STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145286	A. BUILDING _____ B. WING _____	02/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-STAUNTON	215 WEST PENNSYLVANIA AVENUE STAUNTON, IL 62088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Annual Licensure and Certification Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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by:
Based on observation, interview and record review the facility failed to notify the physician of the development of a pressure ulcer for one of fifteen residents (R4) reviewed for physician notification in the sample of 15.

Findings include:

The facility Ulcer Care Plan-Treatment plan documents R4's coccyx pressure ulcer was noted on 1/8/16 and measured 2 centimeters (cm) by 1.8 cm. On 2/14/16, and 2/20/16, R4's pressure ulcer is documented as healed.

On 2/23/16 at 2:00 PM, during a routine skin check, R4 had a hydrocolloid dressing to her coccyx initialed and dated 2/19/16. E4, Registered Nurse (RN) and E11, Licensed Practical Nurse, (LPN) were in the room for the skin check and dressing change. A small area of bright red blood was under the dressing. When the dressing was removed, two pressure ulcers were noted and were measured by E11. A 1cm. by 0.5cm open pressure ulcer in the center of R4's coccyx and a 1.5 cm by 1.0 cm "abrasion that was open and bleeding" were documented. The pressure ulcer was cleansed and a new hydrocolloid dressing was applied.

On 2/23/16 at 2:30 PM E4, stated, "I don't know why she has the dressing on at all. I usually do the treatments and I had her healed off as of 2/7/16. I don't know when it opened up again. We don't have a current order for anything to be on there that I know of."

On 2/25/16 at 2:00 PM, E2 RN, Director of Nurse's stated, " I talked to the midnight nurse.

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She is the one who put it on her. She said there was a dressing on her and she just replaced it. I said how can you do that without an order, since when is that the way we do things around here."

The facility document titled, "Ulcer Care Plan-Treatment plan," documents on 2/7/16 R4's coccyx pressure ulcer was opened and measured 1 cm by 1.3 cm. On 2/14/16 R4's pressure ulcer was documented as healed. On 2/20/16 the pressure ulcer is also documented as healed, however, the current, intact dressing observed on 2/23/16, is dated 2/19/16, a day before the pressure ulcer is documented as healed.

R4's current Physician Orders for February 2016, document that no new Physician order was obtained after the pressure ulcer was documented as healed.

R4's Nurse's Notes for the month of February show no documentation of the Coccyx pressure ulcer as being healed as of the 14th, and no documentation of the pressure ulcer re-opening on 2/19/16. There is no documentation of the Physician being contacted with the information and requesting new orders.

R4's Treatment Administration Record (TAR) for the month of February, documents wound care and a dressing was last applied on 2/14/16.

The facility policy dated 10-20-14, "Wound and Ulcer Policy and Procedure," under the area titled High risk protocol, "When a resident is found to have a wound or ulcer either on admission or during their stay, the following will be completed by licensed nurse: Document assessment of the wound/ulcer in the medical record. Initiate

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F 157	Continued From page 3 treatment. Document treatment on the TAR. Notify the Physician and Power of Attorney." The Facility Policy dated January 2011, and titled Guidelines for Physician Notification of change in condition documents "New onset or worsening of a pressure ulcer."	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to coordinate care for 1 of 1 resident (R10) reviewed for Hospice services in the sample of 15. Findings include: Physician Order Sheet for R10 dated 2/4/16 documents, "(Local) Hospice to eval (evaluate) and treat." On 2/29/16 at 11:00 AM, R10's chart was reviewed and no Hospice visit documentation or Care Plan was found in the chart or in the (Local) Hospice binder. On 2/29/16, R10's Progress Notes were reviewed	F 309		

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F 309	Continued From page 4 and no documentation was available of Hospice Nurse communicating with facility nursing staff on R10's status. On 2/29/16 at 11:00 AM, E15, Licensed Practical Nurse, (LPN), stated "There are no Hospice notes in the chart for (R10) and there are no notes in the (Local) Hospice binder for (R10)." On 2/29/16 at 11:05 AM, E8, Registered Nurse, (RN), stated, "There are no notes in the chart or in the binder for (R10). The Hospice staff do not put any notes in the computer, if there were notes they would be in the binder for (R10) for (Local) Hospice." On 2/29/16 at 112:15 AM, E3, LPN/Minimum Data Set Coordinator stated, "I didn't find any Hospice notes in the chart for R10." On 2/29/16 at 12:30 PM, E2, Director of Nurses, (DON), stated, "Hospice services are between them and the family. I've seen the nurse in the building a couple of times, not sure if a CNA (Certified Nursing Assistant) has been here." On 2/29/16 at 2:00 PM, E2 stated, "The Hospice Care Plan was not in the building until today."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

