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F 000	INITIAL COMMENTS Complaint #1460230 / IL 67608-F224,F273, F275, F276, F314, F353, F354, F490, F493, F520 Complaint #1460422 / IL 67836-F284 A parital extended survey was conducted.	F 000		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility knowingly failed to follow established policies on pressure ulcer assessment and management and knowingly failed to follow physician orders for wound treatment and follow up wound clinic appointments for one of four residents(R1) with pressure ulcers in the sample of 42. These failures resulted in the avoidable deterioration of R1's coccyx pressure ulcer risking R1 for potential Sepsis and death. These collective failures resulted in the neglect of R1. These failures resulted in an Immediate Jeopardy situation for R1. While the immediacy was removed on 1/23/14, the facility remains out of compliance at a severity level two. The facility is	F 224		

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

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still in the process of monitoring the effectiveness of staff training on the Wound Care and Management Program.

Findings include:

1. The facility policy on Wound Care and Management Program dated 2/2012 documents the following:

"It is the policy [of the facility] to manage resident skin integrity through prevention, assessment and implementation and evaluation of interventions..... The facility will use the Braden Scale.....on each resident at admission, weekly for four weeks post admission and quarterly thereafter to assess skin breakdown risk...Residents identified at risk on the Braden...will have interventions put in place for preventative measure.....pressure reducing mattress and/or cushion, be reviewed by dietician.....The facility will assess weekly for current skin conditions...If any new areas are identified....nurse will measure the area; call physician to obtain...treatment order...document area on TAR[Treatment Administration Record] and initiate the treatment....The nurse responsible for treatments will.....review any new areas...All wounds will be reported weekly on the...Skin Integrity-Pressure Ulcer Report...It is the responsibility of the Administrator to review the Pressure Wound Report ...weekly.....PAR[Patient at Risk] Committee Meetings will be held weekly.....the committee should include at a minimum the nurse responsible for treatments, representative from therapy, director of nursing and representative from dietary....The interventions used will be documented on the PAR Committee Meeting Minutes...Physician....are called after the weekly

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Wound Committee meeting with an update of the current wound condition. These calls are documented in the nursing notes....."

The undated facility Policy on Notification of Change in Condition states, "...staff will immediately.....consult with the resident's physician....when there is: A significant change in the resident's physical .....status(..deterioration in health...status in either life-threatening conditions or clinical complications)...."

E14, Assistant Administrator, stated on 1/30/14 at 12:25pm that the PAR Committee Meeting met on 10/31/13 and 11/7/13, but did not meet again until 1/16/14.

The facility Admission Assessment dated 10/18/13 documents there is a Stage 3 "decubitus" on the coccyx. The assessment has no measurements of the ulcer. The area on the assessment titled "Braden/Norton Score" is blank. There is no Skin Assessment identifying R1's risks for the development of new pressure ulcers or risks that would prevent the healing of current pressure ulcers.
mattress. The Skin Integrity Report-Pressure Sores dated 10/25/13 does not document an entry for the coccyx pressure ulcer for R1.

The hospital Consult Notes dated 10/17/13 state R1's albumin level was 1.6(normal range 3.4-5.0), total protein level was 5(normal range 6.4-8.2). The facility RD[Registered Dietician] Nutrition Assessment completed by Z9, RD dated 10/30/13 states R1 has wounds with increased needs. The assessment does not address R1's low albumin and total protein level and there is no recommendation for nutritional suppllements. The

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December 2013 Medication Record does not document any Protein Powder supplement being given to R1 from 12/1-12/26/13, even though it was ordered three times daily on 11/19/13. On 1/22/14 at 1:30pm E8, RN(Registered Nurse) confirmed R1's protein powder supplement was not restarted until 12/27/13.

There is no other documentation of R1's coccyx pressure ulcer until the Daily Skilled Nurse's Note dated 10/31/13 which identifies R1's ulcer as a "new unstageable ulcer on right buttock crossing coccyx to L[left] buttock....." R1's Physician was called and ordered a referral to the wound clinic. The Wound Healing Center records document the facility did not call for an appointment until 11/6/13.
On 1/21/14 at 12:30pm Z1,MD(Medical Doctor) stated "she should have called sooner" and "should be making scheduled appointments sooner."

The Wound Healing Center Notes dated 11/19/13 which returned to the facility with R1, document the following Physician's Orders: "cleanse [coccyx] wound with mild soap and water...pack lightly with Dakins 1/2 strength moistened gauze Apply .....abd[abdominal] pad...change 2 times a day..." The November and December 2013 Treatment Records document R1's coccyx treatment only being done daily, instead of twice a day as ordered from 11/19-11/30/13. The Treatment Record documents the treatment being done twice daily as ordered only seven times from 12/1-12/19/13, with no documentation of the treatment being done from 12/20-12/31/13. The note states to call the Wound Healing Center Office for follow-up and to schedule doppler studies of the lower extremities. Facility

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documentation documents R1 was to return to the Wound Healing Center on 1/20/14. On 1/22/14 at 2:00pm E8, RN(Registered Nurse) that nurse's at the facility should have followed up on the follow up appointment.

There is no documented measurements for R1's coccyx pressure ulcer for 11/30/13 and 12/6/13. The Skin Integrity Report-Pressure Sores dated between 12/13/13 - 12/26/13 document deterioration of R1's coccyx ulcer. Z3, Wound Healing Center Nurse, stated on 1/21/14 at 12:18pm there is no notation in R1's record of the Center being notified of any deterioration of R1's coccyx wound.
On 1/22/14 at 1:00pm E11, LPN(Licensed Practical Nurse) stated she called the Physician on 12/27/13 regarding R1's worsening wound, but did not call at any other time.

