Final Observations

Statement of LICENSURE Violations

300.610a)  
300.1210a)  
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

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 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:

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 are not met as evidenced by:

Based on observation, record review, and interview the facility failed to prevent a stage II pressure ulcer, and failed to monitor the wound for infection. These failures contributed to R3 developing a stage II pressure ulcer on 1/30/14 and deteriorating to an infected stage III ulcer. R3 was hospitalized on 2/4/14 for treatment for sepsis.

This applies to one of three residents (R3) reviewed for pressure ulcer in the sample of 19.

Findings include:

R3's March, 2014 Physician’s Order Sheet documents R3's diagnoses include Dementia, Osteoarthritis, and Anemia.

R3’s Minimum Data Set (MDS) of 3/9/14 documents R3 has severe cognitive impairment. R3 requires extensive assistance of 2 or more persons for bed mobility, transfer, and toilet use. R3 is incontinent of bladder and bowel.

R3’s Braden Scale (Prediction for Pressure Ulcer development) dated 1/12/14 shows a score of 14. (Moderate Risk)

The Wound Assessment Flow sheet shows on 1/30/14 R3 developed a stage II pressure ulcer of the Left Trochanter. The wound measured 2.1cm x 0.8 cm x 0.2 cm. It is described as 75 - 100 % granulation tissue. The same document shows that the edges were ill-defined, scant serous drainage and erythema surrounding the wound.
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The Nurse Practitioner progress note of 2/3/14 (4 days after onset of R3's pressure ulcer) documents R3's pressure ulcer is a stage III with cellulitis and possible sepsis. Recommend transfer to the Emergency Department of immediate evaluation and treatment. The same note shows R3's wound was reported to have "gotten significantly worse over the week-end."

R3's Nursing Notes for 2/3/14 (3:37 PM) documents R3's wound to the left lateral thigh has worsened. It is deep red/purple in color and measures 5.6 cm x 2 x 0.2 cm. The wound is described as 50 - 75% dark red epithelial, 25-50 % granulation, and slough greater than 25 %. The area is indurated and hot to touch, erythema present, and edges are denuded. R3's oral temperature is 101.3 F and she complains of burning pain.

The same date (2/3/14) entry for 5:21 PM, the nursing note shows R3's physician was notified and R3 was to be sent to the hospital for evaluation.

R3's Nursing Notes for 1/29/14 documents a history open areas. The note shows when R3 received a shower, the Certified Nursing Assistants identified a right gluteal open area, the coccyx had shearing, and there are 2 small blisters to the back upper thigh The left gluteal also had an open area. R3's left heel was found to be dry, cracked, and bleeding.

The hospital history and physical dated 2/3/14 documents R3 had been having fevers up to 102 F while at the nursing home. The left buttock area was draining. R3 was also found to have...
Pneumonia. The patient's left buttock is multi-colored with some areas of drainage, erythema and tenderness. A left heel decubitus was also noted. The same report shows R3 has Acute Pneumonia, Infected buttock decubitus and Alzheimer's Dementia. R3's treatment included IV antibiotics.

The hospital consult note of 2/5/14 documents R3 developed this pressure ulcer to the left trochanter over time. On local examination the patient has a fairly large pressure ulcer to the left trochanter area. There is a marked induration which goes at least 3 to 4 inches across, at least an inch deep. On compression there is pus-like material coming out. There is associated tenderness. The Plan included excision of ulcerative necrotic tissue.

E3 (Nurse) said when she returned to work on Monday, (was off the week-end) she saw R3's wound was worse. She said there were no reports of any abnormalities regarding R3's wound from the week-end nurse.

R3's Care Plan for Skin Integrity dated through 3/27/14 documents the following plan for R3. The identified risk factors include fragile skin, altered mental status, limited physical mobility and refuses care.

The goals (not individualized) are listed as: maintain and improve tissue tolerance in order to prevent skin breakdown. Modify or stabilize comorbidities affecting potential skin breakdown. Protect against adverse effects of external mechanical forces; pressure, friction, and shearing.

The approaches include assess the skin daily,
S9999 Continued From page 5

avoid massage to bony prominence's, avoid exposure to incontinence. Uninterrupted sitting in chair.

