation before R10 went to the hospital in November 2012."
The Wound Care Specialist Evaluation dated 6/5/13 for R10 showed, "R10 has a stage III pressure wound of the right heel of at least 174 days duration."

3. The June 2013 Physician's Order Sheet (POS) shows R13's diagnoses include: Hypertension, Cerebral Vascular Accident, Neck Fracture and

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F9999	Continued From page 52 Gait Abnormality. The Nurse's Notes of 1/8/13 documents, "R13 has some new skin issues. Her left great toe and 2nd left toe have purple discoloration at tip has resemblance of a blood blister. The 2nd toe has area which may have been open, but is now healed over but remains purplish." No documentation of R13 toes to include measurements or weekly/daily skin checks were in the Nurses Notes. The care plan of 1/8/13 shows a problem of "dark areas left great toe and 2nd toe." The Care plan does not show risk factors, the cause of the blister/dark areas to the toe or measures to prevent reoccurrence. The Minimum Data Set of 2/20/13 assessed R13 as moderately impaired for decision making. R13 does not ambulate and is totally dependent on staff for mobility on and off the unit. R13 needs extensive assistance for dressing, bathing and toilet-use. No skin issues were noted on the previous assessment. The facility's pressure ulcer treatment policy revised October 2010 documents, "Suspected deep tissue injury: Purple or maroon localized area of discolored skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. Determine cause of pressure and relieve. A pressure ulcer risk assessment will be completed upon admission, with each additional assessment; quarterly, annually and with significant changes. Skin will be assessed on a weekly basis or more frequently if indicated. Staff will perform routine skin inspections daily or every other day as needed."	F9999		

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(B)

300.625l)

Section 300.625 Identified Offenders

l) The facility shall incorporate the Criminal History Analysis Report into the identified offender's care plan. (Section 2-201.6(f) of the Act)

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to incorporate the Criminal History Analysis Report into an identified offender's care plan.

This applies to 1 resident (R8) of 2 reviewed as an identified offender in a sample of 13.

The findings include:

The facility submitted an identified offender reporting form dated 7/31/12 for R8. The document shows R8 was admitted to the facility on 8/22/11 with an offense of battery. The form documents R8 Criminal History Analysis risk determination as "moderate."

R8's Criminal History Analysis Recommendation Report (CHAR) shows "Moderate Risk as requiring closer supervision and more frequent observations than standard or routine for most

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F9999	Continued From page 54 residents in the facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient." The Minimum Data Set of 3/28/13 shows R8 is moderately impaired in decision making. R8 requires limited assistance of 1 staff for transferring and set up help for locomotion on and off the unit. R8 is totally dependent for toilet use and personal hygiene. R8's previous history of criminal behavior and CHAR security risk measures are not included in R8's current care plan. On 6/4/13 at 3:40pm, E2 (RN-Director of Nursing) said R8 did not have a care plan to include the CHAR security recommendations. (B)	F9999		