**ST VINCENT’S HOME**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1440 NORTH 10TH STREET
QUINCY, IL 62301

<table>
<thead>
<tr>
<th>S9999 Final Observations</th>
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<tbody>
<tr>
<td><strong>Statement of Licensure Violations</strong></td>
<td></td>
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<tr>
<td>300.610a)</td>
<td></td>
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<tr>
<td>300.1210b)</td>
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<td>300.1210d(j)</td>
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<tr>
<td>300.3240a)</td>
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</tbody>
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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 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.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to monitor and implement interventions to promote the healing of pressure ulcers and prevent development of new pressure ulcers for one of two residents (R2) at risk for developing pressure ulcers in the sample of fifteen. This failure resulted in the pressure ulcer on R2's heel progressing from a Stage II to Stage III pressure ulcer.

Findings include:

R2's medical record documents R2 has the current diagnoses of Senile Dementia, Arthritis, Osteoporosis, and Contractures. R2's MDS (Minimum Data Set) Assessment, dated 5-30-14, documents R2 requires extensive assist of two for bed mobility and is totally dependent on staff for transfers and ADL's (Activities of Daily Living). R2's Braden Skin Assessment, dated 1/15/14,
documents a Braden score of 13 (moderate risk).

R2's Progress Note dated 10/4/13, documents R2 was noted to have a new open area on left coccyx that measures 3.8 cm x 3.3 cm and the facility failed to identify the Stage of the wound. R2's Plan of Care fails to document the development of new interventions to prevent further skin breakdown, until 10/30/13, when R2 visited the Wound Clinic and added a nutritional supplement.

The facility's Progress Note for R2 dated 5-2-14 documents, R2 developed a skin tear on the left heel. The facility's Wound Assessment dated 5-13-14 documents, R2's skin tear had developed into a Stage II pressure ulcer to left inner heel measuring 1.2 cm x 1.5 cm x 0.5 cm.

A Wound Clinic Report dated 6-25-14, documents R2's coccyx wound as increasing in size and Stage, from a Stage III with no tunneling on 10/30/13, to a Stage IV with tunneling of 2.3 cm on 6/25/14. The Wound Clinic Report dated 6/25/14 also documents (R2) as very debilitated and incontinent, secondary to advanced dementia and describes R2's wound as "deteriorating."

The Wound Clinic Report dated 6/25/14 documents R2's left heel wound as a Stage III. R2's Plan of Care failed to document the development of any interventions to prevent R2's wounds from worsening, after the 6/25/14 Wound Clinic visit which identified the coccyx wound as "deteriorating."

On 7-1-14 at 11:30 am, R2 received incontinence care and has a small open area with evidence of tunneling on the left coccyx. Also R2 has an open wound on R2's left heel.
On 7-2-14 at 11:00 am, E10 (MDS/Minimum Data Set Coordinator) verified R2 started out with a skin tear to the left heel which has now resulted in a pressure ulcer.

On 7-3-14 at 9:30 am, E11 (RN/Registered Nurse, Quality Nurse) indicated R2 did not eat well and was receiving supplements, and described R2 as being contracted and unable to reposition independently. E11 indicated these issues have made R2's pressure ulcers unavoidable. However, R2's weight monitoring for the last 12 months documents R2's weight as being stable at 123 pounds.

R2's Care Plan for Impaired Skin Integrity documents R2 is to be turned side to side every two hours. E11 was unable to provide documentation that R2 was turned side to side every two hours as instructed on R2's care plan.

On 7-2-14 at 3:15 pm, Z1 (Wound Physician) stated, "(R2) has Senile Dementia and is bedridden" and had no other explanation to suggest R2's pressure ulcers were unavoidable. Z1 also verified R2's wound to R2's coccyx has worsened from a Stage III to a Stage IV and R2's heel wound was now a Stage III Pressure Ulcer.

A Pressure Ulcer Prevention and Management Policy dated 5/28/14 documents, "(The facility) actively intervenes to prevent/limit the development of pressure ulcers and to promote and maintain skin integrity."

(B)