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HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET HILLSBORO, IL 62049

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S9999	Final Observations STATEMENT OF LINCESURE 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 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 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	S9999		

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S9999	Continued From page 1 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. These Regulations were not met as evidenced by: Based on interview, observation and record review, the facility failed to provide preventative measures including turning/repositioning and appropriate preventative measures to prevent ulcer from occurring for 4 residents (R3, R4, R6 and R7) of 8 reviewed for pressure ulcer prevention in a sample of 20. This failure resulted in R7 developing an unstageable ulcer on her right bunion area and multiple ulcers under a left leg immobilizer. Findings include: 1. The Minimum Data Set, MDS, dated 4/30/14	S9999		

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(significant change), R7 has severe cognitive impairment and requires extensive assist for bed mobility and total assistance for transfers. The MDS also identifies R7 to be totally incontinent of bowel and bladder.

The Incident/Accident log documents R7 sustained a fractured left femur during care on 4/5/14 and returned from the hospital with an immobilizer on her left leg. The

The Braden Skin Risk assessment dated 5/6/14 identifies R7 as high risk for breakdown. The care plan dated 4/22/14 documents a pressure ulcer suspected deep tissue injury (SDTI) to right medial foot bunion area due to immobility, incontinence and nutritional status. Interventions include: pressure reducing mattress and alternating pressure overlay with heel guard boot (foam boots) at all times except during hygiene, pillows between legs, turn/reposition every 2 hours and as needed, float heels when possible among.

Skin reports dated prior to 4/22/14 fail to reflect any pressure ulcers prior to 4/22/14 when the ulcer was first found. Nurses notes dated 4/22/14 at 1527 (3:27pm) identify the area as Dark purple in color with surrounding tissue red, Doctor notified and diagnosed as SDTI. Labs dated 4/23/14 show low albumin level but normal protein.

The Weekly Pressure Ulcer Report dated 4/24/15 includes R7 and documents that her pressure ulcer at the time it was found measured 1.5cm (centimeters) x 2.5cm and was assessed to be a SDTI at the time. Physician's order for treatment was Sureprep every shift. On the report dated 5/1/14, R7's pressure ulcer measured 1.3cm x

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1.2cm but was 100% eschar/necrotic. Treatment remained the same. On 5/8/14, measurements and treatment remained the same.

On 5/13/14 during tour of the facility, R7's right bunion area was observed to be black/eschar. R7 had a foam boot on. There were multiple cloth incontinent pads on her bed. R7's bed had an air overlay mattress on that was rolled/bunched up at the foot of the bed that E13,Licensed Practical Nurse (LPN)/Wound Nurse the overlay had to be corrected.

On 5/20/14 at 11:45am, R7's wound was again observed with E13, who confirmed that R7 developed the ulcer in the facility. E13 stated she was unsure as to why R7 would develop a pressure ulcer since she wears a foam boot all the time. E13 uncovered R7's foot. R7 had a foam boot on which E13 pulled back. R7's pressure ulcer was stuck to the foam inside the foot and was moist when E13 pulled the skin off the foam. E13 stated the pressure ulcer appeared to getting moist and that she hoped it was just slough off as she was pulling bits of skin off the ulcer.

On 5/15/14 at 10am, R7 was laying in bed with a hospital gown on. She was observed to remain in the same position at 11am, 12pm, 12:30pm, 1pm, 1:20pm and a 1:27pm. She was slouched over to her left side and had slid down in the bed as the bed was elevated approximately 30 degrees. At 1:27pm, E12 Certified Nurses Aide brought her lunch tray and and without repositioning her, attempted to feed her lunch.

On 5/20/14 at 2:25pm, E13 and E27 did a skin check on R7 and found two new areas of pressure under her left leg immobilizer inner thigh

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that had a larger deep red cast surrounding the open areas. E13 stated the immobilizer should be checked every shift as the Nurses are putting Sureprep on the bunion area every shift. On 5/21/14 at 1:49pm, E13 stated she did not measure the open areas under the immobilizer because it was a larger red area with several open areas inside it but that she did contact the physician and received a new order. A progress note written by E13 dated 5/20/14 at 2:48pm documents "writer assessed residents skin to L (left) leg under immobilizer. Noted reddened area with scattered denuded tissue where posterior side of immobilizer touches residents skin. E13 documents physician notified and new order received. A copy of the order was provided for "cleanse area to posterior l thigh under immobilizer and apply calazime and ABD and BID (twice daily) and PRN (as needed) if ABD and immobilizer and ABD becomes soiled AND every day and evening shift."

Review of the care plan dated 4/22/14 fails to include R7's risk of breakdown from the left leg immobilizer and fails to include any interventions specific to pressure ulcers from friction/shearing caused by the constant wear of the immobilizer.

2. The MDS dated 5/5/14 identifies R3 to require extensive assist of two staff for transfers and bed mobility and ctly on her coccyx and deep creases across both buttocks and upper thighs. R3 was also noted to have open beefy red stripes inner thighs bilaterally which appeared to be from the plastic briefs. E5 provided poor incontinent care and R3 was transferred to her wheelchair via a mechanical lift after being dressed. E5 stated R3's brief is not taped due to being too tight on her when they do.