The medical supply company invoice states the air mattress was delivered to the facility on 1/9/14. There is no documentation in R1's record of any prior low air loss off loading mattress being used for R1, even though it was initially ordered on 11/19/13.

E7, LPN stated on 1/18/14 at 1:35pm that R1 was admitted directly to the hospital from the Wound Clinic on 1/15/14 and was last seen by a Wound Clinic on 11/19/13.

Z8, Wound MD, stated on 1/23/14 at 10:50am that in his opinion the facility neglected to provide care to R1's coccyx/sacral pressure ulcer. Z8 stated R1's coccyx/sacral pressure ulcer was an "avoidable ulcer, because its responding now that he's getting care." Z8 stated "There was a hole in [R1's] back and could see his spine up and down.

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[R1] was in life threatening danger of death and Sepsis."

On 1/23/14 at 1:00pm an Immediate Jeopardy was identified. The Immediate Jeopardy situation began on 10/18/13 when R1 was admitted to the facility. The facility staff neglected to identify and assess the presence of a pressure ulcer. The facility neglected to identify risks and implement interventions that would prevent the development of new pressure ulcers or promote healing of current pressure ulcers. These collective failures resulted in the neglect of R1.

E14, Assistant Administrator, was notified of the Immediate Jeopardy on 1/23/14 at 1:00pm.

It was confirmed through interview and record review that the facility took the following actions to remove the immediacy:

R1 was admitted to the hospital on 1/15/14.

1/23/14-Licensed Nurse's were inserviced (re-educated) on the facility Wound Management and Care Program by E13, Assistant Director of Nursing.

1/23/14-Licensed Nurse's were inserviced on the importance of performing nursing assessments within 1-2 hours of admission, measuring and documenting wounds immediately and implementing pressure relieving devices at the time of admission for residents admitted with wounds or at risk for developing wounds by E13, Assistant Director of Nursing.

1/23/14-Licensed Nurse's will not be allowed to work until inserviced by E13, Assistant Director of

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Nursing.

F 273 SS=D 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT

A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to do a comprehensive assessment within 14 days of admission for one of four residents(R5), on the sample of 42.

Findings include:

The computer generated MDS(Minimum Data Set) Due Report dated 1/27/14 states that R5 was admitted to the facility on 12/27/13. The report documents "No Assessment Started" and that R1's assessment is due on 1/9/14.

E16, Director of Clinical Reimbursement stated on 1/27/14 at 1:00pm that she "couldn't find [R5's] assessment in the computer."

The Physician Order Sheet(POS) states R5 has diagnoses of Frost Bite to the toes and hands, Aspiration Pneumonia and C-diff(Clostridium difficile). The POS has orders for treatments to R5's hands/ finger and Contact Isolation for

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F 273	Continued From page 7 C-diff.	F 273		
F 275 SS=E	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete a comprehensive assessment once every twelve months for 6 of 26 residents(R6,7,8,9,10,11) reviewed for annual assessments, on the sample of 42. Findings include: The computer generated MDS(Minimum Data Set) Due Report dated 1/27/14 states "Next Assessment Type, Annual" and documents that annual assessments are due to be completed for the following residents: R6- due on 1/19/14; R7-due on 1/25/14; R8-due on 12/28/13; R9-due on 1/25/14; R10-due on 12/28/13 and R11-due on 1/18/14. E16, Director of Clinical Reimbursement confirmed on 1/27/14 at 1:00pm that the annual comprehensive assessments are not completed for R6,7,8,9,10 and 11.	F 275		
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 276		

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F 276	Continued From page 8 once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete quarterly MDS(Minimum Data Set)assessments for 28 of 38 residents(R4,12-38), on the sample of 42. Findings include: The computer generated MDS(Minimum Data Set) Due Report dated 1/27/14 states "Next Assessment Type, Quarterly" and documents that quarterly assessments are due to be completed for the following residents: R16,17,20,21,35,36 and 37 due on 12/21/13 ; R19 due on 12/27/13 ; R18, 24,32,25 and 26 due on 12/28/13 ; R28 due on 1/3/14 ; R13 and 27 due on 1/4/14 ; R4,12,14,15,29,30 and 38 due 1/18/14; R22,23 and 33 due on 1/19/14 ; R34 due on 1/23/14; R31 due 1/25/14. E16, Director of Clinical Reimbursement confirmed on 1/27/14 at 1:00pm that the quarterly comprehensive assessments are not completed for R4 and R12-38.	F 276		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	F 284		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to have a post discharge plan to ensure care needs are met after discharge for two of three residents(R39,R41) reviewed for discharge plans, on the sample of 42.

Findings include:

1. The Physician's Order Sheet(POS) dated 11/18-11/30/13 states R41 has diagnoses of Urinary Tract Infection, Diabetes and Hypertension.

The Physician's Order dated 12/3/13 states, "[R41] may discharge home on current medications. See primary care[Physician] within 1 week. Refer to eval[evaluate] for Home Therapy Services."

The Social Service Progress notes do not document discharge planning or referrals being made for R41.

The Daily Skilled Nurse's Notes dated 12/3/13 do not document education of R41 about the discharge medications or indicate if medications were sent home with R41 when discharged on 12/3/13.

The Interdisciplinary Discharge Summary dated 12/3/13 is blank in the area titled "Nursing Services." The area titled "Rehab[Rehabilitation] Services" states R41 would benefit from "continued therapies for [increased] safety [with] standing balance....." The summary has nothing documented in the section titled "Comments" and

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does not document any referrals made for home therapy, the need for R41 to see her primary care Physician in 1 week or instruction provided on medication administration.

