STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146158	A. BUILDING _____ B. WING _____	04/17/2015

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HARBOR CREST HOME	817 17TH STREET FULTON, IL 61252

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F 000	INITIAL COMMENTS Annual licensure and certification survey.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide activities to meet individual preferences and level of cognition as well as their physical, mental and psychosocial well-being. This applies to 1 of 12 residents (R3) reviewed for activities in the sample 13. The findings include: R3 ' s care plan documents she has multiple diagnoses including Lewy Body Dementia. The 2/12/15 MDS (Minimum Data Set) documents R3 is rarely/never understood and requires total care with activities of daily living and relies on staff to meet her needs. R3 is non-ambulatory and requires extensive assistance for mobility. R3 was observed at frequent intervals on 4/14/15, 4/15/15 and 4/16/15. At no time was R3 offered activities or engaged in group or individual activities. R3 showed no interest in her surroundings or other residents. R3 showed no objective signs of initiative or motivation. R3 appeared to sleep through most of the three days of observation. On 4/16/15 at 12:35 PM, E6 (Certified Nursing	F 248		

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

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F 248	Continued From page 1 Assistant-CNA) and E7 (CNA) described a typical day for R3 involves assisting her out of bed to her chair and transporting her to the dining room for breakfast. E6 and E7 each stated after breakfast R3 is transported to the West nurses station in the hallway to sit until lunchtime. E6 stated R3 is then transported to dining room for lunch and then she is transported back to nurse ' s station hallway or to her room for a nap until the end of their shift. On 4/16/15 at 1:25 PM, E8 (Activity Director-A.D)) stated residents who are dependent on others for mobility and have altered cognition are offered music therapy once a week for 30 minutes. E8 stated sometimes activity staff will put a radio on in their room to a station they like. E8 stated that she accommodates individual needs and preferences by having a monthly meeting and taking suggestions from nursing staff. R3 ' s care plan for activities states activities will invite, encourage & assist to daily activities. Facility Activity Policy dated September 2011 stated activities will be provided to enhance, enjoyment, memory, stimulation, and to provide a social interactions.	F 248		
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.	F 314		

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F 314	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess and stage pressure ulcers. The facility failed to notify the physician when wound characteristics changed, and the facility failed to reduce or eliminate pressure to a residents heel. This applies to three of four residents (R3, R7 , & R9) reviewed for pressure ulcers in the sample of 13. The findings include: 1. R3's current care plan for April 2015 documents a diagnosis of Lewy Body Dementia. The Physician notes from 5/22/14 documents a history of a left hip fracture and no surgical repair resulting in R3 being non-ambulatory. R3's 2/12/15 Minimum Data Set (MDS) shows R3 requires total care with activities of daily living. R3 is non-ambulatory and requires extensive assistance with mobility and repositioning. R3 has decreased range of motion to both lower extremities. R3's nurses notes of 3/25/15 documents an open left heel wound R3's current care plan for April 2015 relating to skin integrity shows the intervention to elevate R3's heels at all times. The weekly pressure ulcer sheet of 3/25/15 documents R3's wound is an unstable dark scab measuring 1.3x1.0 cm. On 4/4/15 the wound is described as a yellow (devitalized tissue) crater surrounded by pink and measures 0.8 cm x 0.8 cm. The 4/10/15 wound is beefy red with sanguineous (bloody) drainage and is 0.6 cm x 0.6cm. On 4/15/15 E2 documents the wound is 0.8 cm x 1.0 cm x 0.3 cm (depth) and has a yellow wound bed and is a Stage III.	F 314		

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F 314	Continued From page 3 On 4/15/15 at 9:30 AM, E2 was asked about R3's wound now having devitalized tissue and drainage. E2 assessed R3's wound and notified Z1 of pressure ulcer progression. Z1 changed the treatment to a debriding agent (Santyl). On 4/17/15 at 11:00 AM, Z1 was at facility and assessed R3's wound. On 4/17/15 at 1:30 PM, E2 was asked to provide the asessment documentation from Z1 and said there was no documentation available. On 4/14/15, R3's left heel was observed to be resting directly on a folded blanket at 9:45 AM and at frequent intervals until 12:25 PM. On 4/16/15 at 8:45 AM, E9 (LPN) performed R3's dressing change and asked R3 if she was having pain and R3 answered "yes". E9 did not offer or give R3 any pain medications. E9 did not cleanse R3's wound, she applied Santyl (a debriding agent) on an absorbent padded dressing and covered the wound bed. The debriding agent was in contact with the peri wound skin. (Healthy Tissue) On 4/17/15 at 11:30 AM, Z1 stated that she prefer that debriding ointment only be applied to wound bed because it is a debriding agent and it can cause damage to good skin tissue. On 4/15/15 at 1:50 PM, E2 (Director of Nursing-DON) said that R3's pressure ulcer was a Stage 3 with slough. She said her expectation was that the staff would off load R3's heels at all times.and that she would expect that R3's left heel were off loaded at all times. 2. The MDS of 3/12/15 shows R7 was admitted on 10/26/12 with Dementia and a past medical history of a Stroke with hemiplegia. The MDS shows R7 requires extensive assist of 1 staff for bed mobility. R7 ' s Braden Scale (tool for determining pressure ulcer risk) dated 10/19/14, was 11 (high risk).	F 314		

