STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145770	A. BUILDING ______ B. WING ______	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNT CARROLL	**1006 NORTH LOWDEN P.O. BOX 111 MOUNT CARROLL, IL 61053**

(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 Annual Licensure and Certification Survey	F 000		
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 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prevent a pressure sore from worsening by not identify a pressure ulcer and reporting it to the wound nurse prior to progressing to Unstageable for a resident at risk for skin breakdown (R6). This applies to 1 of 5 residents (R6) reviewed for pressure ulcers in the sample of 15. The findings include: The Wound Flow Sheet from 10/23/13 for R6 shows the pressure ulcer on the sacrum was initially assessed on 10/23/13 as 1.0 cm x 1.0 cm and the depth was unable to be determined. The wound bed was 100% covered with eschar (scab). The wound assessment shows the wound is un-stageable. The area on the sacrum has (a)scabbed covering and is erythematous around wound edges. Will encourage to off-load in afternoon and to be on her side in bed. On 10/25/13 the wound comments state, the staff	F 314		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	Continued From page 1 report the area looks worse. Area has increased in size and is not 100% covered with slough. Surrounding area is dark pink, erythematous and indurated approximately 4 cm (around wound opening). On 10/30/13 the wound measurement increased to 2.9 cm x 1.5 cm and 95% covered with slough. The Physician Order sheet shows on 10/30/14 the wound culture taken from the sacral wound tested positive with MRSA (Methicillin Resistant Staphylococcus Aureus) bacteria, and was prescribed to receive an oral antibiotic. On 5/7/14 at 10:40 AM, E3 (RN- Wound Nurse) stated, " I was the first person to assess the wound. I found it on my weekly skin checks. It had not been reported to me by the staff. R6 is incontinent of urine and has a colostomy. Usually, the nurse will look at it after the CNA reports a change in the resident ' s skin and then let me know. R6 is at high risk for skin breakdown because she has had skin issues in that area (sacrum) before. The CNA staff should look at the skin every day during peri-care and report any changes. " E3 stated R6 is turned every 2 hours and receives incontinence care. E3 did not know why this scabbed area was not identified and reported sooner. On 5/7/14 at 8:50 AM, R6 was observed in bed receiving wound care to the sacrum by E6 (Licensed Practical Nurse). E6 stated, " We know the wound is not related to feces as she has a colostomy. But she does have significant incontinence of urine. " The wound on the sacrum was measured3.4 cm x 1.0 cm x 0.4 cm. A second opening on the sacrum measured 0.5 cm x 0.4 cm x 0.2 cm. E6 stated, " R6 has always had a peri-wound that looks angry but it is blanching. R6 will stay on her side if we support it with a pillow. "	F 314		

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F 314	Continued From page 2 On 5/7/14 at 9:00 AM, R6 stated, " It (wound area) hurts when they rough around with it. " On 5/7/14 at 2:15 PM, E4 stated, " If we see a new skin problem we consult with a co-worker and report it to the nurse, immediately when you first see it. " The Minimum Data Set of 2/26/14 shows R6 requires extensive assistance with transfer and ADL ' s. R6 does not ambulate. The Care Area Assessment (CAA) dated 12/2/13 shows R6 is at risk to develop pressure and the Braden score (Risk Assessment for Skin Breakdown score) is 12. The resident cumulative diagnosis list shows R6 has Dementia, MRSA of the Sacral Wound, History of Rectal Cancer with Colostomy, and Stasis Ulcers of the Right Leg.	F 314		