On 2/6/14 at 3:20pm E19, Social Service Director stated she did not know if nursing staff talked to R41 about her medications or if any medications were sent home with R41. E19 stated they did not have an interdisciplinary meeting with R41, because she left earlier than expected. E19 confirmed the nursing and comment portion of the Interdisciplinary Discharge Summary was blank. E19 confirmed there was no discharge planning documented in the progress notes for R41. On 2/10/14 at 11:00am E19 confirmed that she did not make a referral for home therapy services or talk with R41 about her follow up Physician appointment.

2. The POS dated May 2013 states that R39 has diagnoses of Cerebrovascular Accident, Schizophrenia, history of Cellulitis of the Lower Extremities and Congestive Heart Failure.

The Interdisciplinary Discharge Summary dated 5/9/13 in the section titled "Nursing Services" states R39 uses a "wheelchair" and has "no teeth or dentures." There is no further documentation in the Nursing Services or Comments section of the summary, of treatments being done to R39's lower extremities.

The POS dated May 2013 has an order for betadine to be applied to an open area on the left lower leg and wrap with gauze twice daily until healed and for Triple Antibiotic Ointment(TAO) to be applied to the right great toe and covered with a dressing one to two times daily until healed.

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The March, April and May 2013 Treatment Record document the open areas on R39's left lower leg are healed and the treatment is not being done any longer. The POS was inaccurate, as no treatment was being done to R39's legs and great toe at the time of discharge(5/9/13). On 2/6/14 at 10:15 am E15, Care Plan Coordinator and E7, Wound LPN(Licensed Practical Nurse) stated that R39's lower legs were being wrapped with gauze to protect them, but there was no treatment being done, because the areas were currently healed. E15 and E7 stated that R39's right great toe area was also healed.

On 2/6/14 at 1:10pm E19, Social Service Director, stated she sent the Interdisciplinary Discharge Summary(5/9) and the POS dated May 2013 with R39 when he was discharged.

On 2/10/14 at 10:50am E13, Interim Director of Nursing stated there is to be an interdisciplinary meeting including the nursing staff to discuss the discharge plan. E13 stated the Interdisciplinary Discharge Summary should be completely filled out and sent with the resident. E13 stated before discharge residents are to be educated on the medications to be taken at home including the amount and how often the medication is to be taken. E13 stated the medication sent with home with the resident needs to be documented as well as the amount.

The facility policy on "Preparing a Resident for Transfer or Discharge" and "Medications Provided to Discharged Residents:" dated 2/2012 document the following information:

"Nursing Services will be responsible for:.....Preparing the discharge summary and

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F 284	Continued From page 12 post-discharge plan; Providing the resident or representative..with required documents....The Charge Nurse shall verify that the medications are labeled consistent with current physician orders including instructions for use....The Charge Nurse shall review medication instructions with the resident, family member or representative before the resident leaves the facility....."	F 284		
F 314 SS=J	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 interview and record review the facility failed to assess and identify the presence of pressure ulcers, monitor and implement a treatment program to promote healing for one of four residents(R1) with pressure ulcers on the sample of 42. The facility failed to implement interventions for nutrition, pressure relief and ensure treatments were done as ordered by the Physician for R1. The facility failed to evaluate the impact of interventions, identify the deterioration of R1's coccyx pressure ulcer and schedule timely Wound Clinic visits. These failures resulted in the avoidable deterioration of R1's coccyx	F 314		

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pressure ulcer placing R1 at imminent risk of Sepsis.

These failures resulted in an Immediate Jeopardy situation for R1. While the immediacy was removed on 1/23/14, the facility remains out of compliance at a severity level two. The facility is still in the process of monitoring the effectiveness of staff training on the Wound Care and Management Program

Findings include:

The hospital Consult Notes by Z14, Nurse Practitioner dated 10/17/13 state R1 has diagnoses of "Anemia. [R1's] hemoglobin level is 9.5[normal 12-18gram]..... Malnutrition. [R1's] albumin level is 1.6[normal 3.4-5.0gram]...Total protein 5[normal 6.4-8.2].....I will order [R1] some protein supplementation.....to get his albumin level up." The Hospitalist Progress Note by Z13, MD(Medidcal Doctor) dated 10/18/13 states, "Pressure ulcers they are present .....Coccyx stage 3 with red tissue, [less than] 15% slough, no eschar or odor noted. Maceration to periwound. Small drainage....." The note documents that R1 had been hospitalized for 4 days.

The facility Admission Assessment dated 10/18/13 at 7:00pm documents R1 was admitted to the facility. The Assessment documents there is a Stage 3 "decubitus" on the coccyx, but there are no measurements of the area. The area on the assessment titled "Braden/Norton Score" is blank. The area on the assessment titled "At Risk-No Risk" is blank. There is no Skin Assessment identifying the R1's risks for the development of new pressure ulcers or risks that

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would prevent the healing of current pressure ulcers. A blank Braden Skin Assessment was found in R1's record.

E8, Registered Nurse(RN), confirmed on 1/18/14 at 3:30pm there were no measurements documented on admission(10/18/13) for R1's coccyx pressure ulcer. E8 stated on 1/22/14 at 1:30pm that on admission R1 was on a regular mattress. E13, Interim Director of Nurse's confirmed on 1/29/14 at 2:40pm there is no Skin Assessment completed for R1.

The Physician's Order dated 10/18/13 states Zinc Oxide Topical Cream to "coccyx Stage 3" every shift.

The RD[Registered Dietician] Nutrition Assessment dated 10/30/13 states R1 has wounds with increased needs. The assessment does not address R1's low albumin(1.6) and low total protein level(5) or diagnosis of Malnutrition. The assessment states "Diet now regular with MVI[Multivitamin] should provide adequate nutrition for healing" E4, Dietary Manager stated on 1/22/14 at 11:05pm that protein supplements were not started for R1 until 11/19/13.