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F 314	Continued From page 4 R7 ' s Care Plan dated 4/3/15, shows R7 had an open area on his left buttocks measuring 2 cm x 2 cm x 0.01 cm and an open area on his right buttocks measuring 0.5 cm x 1 cm. The facility ' s " Weekly Pressure Ulcer Sheet " dated 4/10/15, shows R7 had an open area on the left buttocks measuring 3.2 cm x 2.2 cm with " tan sludge. " (devitalized tissue) The document stages the pressure ulcer as a stage II. (NPUAP defines stage II as no slough present) The document also shows R7 had an open area on the right buttocks measuring 0.3 cm x 0.5 cm with pink tissue that was documented as a stage I pressure ulcer. (NPUAP defines a stage I as area of redness) On 4/15/15 at 9:22 AM, R7 ' s left buttocks had an open area measuring 1.5 cm x 1.0 cm. The wound bed was moist and 100% covered with a thin layer of white/yellowish tissue. (devitalized tissue/slough) No drainage or odors were present. R7 had a second open area on the right buttocks measuring 1cm x 1cm with 70 % granulation 30% yellow tissue. (slough) On 4/15/15 at 9:22 AM, E3 (Licensed Practical Nurse) stated, "The wound bed looked the same last week. " On 4/15/15 at 1:35 PM, E2 (Director of Nursing-DON) said that R7's wounds were being treated as a stage I and a stage II presure ulcer as the nurse assessed. (Inaccurate according to NPUAP guidleines for staging pressure ulcers.) No other assessments had been done after the nurses assessment. On 4/15/15 at 1:40 PM, E2 assessed the open area on R7 ' s left buttocks and stated, " I would consider that tissue slough, so it would be unstageable. The right one is open too, it would be at least a stage II. " On 4/15/15, E2 documented the wound on R7 ' s	F 314		

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F 314	Continued From page 5	F 314		

left buttocks as 1 cm x 1.6 cm with yellow tissue that is an unstageable pressure ulcer. E2 documented the open area on R7 ' s right buttocks as 1 cm x 1cm with yellow tissue that is an unstageable pressure ulcer.
On 4/17/15 at 11:30 AM, Z1 (Advanced Registered Nurse Practitioner) said she would assess a resident's pressure ulcers only if the nurses reported changes to her. Z1 said the nurses or (the DON) report changes to her. Everyone is basically assessing the wound, and no specific nurse does it. " I trust the nurse's assessments." Z1 stated "If a wound bed becomes covered in slough or a wound was changing for the worst, I would expect to be notified. The development of slough would change the course of treatment. "

3. R9 ' s face sheet documents she was admitted to the facility on 3/11/15 with four pressure ulcers. The pressure ulcers are on her coccyx, left buttocks, and both hips. On 4/3/15, a wound located on the left sacral area was identified as a Stage II pressure ulcer.

On 3/21/15, R9 was seen by Z2 (Medical Doctor-M.D.), no documentation of R9's wounds was written by Z2.

On 3/23/15 and 3/27/15, R9 was seen by Z1 (Advance Registered Nurse Practitioner-ARNP). No documentation of R9's wounds were written for these visits.
The facility pressure ulcer sheet of 4/9/15 shows R9's left hip pressure ulcer is not open and has a whitish colored center. On 4/16/15, E2 (DON), documented the wound as unstageable with yellowish/whitish center and slough versus maceration.

On 4/16/15 at 9:20 AM, R9 ' s left posterior hip ulcer was observed to be smaller than the size of a nickel and open with a white center.

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F 314	Continued From page 6 On 4/15/15 at 2:30 PM, E2 said the floor nurses do the daily wound treatments and will notify Z1 if there are changes or concerns. E2 said the physicians and nurse practitoner do not usually assess wounds unless they are asked to by the nurses. E2 stated wound assessments and documentation should be done at least weekly. E2 said the facility has no specific process for wound assessment and documentation at this time.	F 314		