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F 314	Continued From page 5 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to monitor, initiate treatment, and report changes in the condition of the pressure ulcer to the Physician for one of four residents (R4) reviewed for pressure ulcers in the sample of 15. Findings include: R4's Minimum Data Set (MDS) dated 1/12/16, R4 has a history of Stage two pressure ulcers on her coccyx. R4's MDS documents R4 as requiring total care for bed mobility, and all activities of daily living. R4's skin risk assessment dated 2/10/16 documents R4 is at high risk for pressure ulcers. The facility Ulcer Care Plan-Treatment plan documents the pressure ulcer on R4's coccyx developed on 1/8/16 and measured at 2 centimeters (cm) by 1.8 cm. On 2/14/16 and 2/20/16, the pressure ulcer is documented as healed. On 2/23/16 at 2:00 PM, during a routine skin check R4 had a hydrocolloid dressing to her coccyx initialed and dated 2/19/16. E4 Registered Nurse (RN) and E11 Licensed Practical Nurse (LPN), were in the room for the skin check and dressing change. A small area of bright red blood was noted under the dressing. When the dressing was removed two pressure ulcers were noted and measured by E11. A 1cm. by 0.5cm open pressure ulcer in the center of R4's coccyx and a	F 314		

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1.5cm by 1.0cm "abrasion that was open and bleeding." The pressure ulcer was cleansed and a new hydrocolloid dressing was applied, without an initial or date.

On 2/23/16 at 2:30 PM E4 stated, "I don't know why she has the dressing on at all. I usually do the treatments and I had her healed off as of 2/7/16. I don't know when it opened up again. We don't have a current order for anything to be on there that I know of."

On 2/25/16 at 2:00 PM, E2 Director of Nurses stated, " I talked to the midnight nurse. She is the one who put it on her. She said there was a dressing on her and she just replaced it. I said how can you do that without an order, since when is that the way we do things around here."

The facility document titled, "Ulcer Care Plan-Treatment plan," documents on 2/7/16 the coccyx pressure ulcer remains open at 1cm by 1.3 cm. On 2/14/16 the pressure ulcer was documented as healed. On 2/20/16 the pressure ulcer was documented as healed, despite the intact dressing observed on 2/23/16 at 2:00 PM.

R4's current physician orders for February 2016, document that no new Physician order was obtained after the wound was documented as healed.

The nurses notes for the month of February show no documentation of the Coccyx pressure ulcer as being healed as of the 14th, and no documentation of the pressure ulcer re-opening on 2/19/16, and the Physician being contacted with the information for new orders.

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F 314	Continued From page 7 On 2/29/16 at 9:00 AM, review of the Treatment Administration Record (TAR) documents wound care and a dressing was last applied on 2/14/16. The facility policy dated 10-20-14, titled "Wound and Ulcer Policy and Procedure," under the area titled High risk protocol, "When a resident is found to have a wound or ulcer either on admission or during their stay, the following will be completed by licensed nurse: Document assessment of the wound/ulcer in the medical record. Initiate treatment. Document treatment on the TAR Notification of the Physician and Power of Attorney."	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 8 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prevent contamination of a residents equipment during incontinent care for 1 of 15 residents (R6) reviewed for infection control in the sample of 15. Findings include: On 2/23/16 at 10:25 AM, E4 and E5, Certified Nurse's Aides (CNAs) removed R6's urine soaked incontinent brief to provide incontinent care. After removing the soiled brief, E5 placed the brief on top of R6's foam boot that he was wearing on his right leg. When E4 and E5 rolled R6 to his back the soiled brief rolled onto part of the foam boot R6 was wearing on left leg. When the incontinent care was complete, E5 placed the soiled brief in a plastic bag and disposed it. On 2/25/16 at 2:50 PM E2, Director of Nurse's stated, "Staff are to put soiled briefs in a plastic	F 441		

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F 441	Continued From page 9 bag when doing incontinent care." The facility's RECOMMENDATIONS FOR APPLICATION OF STANDARD PRECAUTIONS FOR THE CARE OF ALL PATIENTS IN ALL HEALTHCARE SETTINGS, not dated, documented, "COMPONENT Textiles and laundry RECOMMENDATIONS. Handle in a manner that prevents transfer of microorganisms to others and to the environment."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have Hospice records in the facility for 1 of 15 resident (R10) reviewed for complete medical record documentation in the sample of 15. Findings include:	F 514		

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F 514	Continued From page 10 Physician Order Sheet for R10 dated 2/4/16 documents, "(Local) Hospice to eval (evaluate) and treat." On 2/29/16 at 11:00 AM, R10's chart was reviewed and no Hospice visit documentation or Care Plan was found in the chart or in the (Local) Hospice binder. On 2/29/16, R10's Progress Notes were reviewed and no documentation was available of Hospice Nurse communicating with facility nursing staff on R10's status. On 2/29/16 at 11:00 AM, E15, Licensed Practical Nurse, (LPN), stated "There are no Hospice notes in the chart for (R10) and there are no notes in the (Local) Hospice binder for (R10)." On 2/29/16 at 11:05 AM, E8, Registered Nurse, (RN), stated, "There are no notes in the chart or in the binder for (R10). The Hospice staff do not put any notes in the computer, if there were notes they would be in the binder for (R10) for (Local) Hospice." On 2/29/16 at 112:15 AM, E3, LPN/Minimum Data Set Coordinator stated, "I didn't find any Hospice notes in the chart for R10." On 2/29/16 at 2:00 PM, E2 stated, "The Hospice Care Plan was not in the building until today."	F 514		