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S9999	Continued From page 5 The facility failed to develop interventions to address R3's non-compliance and/or the irritation caused by the plastic on the incontinent briefs. 3. R6's MDS, dated 3-29-14, documented severe cognitive impairment and total staff assistance of two plus persons physical assistance with mobility, hygiene and tolieting. R6's Care Plan, initiated 4-7-14, documented R6 was a potential for pressure ulcer development. It was also noted R6 had fragile skin. During observation R6's incontinent care 5-14-14 at 9:05a.m. E8 and E9, Certified Nursing Aides (CNA's), removed two thick bed pads, one of which was soiled with urine, from underneath R6 prior to care and placed two clean thick bed pads underneath R6 after incontinent care. R6's buttocks and upper and lower back observed lightly reddened and creased. Interview of E8 and E9, on 5-14-14 at 9:25a.m., E8 and E9 stated they were done with R6's incontinent care without ensuring his bed pad surfaces were smooth without observed uneven surfaces, raised edges and wrinkles against R6's skin. 4. On 05/13/14 at 9:40 AM, R4 was observed sitting in her wheelchair in her room. At 11:20 AM, R4 was in her wheelchair outside her room waiting for staff to come to transfer her to bed. At 11:45 AM, E14 and E15, CNA's, were observed during transfer and incontinent care for R4. E14 removed R4's incontinent brief and an area of light and dark brown drainage was noted on the brief. A suprapubic catheter was observed on the right mid abdomen with dressing intact, as well as a colostomy bag was observed on the left lower abdomen intact. When R4 was rolled to the left	S9999		

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side, light brown drainage was observed oozing out of her rectum, as well as R4's buttocks and lower back were reddened and heavily creased. R4 stated the oozing drainage is not new, but it had gotten much worse. There was an open area observed in between the buttocks in the crease 1 1/2 inches long. The open area was observed to have macerated edges with dark red center. There was no dressing on the open area. There was an open area on the mid back observed without a dressing. E14 was observed to perform incontinent care and noted that R4 was also having her menstrual cycle. There were two open areas in the folds of the inner thighs near the perineal area that were deeply reddened. The dressing to the left side was off the open area and the right side was intact. Both were soiled with red, brown drainage. E16, LPN stated to put the dressing back on the left side and leave both in place. R4 stated that she was supposed to have the dressings changed before lunch. E16 stated she would be doing the dressing changes after lunch. R4 was left lying on an incontinent pad without any dressings on the coccyx or mid back areas.

R4 stated she can turn herself from side to side, but cannot remain on that side without assistance. She also stated that she does not get turned and repositioned on a routine basis, especially at night.

On 05/13/14 at 2:00 PM, E16, LPN was observed during dressing changes for R4. E16 was observed to cleanse the slit-like openings in the inner thighs near the perineal area with wound wash and wiped with a dry 4 x 4 dressing then applied a silver nitrate strip into the creases. No taping. R4 stated that both sides were very painful when touched. E16 was observed to do

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the treatments for the mid back by cleansing with wound wash and dry with 4 x 4 dressing and apply skin prep to the surrounding tissue and apply an Exoderm dressing. Then E16 was observed to use wound wash on the coccyx and dry with a 4 x 4 dressing, then apply an Exoderm dressing and apply A & D ointment on the surrounding skin.

The Physician Order Sheet, POS, dated 04/15/14, documented R4 had the following diagnoses, in part, as Spina Bifida bilateral lower limb paralysis, Neurogenic Bladder, Pressure Ulcers, Lumbago and history of Methicillin Resistant Staph Aureus (MRSA).

The MDS, dated 03/24/14, documented R4 was alert and oriented with no cognitive impairment requiring total assistance of at least two staff for transfers; extensive assistance of at least two staff for bed mobility and toilet use; and extensive assistance of at least one staff for dressing, hygiene and bathing.

The Care Plan, dated 02/28/14, documented limitations in bilateral shoulders and required assistance with Activities of Daily Living (ADL's). There was nothing on the Care Plan presented on 05/15/14 that identified pressure ulcers.

On 05/13/14, The Braden Score for Pressure Ulcer Development was 14, moderate risk. The Braden Score for 04/29/14 was 12, high risk.

A written statement from E16, LPN, dated 05/19/14, documented that E16 did not do the dressing changes at the time of the incontinent care on 05/13/14, due to it being shower day for R4. However, on 05/20/14, R4 stated her shower days are Wednesdays and Saturdays. R4 stated

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S9999	Continued From page 8 she did not receive a shower on the 05/13/14. 5. According to the facility policy entitled "Pressure Ulcer Prevention and Healing Program", the facility is to utilize a program focused on assessment,, planning, implementation, evaluation, and reassessment. Under Implementation, the policy indicates that staff will consider the risk and skin condition and interventions may include bathing, skin care, incontinence care, positioning, mobility and transfer, pressure, friction and shear reduction, nutrition and hydration approaches and restorative/rehab. Manufacturers recommendations for the mattress air overlay includes a statement regarding using appropriate linens which the company sent an email clarifying dated 5/16/14 stating "anything that fits the combined height of the mattress plus the overlay would be considered an appropriate linen." A further email clarification dated 5/16/14 at 3:39pm directly written toward the use of multiple cloth pads over the air overlay documents information received back from the manufacturing team - "Due to the alternating pressure feature of the overlay, some devices and products may not be appropriate for use with this device" and "adding multiple incontinence pads will reduce the alternating pressure efficacy, but it will not completely eliminate it." (B)	S9999		