The Skin Integrity Report-Pressure Sores dated 10/25/13 does not document an entry for the coccyx pressure ulcer for R1. E7, LPN(Licensed Practical Nurse) stated on 1/18/14 at 3:05pm she is in charge of measuring and documenting weekly on the wounds and pressure ulcers. E7 confirmed there is no documentation of R1's coccyx pressure ulcer on 10/25/13.

There is no other documentation of R1's coccyx pressure ulcer until the Daily Skilled Nurse's Note

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dated 10/31/13 at 10:40pm. The Note states, "Contacted [Z6,Medical Doctor(MD)] about the new-unstageable ulcer on right buttock crossing coccyx to L[left] buttock, 7cm[centimeter] x[by] 5cm in size and also the [urinary] catheter always leaking, suspected to make his pressure ulcer getting worse.....scrotum is sort of swelling and retaining urine.....Got an order to have [R1] seen in wound care clinic and urologist. Copy to [E6, Scheduler]..."

The Physician's Order dated 10/31/13 at 9:40pm states, "Schedule wound care [clinic] for further evaluation/treatment of pressure sore on buttocks/coccyx. Schedule urology consult(1st available Dr.[Doctor]). Dx[Diagnosis] hiatus hernia."

The Physician's Order dated 11/1/13 states to "Clean necrotic tissue et[and] surrounding skin with skin prep. Apply hydrogel dressing to necrotic area et cover [with] non border foam until wound clinic appt[appointment]."

The Daily Skilled Nurse's Notes dated 11/1/13 states, "....Communicated to both dayshift et noc [shift] to f/u[follow up] on appt [with] WC[Wound Clinic] and Uro[Urologist] consult....." The Note dated 11/5/13 states, ".....still awaiting WC appt...."

E12, LPN stated on 1/23/14 at 3:30pm he called the Physician and got the order for the Wound Clinic and for the Urology Consult on 10/31/13. E12 stated he continued to document his attempts to follow up on the Wound Clinic appointment and Urology Consult. When asked why he put a diagnosis of Hiatus Hernia for the consults, E12 stated he just picked a diagnosis

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from the ones listed in R1's record.

Z3, RN. Wound Healing Center stated on 1/21/14 at 12:18pm the computerized record documents the facility did not call for an appointment at the center until 11/6/13. Z3 stated the appointment was made for R1 to be seen by Z7, MD Wound Healing Center on 11/19/13.

There is no documentation found in R1's record of R1 having a Urology consult done.

When told staff(E6) did not call to schedule the Wound Healing Center appointment until 11/6/13, Z1, Resident MD for Z6, Attending MD stated on 1/21/14 at 12:30pm "she should have called sooner." Z1 stated the facility should be "making scheduled appointments sooner. Once they get the order, they do not schedule soon enough." Z1 stated R1 did not have the Urology consult done.

E6, Transportation/Scheduler stated on 1/22/14 at 11:20am when she called the Urology office to make the appointment as ordered for R1, she read off exactly what was written in the order(12/31/13), including the diagnosis of Hiatus Hernia. E6 stated she was told by the Urology office that "it's not us, it's gastroenterology." E6 stated she then went and told E11, LPN what the Urology office had told her. E6 stated, "I think [E11] told me to go ahead and make an appointment with Digestive Health." E6 stated she then made the appointment with Digestive Health for R1.

E11, LPN stated on 1/22/14 at 1:00pm she did not remember E6 talking to her about problems getting R1's Urology appointment scheduled.

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There is no Physician's Order found in R1's record for a Gastroenterology Consultation to be done. The Gastroenterology Consult Note dated 12/19/13 documents that R1 went for a gastroenterology consultation on 12/19/13 and a Ambulatory Upper Endoscopy was ordered at that time. E8, RN, Marketing confirmed on 1/22/14 at 2:00pm there is no Physician's Order for R1 to have a Gastroenterology Consultation. E8 stated there was a mixup when E6 called the Urology office to make the appointment for the Urology Consult. E8 stated the nurse's should have called Z1, MD and clarified the diagnosis and reason why the Urology Consultation was ordered on 10/31/13.

The Skin Integrity Report-Pressure Sores dated 11/1/13, 11/6/13 and 11/15/13 states R1 has a "Stage 3" on the coccyx measuring "8 x 13 cm, 25% eschar, 50% slough, scant serous drainage, no odor.."

The Wound Healing Center Notes dated 11/19/13 which returned to the facility with R1, document under the section titled "Problem List" the following: "Pressure ulcer, Urinary Tract Infection, Chronic Kidney Disease, Stage 3, Hypoalbuminemia.... The Physician's Order dated 11/19/13 for treatment to the coccyx pressure ulcer is to "cleanse wound with mild soap and water...pack lightly with Dakins 1/2 strength moistened gauze Apply .....abd[abdominal] pad...change 2 times a day...Avoid pressure at wound site...Wheelchair cushion...turn and reposition every 1-2 hours in bed and wheelchair...Do Not Sit for Long Periods of Time. Off Loading Mattress-low air loss mattress...Nutrition recommendations for optimal

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wound healing-double protein at every meal. May offer protein supplements 2-3 times a day...Call Wound Healing Center ...if you have any questions about the care of your wounds....Wound Clinic Office Follow-Up...Lower Extremity Arterial Doppler on or after 11/19/13 and Lower Extremity Arterial Duplex on or after 11/19/13." The Wound Healing Center Notes did not specify when R1 was to return to the Wound Center for a followup appointment. E8, RN stated on 1/22/14 at 2:00pm the facility nurse's should have followed up with the Wound Center to find out when R1 was to be seen again.

