STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

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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 care needs of the resident.	S9999		

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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 Regulations were not met as evidenced by: Based on record review and interview the facility failed to develop and implement policy and procedures in the care and treatment of surgical wounds. This applies to 1 (R1) of 3 residents	S9999		

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S9999	Continued From page 2 reviewed in the sample for wounds. This failure contributed to R1 developing a worsening, non-healing surgical wound. The findings include: Review of readmitting nursing note dated 9/2/14 (original admit of 8/22/14) states R1 is a 72 year old admitted with history of CABG (coronary artery bypass graft). Per admission skin evaluation dated 8/22/14 R1 is noted to have surgical wounds to mid chest, 2 small abdominal incisions and left upper and lower inner thigh. A nurse ' s note dated 8/26/14 states the CABG was performed 8/20/14. R1's readmitting POS (physician order sheet) dated 8/26/14 shows an order for steri- strips on upper left thigh, wash with wws (E4, wound nurse, stated 10/15/14/ at 2:30pm, this is a sterile saline wash), pat dry, apply 4 x 4 gauze and tale if draining daily. Per POS this order was changed on 9/23/14 and states "A left thigh dressing order to: cleanse left thigh with wws, apply santyl nickel thick to wound. Cover with dry dressing. Change daily and prn(as needed)." E5 (nurse) stated on 10/15/14 at 2:05pm that she had been caring for R1 for several weeks and began noticing his left upper thigh wound was not healing and was in fact, getting worse. E5 said there was no baseline assessment of the wound other than it had steristrips. These steri strips fell off and the wound became circular, instead of incisional, about the size of a quarter with about 80% slough, said E5. When asked if this worsening progression was documented in the medical record, E5 stated they do not chart on surgical wounds. E5 said she did notify the wound	S9999		

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S9999	Continued From page 3	S9999		

nurse (E4) on 9/23/14 who said it was ok to get the order changed to Santyl. However there is no nursing documentation regarding why this change was necessary. E5 said that she discharged R1 on 10/3/14 after showing R1's family member how to change the dressing but did not give any supplies to go home with other than the santyl ointment. E5 said she entered a 'late entry' of R1's wound description 8 days after discharge.

A non-pressure wound report was provided to the survey team at 10:45am on 10-15-14 and R1 was not included in the list of residents with non-pressure wounds.

E4 stated at 11:40am that when a patient comes in with normal surgical wounds, steri-strips or staples, the wound team does not follow them. The staff nurses change the dressings daily and that's why they are not placed on the non-pressure wound report. E4 went on to add that the admitting nursing assessment of R1 does not contain a description of the wound, and E4 stated the facility does not have policies and procedures for assessing, monitoring and documenting non-pressure wounds. The policy and procedure for pressure sores is applied to the management of other facility wounds. The pressure ulcer treatment policy (draft of 3/18/13) documents, " Residents with pressure ulcers will have appropriate assessments, interventions and evaluation of treatment implemented." The procedure for Pressure Ulcer Assessment and Evaluation (page 3) documents, " that daily monitoring will be performed and documented, including the presence of possible complications." This policy continues to add that the pressure ulcers should be evaluated at least weekly and the evaluation documented in the clinical record. This includes: Location, size, description of

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wound bed and type of tissue and description of tissue the surrounding wound. E4 confirmed that this had not been done to R1's worsening left upper thigh post surgical wound. Nor was it done or documented upon discharge on 10/3/14.

Admitting nursing skin evaluation form dated 8/22/14 shows a body diagram and identifies R1 with 5 wound sites. The narrative assessment grid lists all 5 locations as incision wounds but only documents the measurements of 2 of the wounds (small mid abdominal incisions). The mid chest and 2 left thigh incisions are not measured and only state there is no drainage.

E4 stated that surgical wounds are not monitored or evaluated and charted on unless there is a negative development. E4 was unable to provide documented descriptive assessment of R1's left thigh wound from the original admission date (8/22/14) until date of discharge 10/3/14.

E4 confirmed there was no care plan specific to R1's surgical wounds.

(B)