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FAIR OAKS HEALTH CARE CENTER	471 TERRA COTTA AVENUE CRYSTAL LAKE, IL 60014

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210b) 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 and dated minutes of the meeting. 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	S9999		

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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:

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 300.3240 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 WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, the facility failed to train and educate the nursing staff on how to stage a pressure ulcer and to correctly identify the site of the wound and failed to demonstrate the accurate way of measuring wounds. The facility also failed to develop and implement specific and individualized interventions to promote healing. This applies to four (R 2, R 1, R 7 and R6) of five residents (R1,R2, R5, R6 and R7) reviewed for pressure ulcers in the sample of 12.
These failures contributed to the worsening of

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R2's pressure ulcer. R2's left heel and right ankle progressed to unstageable pressure ulcers.
The findings include:
(1) R2's Admission Body Audit dated 03-21-14 showed R 2 was admitted with the following:
1. Location # 8 - right (ankle) foot - identified as (pressure) ulcer.
2. Location # 13 - left heel - open area.
R2's weekly skin charting dated 03-21-14 for the right lateral ankle (# 8) showed this was identified as pressure ulcer, described, and measured at 1.5 cm X 2.0 cm pink with black areas, surrounded by a ring of yellow, no measurable depth; surrounding skin is red. The stage was not identified.
R 2's weekly skin charting for the left heel dated 03-21-14 identified as open area to left heel. Description: 1.8 cm X 2.0 cm superficial pink wound.
R 2 ' s weekly skin charting dated 04-21-14 reads " left heel healing well. "
The pressure ulcer list dated 04-22-14 showed R 2 has only 2 areas of admitted pressure ulcer (1) coccyx and (2) Right lateral ankle with comments that these ulcers are " better. "
On 04-24-14 at 11:00 AM, E 5, LPN (licensed practical nurse) was observed during R2's pressure ulcer treatment; E 5 measured and describes the wounds as follows:
1. Right ankle - with moderate amount of brownish drainage, very tender to touch, wound is 100% covered with thick greenish slough, measured at 2.0 cm X 2.0 cm. " I don ' t know how and what to stage this is. "
2. Left heel (area # 13) - with brownish/black discolored area, very tender to touch, no dressing noted and measured at 2.0 cm X 2.0 cm.
The NPUAP- National Pressure Ulcer Advisory Panel categorizes this wound as Unstageable. A full thickness tissue loss in which the actual depth

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of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

On 04-23-14 at 1:55 PM, E 6/ Medicare Nurse stated, " We don't usually stage the wounds. No, we do not have a comprehensive assessment. We only use the Braden Scale for Predicting Pressure Sore Risk Assessment (which E 6 was unable to locate in R2's clinical record). We use the weekly skin charting (which does not identify the Stage) and the care plan. E 6 reviewed and presented 21 pages of R2's plan of care and E6 stated, " There's no skin or ulcer care plan in here. "
On 04-24-14 at 11:30 AM, R 2 was observed in bed with no off-loading device in place.

(2) On 04-22-14 at 1:30 PM, E 2 (Director of Nursing) presented the facility's pressure ulcer list. The list showed four (R 2, 7, 15 and R 16) residents admitted with pressure ulcers. This list does not identify the stages of the pressure ulcers. E 2 also presented the weekly skin charting for the identified residents, which also does not identify the Stages. E 2 explained (showing the weekly skin charting) " if you read the description then, you can figure out what stage the wound is. " E 2 agreed the facility has not been identifying the stages of the wound in their wound assessment, progress notes or tracking sheet.
E 2 said, " The afternoon shift nurses do the treatment for residents with pressure ulcers. E2 also expressed the Medicare Nurse (E 6) will do the initial assessment and recommends the treatment modalities. " On 04-23-14 at 1:55 PM, E 6 stated, " I really don't have formal wound training but we have computer training (on wounds) yearly.

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S9999	Continued From page 4 R7 was admitted to the facility on 3/25/14 with a documented Stage III coccyx wound. The physician order sheet and R7's face sheet document R7's diagnoses of cerebral ischemia, peripheral vascular disease, right lateral thigh abscess, right femoral-femoral bypass, chronic obstructive pulmonary disease, neuropathy. On 4/23/14 at 1:30 pm, E5 (licensed practical nurse, LPN) changed R7's dressing. There were 2 brownish spongy dressings (hydrocolloid), there was a a small scabbed wound on the left buttock. E5 described this as, reddish brown in color and closed. E5 stated " I wouldn't stage this wound but if I had to I would call it a stage 1. " E5 described the coccyx wound as " pink in color with a whitish color tissue inside the wound covering 100% of the area. " E5 stated this was not exudates but didn't know what to call it. E5 proceeded to measure the area at 1.0 cm X 0.8cm with a 1.0cm induration and a depth of 0.3cm. The surrounding compromised tissue that surrounds the wound and brownish in color was not measured. E5 stated that was not part of the wound and that is how she measures the wound but was not sure how everyone else does. Wounds were cleaned and dressed per physician orders. R7 reports there is pain there if she sits too long or lays on it too long. On 4/23/14 at 1:30 pm E5 stated she has not had any formal training on wounds or wound care and the facility requires an annual computer in-service on wounds to be done and that is where they learn about staging and measuring wounds. E5 stated wound care and dressing recommendations were done by the medicare nurse that is here 5 days a week during the day shift. E5 is not aware of any trained wound nurse in the facility but states, " I don't usually take care of wounds because they are done on the 3pm-11pm shift.	S9999		