The Treatment Record dated 11/1-11/30/13 states 11/19/13- coccyx-Clean with mild soap and water, pack lightly with 1/2 strength Dakins solution with gauze dressing two times a day. The record documents R1's treatment to the coccyx pressure ulcer is only being done once a day, instead of twice a day as ordered. The Treatment Record dated 12/1-12/31/13 documents the treatment being done twice daily as ordered seven times from 12/1-12/20/13. There is no documentation of any treatment being done to R1's coccyx from 12/21-12/31/13.

The Wound Healing and Limb Preservation Center History and Physical dated 11/19/13 documented by Z7, MD states, "......evaluation of multiple ulcer...to lower extremities....[R1] has a caregiver with him from the nursing home...Unfortunately we do not have any records from the nursing home accompany him....history..indicates.....he states.... these have been present for at least the past month and probably longer, especially the coccyx one... [R1] states he was told several years ago he had bad blood flow or arterial disease in his

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legs.....the coccyx decubitus ulcer. It is measuring 7.0 x 6.5[cm], straight down depth of 0.6.....A tremendous amount of fibrin slough her throughout with a lot of necrotic debris that...is getting a bit of odor....." The History and Physical documents the coccyx area was debrided. The History and Physical states, "...the plan will be to.....schedule [R1] for a Doppler duplex before he returns for a next visit in two weeks or it could be the same day....."

On 1/18/13 at 11:30am E6, Transportation/Scheduler stated she took R1 to the Wound Healing Center to see Z7, MD on 11/19/13. E6 stated that Z7 ordered vascular studies for R1 and wanted to see him after the vascular studies. E6 stated she was unable to get R1 scheduled for the vascular studies until 12/31/13 and R1 was to go to the Wound Center after the vascular studies were completed. When asked why it took so long to get an appointment with the Wound Healing Center E6 stated, "For 2 and 1/2 weeks our outside transport company was closed. Our facility was doing all the transportation. It's possible we were booked and [Z7's] availability. Nobody told me that [R1] was worse or urgent-to be seen by vascular, Z7's office or nursing at the facility."

On 1/22/14 at 1:55pm Z5,Receptionist at Heart and Vascular Clinic stated the computerized record documents E6 called to make the appointment for R1's Doppler studies on 11/27/13. Z5 stated R1's appointment was scheduled for 12/31/13.

The Skin Integrity Report-Pressure Sores dated 11/25/13 states R1 has a "Stage 3" on the coccyx measuring "8 x 13 cm, 25% eschar, 50% slough,

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scant serous drainage, no odor.."

There is no documented measurements for R1's coccyx done again until 12/13/13. E8, RN stated on 1/18/14 at 3:30pm there were no wound or pressure ulcer measurements done on 11/30/13 and 12/6/13 because E7, Wound LPN was on vacation.

The Skin Integrity Report-Pressure Sores dated 12/13/13 states R1's coccyx ulcer measured "7 x 8.3.2" with "50% eschar, 75% slough, mild odor. scant serous drainage, Stage III." E7, Wound LPN stated on 1/28/14 at 3:45pm the measurement of R1's coccyx on 12/13/13 is 7cm by 8cm by 3.2cm depth. E7 stated there was a typographical error on the form.

There is no documentation in R1's record of the Wound Healing Center or the Physician being notified of the deterioration and increase in eschar/slough of R1's coccyx pressure ulcer.

Z3, Wound Healing Center Nurse, stated on 1/21/14 at 12:18pm there is no notation in R1's record of the Center being notified of any deterioration of R1's coccyx wound.

E7, Wound LPN stated on 1/18/14 at 3:05pm she "did not call the Wound Center, usually the nurse's in charge on a daily basis, they make most of the Doctor calls."

The handwritten Wound Report-Pressure dated 12/20/13 states R1's coccyx pressure ulcer measures "7 x 8-unstageable." There is no documentation of drainage, odor, depth, eschar or slough.

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The Communication Form and Progress Note dated 12/26/13 at 3:15pm states that R1 became non-responsive with a low blood pressure, Z1, MD was called and wanted R1 sent to the hospital for evaluation. The note states that R1 then "became responsive when put back to bed....{R1] told nurse and EMT's[Emergency Medical Technician's] that he didn't want to go to [hospital]..."

E11, LPN stated on 1/22/14 at 1:00pm stated on 12/26/13 R1's blood pressure was low and he was non responsive, so she called Z1 then. E11 stated on 12/26/13 Z1 ordered for R1 to go to the hospital, but by the time the paramedics arrived, R1 was awake and refused to go. E11 stated she called Z1 back and told her R1 refused to go to the hospital. E11 stated Z1 then ordered some laboratory work to be done for R1.

The Wound Report-Pressure dated 12/27/13 states R1's coccyx pressure ulcer measures "5.5 x 7-tunneling(worse), unstageable, 90% slough. Foul odor, heavy serous drainage. MD notified....."

The Physician's Order dated 12/27/13 states, "...Protein Powder as directed p.o[by mouth] bid[twice daily] , Wound Clinic appt. ASAP[as soon as possible]on 1st[first] available Dr. [Doctor]....."

E11, LPN stated on 1/22/14 at 1:00pm that she called Z1,MD on 12/27/13 about R1's coccyx wound being worse, but did not call any other time.

The November Medication Record dated 11/1-11/30/13 documents Protein Powder 1

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scoop being given 3 times a day as ordered on 11/19/13. The December Medication Record dated 12/1-12/31/13 does not document any Protein Powder supplement being given to R1 from 12/1-12/26/13. The Record documents the Protein Powder supplement being restarted twice daily on 12/27/13.

