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 10/07/2014

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PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

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S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210d)3) 300.1210d)5) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the	S9999		

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S9999	Continued From page 1 resident's medical record. 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 observation, interview and record	S9999		

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review, the facility failed to identify new pressure ulcers, obtain orders for care and treatment of new and deteriorating pressure ulcers, notify the physician of new wounds and status change of existing wounds and failed to document care and status of wounds for two of three (R3 and R4) residents reviewed for pressure ulcers.
This failure resulted in R3 developing new wounds while in the facility without physician notification and also resulted in wounds deteriorating without changes in care.
Findings include:
1). R3 was an 84 year old female admitted to the facility on 8/7/14. Her medical records documented the following diagnoses: rehab procedures, pain, fall, hypertension, hypertrophied, diabetes mellitus, dysrhythmia, and anemia.
R3's admission assessment documented she was admitted with one pressure ulcer on her left buttock. Her medical record showed she acquired other pressure ulcers in the facility. R3's Wound Care sheets documented the following pressure ulcers and assessment dates:
8/8/14 Left buttocks, slough 80%;
8/22/14 coccyx 100% slough;
8/22/14 Right buttock 60% slough
R3's Medicare nursing notes for 8/22/14- 9/7/14 document: Integumentary- Dressing to coccyx present and intact; some included -no new skin issue. Her Medicare nursing documentation on 9/7/14 documented " intact " . The development of 2 pressure ulcers was not reflected in the documentation.
R3's care plan for pressure ulcers documented: See POS and TAR for current orders. R3's POS (Physician's Order Sheet) documented the following treatment order: Cleanse left buttock and apply hydrocolloid dressing, change Tuesdays and Fridays. There were no orders

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noted in R3 ' s medical record for the acquired coccyx and right buttock wounds. R3's TAR (Treatment Administration Record) contained no documentation of treatments being performed on her coccyx or right buttock.
R3's coccyx wound measured (8/22/14) 1.10 X 0.7; area 0.77cmSQ and (9/5/14) the wound increased to 1.9 X 1.7, area 3/23 cmSQ with no treatment orders.
R3's right buttock pressure ulcer measured (8/22/14) 1.10 X 2.00, area 2.20cmSQ and (9/5/14) 2.00 X 1.70 X unknown, area 3.40cmSQ with no treatment orders.
On 10/2/14 at 11:45am, E4 (Wound Care Nurse) stated that R3 was admitted with one wound to her left buttock. E4 stated on admission, the pressure ulcer contained slough, but she didn't know what color, because it wasn't documented. E4 stated " I would say yellow. " E4 added the treatment order on 8/7/14 was for Santyl (debriding agent). E4 stated R3's pressure ulcer was unstageable with 100% slough, but she changed the order to a hydrocolloid dressing. E4 added the facility's policy for pressure ulcers is to turn and reposition the resident every 2 hours. E4 also stated that if the resident is in a wheel chair (w/c) the policy is to reposition them as frequent as possible, every 1-2 hours. E4 was presented with the wound sheets identifying the coccyx and right buttock ulcers and asked to present physician's orders for treatment. E4 stated " I don ' t see it. It was just written for left buttock as far as I can tell. Even into the next month, it still says left buttock. " When asked why there weren't orders for the 2 acquired wounds, E4 stated the facility placed a hydrocolloid dressing on all the wounds. Although there was documented slough tissue in the wounds, E4 stated " we wanted to keep the same treatment for all the wounds. "

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R3's assessment sheet for the right buttock ulcer documents: probable decline, E4 stated the wound was identified with 60% slough and unstageable. E4 stated there were no orders " the only thing is left buttocks. " On 8/28/14, the right buttock wound sheet documented no improvement. When asked about treatment orders, E4 stated, " It's still the same. " On 9/5/14 the assessment sheet documented the wound had increased in area size. E4 also stated there were no written orders for the coccyx wound that R3 acquired.

On 10/6/14 at 9:50am, E6 (Nurse) stated R3 had pressure ulcers on her coccyx area and both buttocks. E6 stated treatments for the pressure ulcers would be documented in the Medicare nursing notes and on the TAR. When asked to present such documentation. E6 stated the treatments for R3's coccyx and right buttocks are not documented on her TAR. E6 then checked the computerized TARs and stated " I don ' t see it in here. "

R3's MDS (Minimum Data Set) Assessment 8-14-14 codes R3 as having only one unstabable ulcer due to slough. R3's care plan dated 8-7-14 and updated 8-22-14 in Skin Integrity documents under approaches to: "Assess and document length, width and depth in centimeters; presence of tunneling or undermining, tissue type, drainage, odor, pain, wound margins" and "Daily skin checks with care and record" and "notify the physician if no progress."

