STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004048	A. BUILDING: _____ B. WING _____	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CREST HOME	817 17TH STREET FULTON, IL 61252

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S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210d)2) 300.1210d)5) 300.1220b)3) 300.3240a) 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	S9999		

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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.

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.

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,

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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. (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 identify a resident as high risk for pressure ulcers, and failed to implement interventions to prevent a resident from developing pressure ulcers. These failures resulted in R33 developing an unstageable pressure ulcer to the left lower extremity, and a Stage II pressure ulcer to the coccyx.

This applies to 1 of 4 residents (R33) reviewed for pressure ulcers in the sample of 12.

The findings include:

R33's Minimum Data Assessment (MDS) of 2/12/14 shows diagnoses to include Heart Failure, Hip Fracture, and Chronic Obstructive Pulmonary Disease. The 2/12/14 MDS shows R33 requires total dependence on staff for transfers, and extensive assistance with movement in bed, dressing, hygiene, and toilet use. The 2/14/14 MDS documents R33 has

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moderate cognitive impairment with difficulty recalling information. This MDS assessment shows R33 is at risk for developing pressure ulcers and has one "unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar". This assessment also documents "Most Severe Tissue Type" as "eschar-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges".

R33's Physician Order Sheet (POS) dated 11/27/13 documents an order for "immobilizer to lt (left) leg all the time x 1 month".

The skin assessment for "Predicting Pressure Sore Risk" dated 11/1/13 shows a score of 13, placing R33 at "moderate risk" for skin breakdown (moderate risk total score 13-14).

E2 (Director of Nursing -DON's) "Nurse's Notes" documentation dated 1/23/14 for R33 shows "Noted pressure area on LLE [left lower extremity] lateral [side] as a result of leg immobilizer. ARNP (Nurse Practitioner) notified, area 2cm x 2 cm unstageable. Noted error related to leg immobilizer , nurse failed to notify CNA [Certified Nurse Assistant] of D/C [discontinue] immobilizer, resulting in pressure ulcer, unstageable "

The 1/23/14 "Error Report" shows (R33's) "leg immobilizer x 1 month...not removed after 1 month - nurse failed to instruct CNA's"..."outcome to resident - nonstageable pressure ulcer to left lower leg".

On 3/6/14 at 10:00 AM, E3 (Registered Nurse - RN) removed the dressing to R33's left leg. R33 had a quarter-sized dry brown/black circular area to her left outer leg. E3 said the wound was

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"unstageable due to a necrotic hard core, and it was unable to stage because she can't see what's underneath". E3 measured the wound and said it was 4cm x 3.4 cm and said " I don't know why they have it charted as smaller, it is bigger than what they have".

On 3/6/14 at 10:00 AM, E2 (DON) said R33 should have been identified as a high risk for skin breakdown on admission due to her immobilizer, abductor pillow, and inability to move herself. E2 said the immobilizer was ordered to be discontinued on 12/14/13, but was not removed until 1/24/14 (over one month later). E2 said when the immobilizer was removed, R33 had the unstageable pressure sore to her left outer leg. E2 also said the nurses did not remove the immobilizer to assess the skin underneath, or perform skin cleaning/hygiene (from October 31, 2013 to 1/23/14). E2 said the physician should have been notified to get orders on how often to remove the immobilizer for skin assessments and showers on admission.
E2 said the facility does not have a policy in place for skin assessments for residents who are high risk for pressure ulcers. E2 said the nurse should be doing a head to toe assessment at least weekly if the resident is high risk.

On 3/6/14 at 9:50 AM, E3 and E12 (Licensed Practical Nurse) said the nurses do not do head to toe skin assessments on residents if they are high risk for breakdown on a scheduled basis. E3 and E12 said the CNA's do the weekly skin checks during showers and baths and notify the nurses if they see anything of concern. E3 and E12 said they do not do weekly assessments on the residents even if they have a pressure ulcer identified. R33's "Weekly Pressure Ulcer Sheet" documents a wound assessment for the

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S9999	Continued From page 5 Unstageable area to the left lower leg on 1/23/14, 2/6/14, 2/16/14, and 2/24/14. On 3/5/14 at 10:58 AM, Z1 (Nurse Practitioner) stated "the nurses should have removed the immobilizer at least once per day to assess the skin condition, clean the skin, and apply lotion". The undated facility policy "Skin Assessment and Wound Care Policy" states "The nurse will be responsible for weekly skin checks and documentation of any skin alterations". 2. On 3/6/14 at 10:00 AM, E2 said R33 also developed a Stage II pressure area to her coccyx which was identified on 11/19/13. R33's "Weekly Pressure Ulcer Sheet" dated 11/19/13 shows a "Stage II on Right Coccyx open, measuring 0.5x 0.5". The 11/19/13 "Nurse Notes" document R33 has ".5cm x .5cm open area on right side of coccyx, superficial depth". R33's "Skin Breakdown" care plan did not include interventions to complete an assessment weekly, remove immobilizer to assess the left lower extremity, reposition every two hours, or interventions specific to preventing a pressure ulcer from occurring. (B)	S9999		