PT(Physical Therapy) Daily Treatment Notes addressing Ultrasound to the coccyx pressure ulcer and Therapeutic Activities document the following information for R1: 12/23/13-"Wound not bandaged, upon opening disposable [brief], wound was wet, red....." ; 12/24/13-"...bandage removed to access site. Bandage wet and very smelly....." ; 12/27/13-"Dialogue with nursing as to the WET and SMELLY wound, requesting a doctor call as to concerns and requesting an appointment for possible infection.....will withhold US[ultrasound]...until decision about infection is answered..."

The Physician's order dated 12/30/13 states, "Per consult with PT. Place [R1's] PT on hold until status of wound is determined."

The Nurse's Note dated 12/30/13 at 9:30am states, "....wound to coccyx noted to be very foul smelling, diameter, width appears not to be changed, area around wound macerated. Large amount of sloughing noted, black necrotic area at top of wound.....[R1] to Wound Clinic tomorrow...."

E6,Transport/Scheduler stated on 1/18/14 at 11:30am R1 had vascular studies and a Wound Center appointment scheduled for 12/31/13. E6 stated the vascular studies took longer than expected and Z7 was unable to wait to see R1

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because of scheduled meeting. E6 stated she was told to call the Wound Healing Center to reschedule the appointment for R1. E6 stated the first available appointment with Z7, Wound Physician was 1/20/14.

The Wound Report-Pressure dated 1/3/14 states R1's coccyx pressure ulcer measured "5 x 9 x 5[depth] [greater than] 75% necrotic, foul odor-moderate serosanq[serosanquinous] drainage."

The Nurse's Note dated 1/7/14 states, "Dressing on coccyx ulcer changed. Dimensions as follow: 4.0 x 6.5cm, 4.5cm depth. 4cm tunneling 12 o'clock, 5.5 tunneling at 6 o'clock....."

The Nurse's Note dated 1/8/14 at 1:30pm states Z1, MD was notified regarding "no improvement in coccyx wound and foul odor..."

The Physician's Order's dated as follows state: 1/8/14- "Alternating pressure mattress on bed, Obtain a wound culture of coccyx wound, [Urine for Culture and Sensitivity] blood culture x[times] 2, Begin Bactrin DS.....after obtaining cultures.." ; 1/12/14-Discontinue Bactrin DS due to sensitivity; 1/13/14-"Change [urinary] catheter, Repeat urine culture..." ; 1/13/14-" ..... "Start IV[Intravenous] Ertapenem 500mg[milligrams] daily x 7 days."

The invoice from the Medical Supply Company dated 1/9/14 states the air mattress was delivered for R1. Z2, Company Representative stated on 1/21/14 at 1:26pm the mattress delivered on 1/9/14 for R1 was a pressure relieving low air loss product, which is used for the prevention and treatment of Stage 3 and 4 pressure ulcers. There is no documentation in R1's record of any

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prior low air loss off loading mattress being used for R1, even though it was initially ordered on 11/19/13 by Z7, Wound Healing Center Physician.

The Wound Report-Pressure dated 1/10/14 states R1's coccyx pressure ulcer measured "8 x 8 x 3[depth]-unstageable [greater than] 75% necrotic tissue-tunneling-foul odor, Mod[moderate] serosanq dr[drainage]."

The Laboratory Report dated 1/11/14 and 1/14/14 document Urine Culture of Escherichia Coli ESBL(Extended Spectrum Beta-Lactamases) . The Urine Sensitivity Report dated 1/11 and 1/14/14 document sensitivity to Ertapenem. The Laboratory Report dated 1/10/14 for the coccyx wound document "heavy growth.....No work up...These organisms resemble normal fecal flora.....Moderate growth Streptococcus Agalactiae-Group B...susceptibility testing....not routinely performed...susceptible to Penacillins.....Alternate drug choices are first generation Cephalosporins, Erythromycin, Clindamycin or Vancomycin."

Z1, Resident MD for Z6, Attending MD stated on 1/21/14 at 12:30pm she was unavailable from 11/20--12/20/13. Z1 stated when she returned to work on 12/20/13 she "was not told by her colleagues that they were called [about R1]." Z1 stated she remembered telling staff to do the protein powder and get a Wound Clinic appointment as soon as possible(12/27/13). Z1 stated she also ordered a culture and sensitivity of the wound and urine(1/8/14). Z1 stated, "The area[coccyx] kept getting worse-I asked them if [R1] had a special mattress on and they assured me he did." Z1 stated at one point she told staff to send R1 to the hospital but R1 refused to

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go(12/26/13).

The Communication Form and Progress Note dated 1/15/14 states that R1 has a new appointment with another Wound Clinic on 1/15/14. The Note documents that Z1, MD was notified and stated it would be fine for R1 to be seen at the other Wound Clinic. The Note documents that R1 was admitted from the Wound Clinic to the hospital.

E7, LPN stated on 1/18/14 at 1:35pm that R1 went to another Wound Clinic on 1/15/14 because he was able to be seen 5 days earlier, than the appointment(1/20/14) which was scheduled at the Wound Healing Center. E7 stated that R1 was seen at the Wound Healing Center on 11/19/13.

The Wound Care Consultation Report dictated by Z8, Wound MD dated 1/15/14 states, "...seen today for evaluation of a sacral decubitus ulcer.....It has been there for the last several months...[R1] was here in the hospital.....At that time in September of last year[2013], [R1] had a stage II decubitus ulcer in the sacrum and lumbar area....Sacral decubitus is 8cm in length, 6cm in width, 5.4 in depth. [R1] has undermining 10 o'clock to 7cm; 5 o'clock, 3.5cm; 8 o'clock, 4.5cm; 12 o'clock, 2.9cm. The cavity is 6 x 4cm. There is granulation tissue present. The bone is exposed present. There is slough present and drainage that is serosanquineous and has odor. Drainage amount is large. The skin condition is very necrotic. Impression and Plan: Severe sacral decubitus ulcer, Stage IV. Will admit....consult with General Surgery, do surgical debridement..."