On 3/26/14 at 11:15 AM, E14 (CNA) said that R3 will tell us if she wants to lay down. We lay her down if she asks us. During the survey on 3/26/14, R3 was observed up in her wheel chair from 7:15 AM until 11:30 when surveyor asked to observe R3's wound on her left hip.

According to the facility Pressure Ulcer Prevention Policy and Procedure page 6 and 7:

All residents who are at risk for skin breakdown should avoid long periods of sitting in a chair without being repositioned. According to the AHRQ Guidelines, the resident should be repositioned, shifting the points under pressure at least every hour or be placed back in bed. Many residents may not tolerate sitting in a chair in the same position for even an hour and may require more frequent position changes. Evaluate the resident's tissue tolerance on an individual basis.

When a resident refuses, evaluate the basis for the refusal and identify potential alternatives.

(B)

300.1210a)
300.1210b)
300.1210d)(2)
300.1210d)(5)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
**SUMMARY STATEMENT OF DEFICIENCIES**

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**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 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 conditions.
Continued From page 7

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 are not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide one resident (R16) out of 19 sampled residents with foot care and foot wear and this deficient practice resulted in R16 developing a wound that became infected on the right foot that needed treatments with antibiotics.

The findings include:

On 03-24-14 at 10:08 AM, R 16 was propelling his wheelchair with his feet towards the hallway. R16 's right foot was swollen and has a bandage wrap around toward the middle-front half of the foot. R 16 has no shoe or socks on the right foot. On 03-25-14 at 11:05 AM and 1:45 PM, the same observation was noted. R 16 said, "I have a sore on my right foot. My shoe was too tight and it keeps rubbing off on my foot. It opened up then it got worsen. The nurse (Treatment Nurse/E3) said it is infected. I went for bone scan and they said I have osteomyelitis they put me on antibiotic. No, I never refuse to take my antibiotic; I know that is
Continued From page 8

very important. They (staff) told me that the
doctor wants me to wear a special boot but they
gave me the boot yet. Yes, I would like to
elevate my right foot when am on a wheelchair so
I don't drag it like this."

On 03-25-14 at 2:40 PM, E 3 explained, "on
02-03-14 he (R 16) developed an abrasion from
his shoe. A week later, the Certified Nursing
Assistant told me the dressing came loose. It was
on 02-10-14 the wound got worsen, it has 75 to
100% slough. It was on his right dorsal (part) of
the foot. He was started on antibiotic (Cipro 750
mg BID X 10 days) because of signs and
symptoms of infection. The whole area (right foot)
was red, tender and with moderate amount of
drainage with foul odor. We sent him for bone
scan and showed osteomyelitis. They
recommended MRI to be done but we did not
schedule it.

The communication "fax" form dated (1)
02-03-14 from the facility staff to the doctor
reads: observed open wound to right big toe, no
drainage, and scant amount of blood 0.7 cm X
0.5 cm X 0.1 cm ...apply triple antibiotic ointment
and cover with transparent dressing ... (2)
02-17-14 (from E 3 to the doctor) reads: open
area to right dorsal foot worsened. Black/yellow
/red in color ...measures 2.2 cm X 1.5 cm X 0.2
cm ... Telephone message dated 02-17-14 at
02-17-14 (from doctor’s office to nursing home)
reads spoke with nurse (at nursing home) skin
tear on right dorsal foot is worse- now necrotic
area with pink/red surrounding ... R 16’s Physician Order Sheet dated 03-20-14
showed an order to provide R 16 with off-loading
shoe (boot) on the right foot. On 03-25-14 at 2:50
PM, E 3 and E 7 explained the facility is still
waiting for the delivery.
The foot rest was discussed with the Restorative
Nurse/E7 at 4:00 PM; E 7 stated, "He (R 16)
CROSSROADS CARE CTR WOODSTOCK
309 MCHENRY AVENUE
WOODSTOCK, IL  60098

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<td>Refuses to have leg rest. &quot; R 16 told E 7 &quot; No I did not; it was not even offered to me. I would like to elevate my leg because it hurts at times. &quot;</td>
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<td>E 3 was unable to provide a comprehensive a foot assessment for R 16 and there was no plan of care initiated related to R 16 ' s right foot wound. The Director of Nursing / E 2 and E 3 confirmed these finding on 03-25-14 at 3:02 PM.</td>
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