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S9999	Continued From page 5 On 4/23/14, R7 was noted to have an 18lb weight loss in one month. A hydration risk evaluation of 8 (8 or higher places the resident at high risk). R7's Braden score on 4/8/14 was 18 and on 4/15/14 it was also 18 (a score of 12 or less places the resident at high risk). The weekly skin charting for the right buttock on 4/15/14 documents the wound to be an abrasion/open area with measurements of 1cm x 0.75cmwith no depth and superficial. The coccyx weekly skin charting documents that wound to be 1.0cm x 0.5cm x 0.2cm open area, with scant yellow drainage. There is no staging involved in the weekly skin charting or tracking, improving or worsening of wounds. Also, it is unknown if the measured areas are consistent with all staff as there is no formal education provided. There was no physician assessment of the R7 ' s wounds. On 4/24/14 at 11:00am, E9 (registered nurse, RN) was changing the dressing on R1's Posterior upper thigh/gluteal fold area. E9 stated this was friction created from sitting in the wheelchair. E9 has a medical diagnosis of multiple sclerosis as documented on the physician order sheet and is wheel chair bound. R1 has redness to both posterior gluteal folds and open abraised areas on the left posterior thigh. E9 stated she would stage this as a stage 1 pressure sore but is not comfortable with staging because she usually doesn't take care of wounds they are done on the 3pm-11pm shift. E9 stated she recently took the computer annual in-service on pressure sores on the computer and that is how she knows how to stage this wound. E9 stated she was unaware if there was a wound nurse in the facility but didn't think so and that the medicare nurse usually made dressing recommendations to the physician if needed. There were no physician assessments of R1's wounds. No sting barrier and transparent dressing applied to both areas.	S9999		

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R1's careplan for skin integrity originally dated 8/2013, with updated goals to continue to 5/2/2014 , documented in handwriting on careplan the following: 12/23 bacitracin to left upper extremity twice a day for 3 days. 12/26 keflex 500mg three tab daily three times a day for 7days, Risaquad one tab daily for 14 days. 4/20 nystatin to left antecubital for redness. There is no specific problem initiated for R1's gluteal fold redness. There is an intervention listed for no sting barrier and transparent dressing to left posterior thigh until healed that was entered 8/2013 but not specifically care planned. The other interventions were to check for incontinence every 2 hours and turn and reposition every 2 hours. R1 stated he does go back to his bed about every 2 to 2 ½ hours to be changed but is physically unable to reposition himself in his wheelchair. There is no assessment or documentation on how the facility decided two hours was the appropriate length of time for R1 to be sitting.

On 4/24/14 E1 provided a copy of the facilities policy and procedure on pressure sores. This policy is documented to be updated on 6/2013. The policy states a stage 1 pressure sore is a persistent area of redness (with no break in the skin) that does not disappear when pressure is relieved. Stage 2 is described as a partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater. R1's weekly skin charting for the left gluteal fold on 4/1/14 documents a scabbed over 1 cm x 2 cm area. The dressing change observed on 4/24/14 at 11:00am showed open abrasion areas on the left posterior gluteal folds and redness to both areas that did not disappear after repositioning.

On 4/24/14 at 3:00pm E1 and E2 both stated R1 friction and shearing on the gluteal folds was not

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a pressure sore.
According to R6 ' s TAR (Treatment Administration Record) for February 2014, states resident is to have heels off-loaded while in bed and Tincture of Benzoin to bilateral heels every night for boggy heels.
According to R6 ' s TAR for March 2014, states resident has treatments to areas on right and left heel and to keep heels off loaded while in bed.
According to same MAR resident also received treatments of hydrocolloid dressing to left butt and change every seven days and as needed until healed, laniseptic cream to reddened buttock area every shift until healed and tincture of benzoin to bilateral heels every night for boggy heels until resolved.
According to R6 ' s TAR for April 2014 has received treatments of: Benzoin to left and right heel daily until resolved, off-loading of heels while in bed, hydrocolloid to left butt change every seven days and as needed until heeled, Laniseptic cream to reddened buttock area every shift until healed.
According to R6's weekly skin charting for left and right heels on 4/8, 15 & 22/14 resident ' s heels were " boggy "
According to R6 ' s weekly skin charting for left buttock, on3/24/14, resident has area described as 2cm x 1cm non-blancable purple area surrounded by blanchable erythema with hydrocolloid dressings. On 03/31/14 area to left buttock is 2cm x 1cm non-blanchable purple area surrounded by blanchable erythema with hydrocolloid treatments cont. On 4/8/14 area on left buttock is pink/reddish. On 04/15/14 area on left buttock is pink and red. On 4/22/14 area on left buttock is pink and red.
04/23/14 at 9:00am E10 RN stated she did not know why the area on R6 ' s buttock was being treated and was not sure if it was pressure or

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S9999	Continued From page 8 not. At that time R6 had a 6 x 5 x 0cm reddened area on left buttock and redness did not dissipate when pressure was relieved. E10 also stated R6 ' s heels were both " Mushy " feeling at heels, red and tender to touch at times and R6 is to have heels off-loaded while in bed. E10 was unable to state what the area on the heels was classified as but stated it could possibly be pressure areas. On 04/24/14 at 2:15pm E9, RN stated pressure ulcers were staged 0-3 and was unable to describe how to measure depth of a wound. E9 stated she had never heard of an un-stageable pressure area. On 4/24/14 E2 DON provide a manual entitled "Chronic Wound Care" that she designated as what staff has to use to address, measure, assess and stage pressure areas. On page 228 under stage I pressure ulcer: Non-blanchable erythema of intact skin; Discoloration of the skin, warmth, edema, induration or hardness may also be used as indicators. On page 229 in box 14.1 it states a stage I pressure ulcer is an observable pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one of more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red blue or purple hues. (B)	S9999		