Z8, Wound MD, stated on 1/23/14 at 10:50am

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that R1's coccyx/sacral pressure ulcer was "avoidable ulcer, because its responding now that he's getting care." Z8 stated "There was a hole in [R1's] back and could see his spine up and down. [R1] was in life threatening danger of death and Sepsis."

On 1/23/14 at 1:00pm an Immediate Jeopardy was identified. The Immediate Jeopardy situation began on 10/18/13 when R1 was admitted to the facility. The facility staff failed to identify and assess the presence of a pressure ulcer. The facility failed to identify risks and implement interventions that would prevent the development of new pressure ulcers or promote healing of current pressure ulcers. These collective failures resulted in the avoidable deterioration of R1's pressure ulcer.

E14, Assistant Administrator, was notified of the Immediate Jeopardy on 1/23/14 at 1:00pm.

It was confirmed through interview and record review that the facility took the following actions to remove the immediacy:

R1 was admitted to the hospital on 1/15/14.

1/23/14-Licensed Nurse's were inserviced(re-educated) on the facility Wound Management and Care Program by E13, Assistant Director of Nursing.

1/23/14-Licensed Nurse's were inserviced on the importance of performing nursing assessments within 1-2 hours of admission, measuring and documenting wounds immediately and implementing pressure relieving devices at the time of admission for residents admitted with

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F 314	Continued From page 27 wounds or at risk for developing wounds by E13, Assistant Director of Nursing. 1/23/14-Licensed Nurse's will not be allowed to work until inserviced by E13, Assistant Director of Nursing.	F 314		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have sufficient staff to meet the direct care needs of residents, including pressure ulcer assessment, evaluation and management,	F 353		

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a functional PAR(Patient at Risk) committee and timely Initial, Annual and Quarterly MDS's(Minimum Data Set) assessments, on 10 of 14 days reviewed. These failures have the potential to affect all 73 residents residing in the facility.

Findings include:

1. The staff schedule from 1/1-1/14/14 was reviewed. During the period of 1/1-1/14/14 the facility had an average of 74 residents requiring 194.5 hours of minimum direct care, with 145 hours to be from direct care staff. The direct care staff hours below the 145 hour state minimum derived from the time cards are as follows: 1/1-124.2 hours; 1/2-130.84 hours; 1/4-111.92 hours; 1/5-94.38 hours; 1/6-109.62 hours; 1/7-140.37 hours; 1/10-132.36 hours; 1/11-117.67 hours; 1/12-116.29 hours and 1/13-142.98 hours.

E14, Assistant Administrator, confirmed on 1/27/14 at 12:15pm the accuracy of the direct care staff hours.

2. During this time period(1/1-14/14) the facility staff failed to provide care to R1's coccyx pressure ulcer in the following areas: pressure relief, nutrition, following Physician's orders for treatments, timely scheduling of wound clinic appointments, assessment/monitoring and identifying deterioration of a pressure ulcer. This care is to be provided by Registered Nurses, LPN's(Licensed Practical Nurses), CNA(Certified Nurse Aides) , Scheduler/Transportation Aide and Wound LPN.

E7, LPN stated on 1/18/14 at 1:35pm that R1 was admitted to the hospital on 1/15/14 following an

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F 353	Continued From page 29 appointment with the Wound Clinic. Z8, Wound MD(Medical Doctor), stated on 1/23/14 at 10:50am that R1's coccyx/sacral pressure ulcer was an "avoidable ulcer, because its responding now that he's getting care." Z8 stated "There was a hole in [R1's] back and could see his spine up and down. [R1] was in life threatening danger of death and Sepsis." 3. The facility failed to have sufficient staff to ensure there is a functional PAR committee. E14, Assistant Administrator, stated on 1/30/14 at 12:25pm that the PAR Committee Meeting met on 10/31/13 and 11/7/13, but did not meet again until 1/16/14. E14 confirmed the PAR committee is to meet weekly to discuss resident care issues. The PAR committee is to be comprised of the Director of Nursing, Social Service Director, Wound Nurse, MDS(Minimum Data Set)/ Care Plan Nurse and a representative of therapy and dietary. 4. The facility failed to have sufficient staff to ensure completion of initial, annual and quarterly MDS assessments in a timely manner. E16, Corporate Director of Clinical Reimbursement, confirmed on 1/27/14 at 1:00pm that MDS assessments are not being done when due. E16 stated that E7, Wound LPN was to be doing the MDS assessments while E15, MDS Coordinator was on medical leave. The assessment team is comprised of RN's, LPN's CNA's, and staff from activities, dietary and social service. The Facility Data Sheet dated 1/18/14 documents that 73 residents currently reside in the facility.	F 353		
F 354	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK,	F 354		

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F 354 SS=D	Continued From page 30 FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have Registered Nurse(RN) coverage for 8 consecutive hours on two of fourteen days reviewed. The facility failed to maintain RN staffing in accordance with the states minimum staffing requirements. These failures affected R1, one of four residents reviewed for pressure ulcers in the sample of 42. Findings include: The staff schedule from 1/1-1/14/14 was reviewed. On 1/2/14 and 1/5/14 there was no RN scheduled to work at least 8 hours. During the period of 1/1-1/14/14 the facility had an average of 74 residents requiring 194.5 hours of minimum direct care, with 19 hours to be from RN's. The RN hours below the 19 hour state minimum derived from the time cards are as	F 354		