The CNA Daily check sheet for R3 is coded as "0" (meaning no skin issues) for August 7 to August 14 when R3 had been admitted to the facility with a skin issue. Additionally when R3 developed new skin issues in the facility, the daily skin sheet continued to document "1" (meaning skin issue present but not new.)

On 10/6/14 Z1 (Physician) stated the facility used

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to send weekly reports of notification of pressure ulcers. Z1 stated, " When it gets to the point that it's getting worse or out of hand, they give us a call. " Z1 stated he did not receive a call that R3 developed or had worsening wounds in the facility. Z1 stated if the facility had informed him of such he or Z2 (Nurse Practitioner) would've looked at R3's wounds. A review of Z2's progress notes dated 8-27-14 and 9-2-14 for R3 do not address any of R3's wound nor the development of new wounds.

2). R4 is an 87 year old female whose medical record documents the following diagnoses: fall, UTI, malaise, muscle weakness, atrial fibrillation, lumbar fracture, COPD, spinal stenosis, Rheumatoid Arthritis, and arterial disease.

R4's Wound care sheets document she was admitted with a Stage 2 pressure ulcer on her coccyx. The report documents the measurements as 5.9 X 5.0 X 0 with light serous drainage. Her treatment order documented hydrocolloid dressing two times a week and as needed. R4's wound care report dated 9/25/14 documents the wound is 5.9 X 5.0X 0 and beefy red - pale pink in color. However, the picture of the wound showed the center was purple and consistent with deep tissue injury (DTI). The report continues to document drainage from the wound. The documentation did not mention the purple area or interventions thereof. On 10/1/14 the wound now measured 10.2 X 6.00 X unknown. The facility now ordered Silvadene and Aquacel. The wound sheet documented 90% necrotic tissue. On 10/2/14 visualization of R4 wound showed large amount of brown soft necrotic tissue.

On 10/2/14, between 9:00- 11:00am, R4 was sitting in her wheel chair. E7 (Certified Nursing Assistant/CNA) stated R4 had been sitting in the chair since 8:00am. R4 was noted in the same

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position without relief at random intervals.
On 10/6/14, R4 was sitting at the nursing station in her chair between 9:00am -12:00pm. R4 was in the same position at various intervals. When asked how long she had been sitting in the chair, E8 (CNA) stated since 7:00am.
10/2/14 at 1:10pm, E9 (Wound RN) stated she wrote the order for R4 to have a hydrocolloid dressing two times a week. E9 looked at the photo with the purple discoloration and stated " I see the purple here; yes it appears to be deteriorating. " E9 stated, "The only thing we could do for DTI is remove the pressure. " E9 was asked to present documentation on the assessment of the DTI and the decision to keep the current intervention. E9 looked through R4's medical records and did not find documentation on the decline. E9 stated that she faxed a copy of the report to Z3 (Medical Doctor) but did not speak to him about R4 ' s wound.
R4's medical record documents an order for daily skin checks. However, her TAR showed several days with no signature indicating the skin checks were done.
On 10/6/14 Z3 (Medical Doctor) stated he relies on the wound care nurse to implement treatment orders. Z3 stated he received no call specifically stating R4 ' s wound had declined. Z3 stated it is not appropriate for a hydrocolloid dressing two times a week if a pressure ulcer has DTI and drainage. Z3 stated, " If it's declined, they can call me and I can refer her to a wound care doctor. If they are applying a dressing only two times a week and it's draining. That ' s not appropriate. "
The facility ' s policy for pressure ulcers documents:
Policy Statement-Residents with pressure ulcers will have appropriate assessments, interventions and evaluation of treatment implemented. The

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resident ' s Licensed independent Practitioner (LIP) will be notified of all pressure ulcers. A LIP order is required for all pressure ulcer treatments.
Notification and licensed Independent Practitioner Orders-
c. The licensed independent practitioner may request pressure ulcer treatment to follow the facility protocol for pressure ulcer treatment. Specific wound dressing orders will then be confirmed with the licensed independent practitioner based on characteristic of the wound.
When a pressure ulcer is present, daily monitoring will be performed and documented. Monitoring includes:
-An evaluation of the ulcer if no dressing is present
-An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking).
-The status of the area surrounding the ulcer (that can be observed without removing the dressing).
-The presence of possible complications, such as increasing area of ulceration or soft tissue infection
Pressure ulcers should be evaluated at least weekly and the evaluation documented in the clinical record. Evaluation of pressure ulcers should include:
-Location of pressure ulcer
-Stage of ulcer
-Presence of tunneling, sinus tract or undermining.
-Description of tissue surrounding wound and wound edges

(B)