STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009401	A. BUILDING: _____ B. WING _____	08/01/2014

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S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210d)5) 300.1220b)3) 300.3240a) 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 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	S9999		

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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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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:

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Based on record review, interview and observation the facility failed to prevent the development of an unstageable pressure ulcer to one of two residents (R13) in the sample of 15 with acquired pressure ulcers by not implementing individualized interventions and evaluating and revising R13's care plan based on appropriate interventions and monitor for the effectiveness of the interventions.
These failures resulted in the decline of R 12's redness to pressure ulcers on her coccyx to Stage II and then further decline to an unstageable pressure ulcer.
The findings include:

Review of the most recent MDS (minimum Data Set) dated 7/5/14 shows R13 is 70 years old with multiple diagnosis including history of bladder cancer, hemiplegia due to stroke, history of clostridium difficile and muscle weakness. Per this MDS, R13 does not have any cognitive impairment, scoring a 15 on the BIMS. Also per MDS, R13 requires extensive physical assistance for bed mobility and transfers and has no pressure ulcers identified. E10 (nurse) stated on 8/1/14 at 9:50am R13 gets up for meals and therapy via a sit--to-stand lift. R13 may be incontinent of bowel sometimes but will ask to use the bathroom for the most part. E10 said R13 utilizes a catheter.

R13 was observed on 7/30/14 at 2:00pm to be lying in bed, alert and oriented. Z1 (wound doctor) and E5 (staff nurse) were present. R13 stated the wound to her coccyx was new in the past week or so and developed in the facility. Z1 stated this is the first time he is evaluating R13. Upon observation of R13's wound Z1 stated this wound contains an unstageable pressure ulcer to the coccyx. Z1 stated there is an area of this

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wound that is slough and the depth is unable to be determined. The edges are irregular and the unstageable area needs to be debrided. Z1 said there were other stage II areas present but he (Z1) was going to identify this area as one pressure ulcer since the areas of pressure breakdown were in such close proximity and measured the wound as 4 x 3.2 cm.

E4 (wound nurse) stated on 7/31/14 at 2:15pm that R13 was admitted with redness to the buttocks on 5/16/14. R13 returned from the hospital on 6/9/14 with an order for Calazime ointment for the excoriation noted to the coccyx and a foam dressing was applied. E4 stated this breakdown most likely is the result of incontinence. When asked to provide interventions to remove or alter this as a factor, E4 stated R13 is kept clean and dry.

The nursing readmission dated 6/9/14 documents redness to the buttocks and coccyx. E4 said the coccyx was identified as a stage I at that time. The care plan of 6/9/14 identifies this same assessment of the coccyx. The intervention listed on this care plan is to "provide weekly assessment and measurement. Measure length, width and depth where possible." E4 stated there is no documented monitoring/assessment of this area until she (E4) assessed it as a stage II on 7/25/14. The weekly pressure ulcer record completed by E4 and dated 7/25/14 shows R13 has a stage II pressure ulcer measuring 4 x 3 cm with scant drainage and mild excoriation. The narrative portion states R13 with "new order for a hydrocolloid dressing, assessed due to previous excoriation. Open area noted. Will get orders to consult with (Z1, wound doctor)." When asked if R13's tissue tolerance had been analyzed in order to develop and implement a more specific

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repositioning plan to promote healing, E4 stated the facility does not perform tissue tolerance analysis.

Review of facility policy and procedure regarding the treatment of pressure ulcers states "...Pressure ulcers will be monitored daily. ..." E4 confirmed on 7/31/14 at 2:15pm there was not daily monitoring of the pressure ulcer from 7/24/14 until 7/30/14, when it was identified as an unstageable ulcer by Z1. E4 stated she has not had formal training in the management of pressure ulcers.

E4 stated she made the referral to Z1 on 7/29/14 and Z1 assessed R13 on 7/30/14. Z1's documentation from this assessment dated 7/30/14 states R13 "...now presents with lower back and buttocks pressure ulcer. The patient is reported to have history of sacroccygeal pressure ulcer, which resolved." Z1 identified the ulcers as:

1. Decubitus ulcer of lower back (primary)
2. Pressure ulcer of buttock
3. Pressure ulcer, unstageable
4. Pressure ulcer stage II

Notes: Right buttocks and Sacrococcygeal Pressure ulcer; stage II, and a few small/satellite unstageable areas. Most of (R13's) wound surface is stage II; and the remainder is unstageable, covered with eschar, thus unable to assess the depth of soft tissue involvement.

Review of the pressure ulcer record completed by E5 (nurse) who was present during Z1's assessment on 7/30/14 incorrectly documents the wound as a stage II and the wound bed as pink.

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