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F 354	Continued From page 31 follows: 1/1-8.25 hours; 1/4-15.8 hours; 1/6-17.05 hours; 1/7-8.17 hours; 1/8-15.16 hours; 1/9-16.27 hours; 1/10-8.05 hours; 1/12-8.27 hours; 1/13-17.37 hours and 1/14-16.72 hours. E14, Assistant Administrator, confirmed on 1/27/14 at 11:30am the RN hours for the two week period of 1/1-1/14/14 were accurate. E14 confirmed there was no RN working on 1/2 and 1/5/14. During this time period(1/1-1/14/14) the facility staff failed to provide care to R1in the following areas: pressure relief, nutrition, following Physician's orders for treatments to the coccyx pressure ulcer, timely scheduling of wound clinic appointments, assessment/monitoring and identifying deterioration of a pressure ulcer. E7, LPN(Licensed Practical Nurse) stated on 1/18/14 at 1:35pm that R1 was admitted to the hospital on 1/15/14 following an appointment with the Wound Clinic. Z8, Wound Physician, stated on 1/23/14 at 10:50am that R1's coccyx/sacral pressure ulcer was an "avoidable ulcer, because its responding now that he's getting care." Z8 stated "There was a hole in [R1's] back and could see his spine up and down. [R1] was in life threatening danger of death and Sepsis."	F 354		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 490		

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well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility administration failed to ensure adequate Registered Nurse(RN) and direct care staffing, functional QAA(Quality Assessment and Assurance) and PAR(Patient at Risk) committees, timely and completed initial/quarterly and annual MDS(Minimum Data Set) assessments and failed to follow established policies on pressure ulcer assessment and management. These failures have the potential to affect all 73 residents residing in the facility.

Findings include:

1. The facility administration failed to have RN coverage on 1/2 and 1/5/14 and have enough direct care staff hours to meet the minimum care needs of the residents. E14, Assistant Administrator confirmed on 1/27/14 at 11:30am that there was no RN coverage on 1/2 and 1/5/14 and confirmed the direct care staff hours fell short of the required minimum staffinf ratio on 10 of 14 days in January 2014..

2. The facility administration failed to ensure there is a functional QAA committee. E14 Assistant Administrator stated on 1/27/14 at 3:30pm the last QAA meeting was held on 7/24/13. E14 confirmed that Z10, Medical Director, a member of the committee, did not attend the meetings on 4/24/13 and 7/24/13.

3. The facility administration failed to ensure there is a functional PAR committee. E14, Assistant

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F 490	Continued From page 33 Administrator, stated on 1/30/14 at 12:25pm that the PAR Committee Meeting met on 10/31/13 and 11/7/13, but did not meet again until 1/16/14. E14 confirmed the PAR committee is to meet weekly to discuss resident care issues. 4. The facility administration failed to ensure completion of initial, annual and quarterly MDS assessments in a timely manner. E16, Corporate Director of Clinical Reimbursement, confirmed on 1/27/14 at 1:00pm that MDS assessments are not being done when due. 5. The facility administration failed to ensure facility staff followed policies on pressure ulcer assessment and management. The failures included the following areas: pressure relief, nutrition, following Physician's orders for treatments/scheduling of wound clinic appointments, assessment/monitoring and identifying deterioration of a pressure ulcer. The Facility Data Sheet dated 1/18/14 states 73 resident currently reside in the facility.	F 490		
F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility	F 493		

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F 493	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility governing body(corporation) failed to appoint a Licensed Administrator to provide oversight and to ensure compliance in Registered Nurse(RN) and direct care staffing, functional QAA(Quality Assessment and Assurance) and PAR(Patient at Risk) committees, completion of initial, quarterly and annual MDS(Minimum Data Set) assessments and implementation of established policies on pressure ulcer assessment and management. This failure has the potential to affect all 73 residents residing in the facility. Findings include: On 1/21/14 at 9:30am E14, Assistant Administrator, stated that E1's, Licensed Administrator, employment had been terminated on 1/20/14 by the E18, Owner. E14, Assistant Administrator stated on 1/27/14 at 2:45pm that the facility currently has no licensed Administrator managing the operations of the facility. E14 stated that E17, Corporate Director of Operations was not going to be the temporary Administrator. E14 stated she was not going to be submitting the paper work to get a temporary Administrator's license. E14 confirmed on 2/5/14 at 10:58am that the facility still does not have a licensed Administrator. Ongoing investigation from 2/18/14 to 2/11/14 demonstrated that the facility is out of compliance in the following regulatory areas: F224, F273, F275, F276, F314, F353, F354, F490 and F520.	F 493		

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F 493	Continued From page 35 The Facility Data Sheet dated 1/18/14 states that 73 residents reside in the facility.	F 493		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have a functional Quality Assessment and Assurance(QAA) committee which met quarterly, with Physician attendance. This failure	F 520		

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has the potential to affect all 73 residents residing in the facility.

Findings include:

The Quality Assurance Meeting Sign In Sheet dated 4/24/13 and 7/24/13 documents the meeting was held, but Z10, Medical Director, a committee member, did not attend either meeting. There is no further documentation of a QAA meeting being held after 7/24/13.

E14, Assistant Administrator stated on 1/27/14 at 3:30pm the last QAA meeting was held on 7/24/13. E14 stated that E1, Former Administrator canceled the QAA meeting which was scheduled for October and did not reschedule it. E14 confirmed that Z10 did not attend the QAA meetings in April and July 2013.

The Facility Data Sheet dated 1/18/14 states that 73 residents reside in the facility.