STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145972	A. BUILDING _____ B. WING _____	C 08/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE COR MARIAE CENTER	**3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114**

(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 Complaint investigation survey #1413326/IL71145	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 avoid friction and shearing forces when repositioning residents. This contributed to the development of sacral/coccyx pressure ulcers to 2 residents at risk for skin breakdown. This applies to 2 of 3 residents (R1, R2) reviewed for pressure sores in the sample of 3. The findings include: 1. R1's admission assessment dated 7/8/14 shows R1 is a large male requiring extensive assist with bed mobility, transfers, and tolieting. He is 6 foot 5 and weighs 354 lbs and is totally dependent on staff for activities of daily living. During care provided on 08/5/14 at 945 AM, E4 and E5 (both Certified Nursing Assistants- CNAs) used a piece of nylon fabric pulling it forcefully up and towards the edge of the bed to reposition R1. On 8/5/14 at 9:30 AM, E2 (Registered Nurse- RN)	F 314		

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

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F 314	Continued From page 1 said the use of the repositiong device was not being used correctly. They should have used 2 pieces of nylon fabric one on top of the other. The 2 pieces of fabric slide against each other reducing friction and shearing. On 08/06/14 at 815 AM, E5 and E6 (both CNA's) were repositioning R1. They did not use the nylon repositioning device on R1. E5 and E6 used a cloth incontinent bed pad which was under R1 ' s buttocks. E6 grabbed the edge of the pad and pulled forcefully up towards the edge of the bed. E1 (Director of Nursing- D.O.N.) was interviewed on 8/6/2014 at 10:00 AM about the repositioning of R1 and stated that they were inserviced on the use of the nylon pad and should have used it for R1. The 7/8/2014 admission assessment showed no skin break down for R1. The nurses notes dated 07/18/14 show R1 had shearing to the right buttock. The wound care physician would be contacted. The wound care note dated 7/29/14 showed R1 had shearing to the right and left buttock measuring 4.7 x 5.8 x 0.1 cm that was sustatined during transfer with a changing pad. The care plan of 7/21/14 showed R1 is at high risk for pressure ulcers. The plan says, "Use lift sheet/slip sheet to reposition to decrease friction and shear. 2. The August Physician Order Sheet for R2 lists diagnoses to include Cerebral Vascular Accident, Diabetes Mellitus, and Hypertension. The Minimum Data Set (MDS) on 7/3/2014 shows that R2 requires extensive assist of one person for bed mobility and transfers. R2 ' s skin risk Care Plan dated 5/19/2014 includes the intervention to use a lift sheet/slip	F 314		

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F 314	Continued From page 2 sheet to reposition, decrease friction and shear. R2 ' s Care Plan dated 6/27/2014 for pressure ulcers includes the approach to use two persons to assist with repositioning to avoid skin friction/shearing. On 8/6/2014 at 10:00 AM, E7 (Certified Nursing Assistant- CNA) was observed repositioning R2 in bed. R2 was lying on a cloth incontinence pad, E7 grabbed the edges of the incontinence pad and pulled the incontinence pad under R2 ' s buttocks forcefully up and towards the edge of the bed. R2 was wearing a wet incontinence brief. On 8/6/2014 at 10:30 AM, E6 (Registered Nurse-RN) said, the staff are to be using a nylon repositioning device designed to prevent friction and shearing. On 5/5/2014 the nursing admission assessment for R2 documents no skin breakdown. The physician progress notes show from 6/9/2014-7/3/2014 R2 had right buttock shearing and excoriation. The coccyx wound assessment dated 7/3/2014 documents the coccyx is now unstageable. The RD (Registered Dietician) progress note dated 7/11/2014 showed coccyx (wound) noted to have worsened measuring 2.0 x 2.5 x unknown. A new right heel wound measuring 8 x 3.0 x unknown. On 7/15/2014, Z2 showed the coccyx pressure ulcer is unstageable. The right lateral ankle wound is now unstageable measuring 1.5 x 1.0. On 7/18/2014 E3 (Registered Nurse- Wound Care Certified) shows, resident continues with unstageable pressure ulcer to the right lateral ankle that was facility acquired. On 7/25/2014 the physician wound care assessment shows facility acquired pressure ulcer unstageable on the coccyx measuring 1.80 x 2.40 x unknown depth.	F 314		

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F 314	Continued From page 3 On 8/6/2014 at 10:30 AM, E6 (Registered Nurse-RN) said, the staff are to be using a nylon repositioning device designed to prevent friction and shearing.	F 314		