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F 000	INITIAL COMMENTS	F 000		
F 221 SS=D	Annual Licensure and Certification Survey 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess the need to use a safety belt as a physical restraint. This applies to 1 of 2 residents(R15) reviewed for restraints in the sample of 15. The findings include: R15's Face sheet shows R15's diagnoses include Dementia with behavioral disturbances, Anxiety and Agitation. R15's Minimum Data Sheet (MDS) assessment of 12/9/13 shows that R15 has severe cognitive impairment. R15 requires extensive assistance of one person for transfers. On 1/14/14 at 10:30 AM , R15 repeatedly tried to get out of his wheelchair. R15 was wearing a waist belt that prevented him from standing. On 1/14/14 at 10:30 AM, E8(Restorative Nurse) said if a resident is able to release the belt on command it is not a restraint and we do not do a	F 221		

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

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F 221	Continued From page 1	F 221		

restraint assessment.

On 1/15/14 at 8:40 AM, R15 was observed sitting in his wheelchair in the common area near south hall. R15 was wearing a waist belt. E6 (Licensed Practical Nurse -LPN) said R15 wears the belt for safety. E6 asked R15 to remove the belt. R15 did not respond, did not move, and did not attempt to remove the belt. E6 said he can remove it when he is agitated.

On the same day at 9:05 AM, E5 (CNA) said if we ask R15 to remove the seatbelt he is usually not able to do it. E5 asked R15 to remove seatbelt, R15 did not comprehend what he was being asked to do.

At 1:05 PM, Z1(CNA) was observed struggling with R15 to apply the seatbelt. R15 kept on grabbing and twisting Z1's hands. Z1 said you need this on so you won't get up. Z1 said " He is a handful". I was trying to lay him down but he won't stay in bed. E5 (CNA) entered the room and tried to help apply the belt on R15. E5 kept repeating to R15," you need this on for your safety".

R15's Nursing notes dated 12/3/13 document that R15 is not able to understand teaching due to his advanced dementia.

R15's Nursing notes dated 12/4/13 documents that R15 was found on floor in the bistro area with an overturned table.

R15's Nursing notes dated 12/6/13 shows that a safety belt was applied for repeated attempts to stand.

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F 221	Continued From page 2 R15's Care plan dated 12/6/13 for fall risk showed an intervention for non-restraint safety belt when up in his wheelchair. An Incident report dated 12/10/13 at 7:15 AM shows that R15 was found on the floor of his room. On 1/15/14 at 2:00 PM,E2 (DON) said, we don't have policy on restraints, we only apply safety belts if the resident can remove them.	F 221		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that an incontinent resident was toileted every 2 hours. The facility also failed to provide thorough perineal cleansing following an incontinent episode. This applies to 2 of 6 residents (R24, R9) reviewed for incontinence in a sample of 15. The findings include: 1. The Physician ' s Order Sheet dated 1/2014 shows that R24 has diagnoses including Dementia and Diabetes Mellitus. The Minimum Data Set of 12/12/13 shows that R24 requires extensive assist of 1 staff for toileting. This same document also shows that	F 312		

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R24 is frequently incontinent of bladder and occasionally incontinent of bowel.
On 1/14/14 R24 was observed multiple times between 7:45 AM and 1:05 PM. R24 was moved between the activity lounge, the dining room, therapy room and finally to his room. R24 was not taken to the bathroom during this time. At 1:05 PM, E11 (CNA) was asked if R24 ever used the toilet. E11 stated, " He can ... " E11 then assisted R24 to transfer from the wheelchair to the bed. R24 ' s adult diaper was heavy and saturated with urine. R24 had deep creases on his buttocks and his buttocks and scrotum were slightly reddened. E11 wet a washcloth in a basin of soapy water and washed R24 ' s perineal area. Without drying the area, E11 applied a clean adult diaper.
On 1/15/14 at 3:40 PM, E3 (DON) stated, " The expectation is that the residents are toileted approximately every 2 hours. "
The policy entitled Perineal Care dated January 2002 states, " Dry area (perineum) thoroughly. "

2. On 1/14/14 at 9:45 AM, E9 and E10 (Certified Nursing Assistants - CNA) were giving R9 a bed bath. E9 removed R9 ' s soiled incontinence brief and turned R9 onto her side. E10 washed the buttocks and rectal area, and reached between R9 ' s thighs with the washcloth to wipe the outer labia area. After drying the skin, E10 positioned a clean incontinence brief on R9 and turned her onto her back. E9 secured the brief and proceeded to finish dressing R9. The front perinea area, abdominal creases and groin areas were not washed during the bed bath.
On 1/14/14 at 10:15 AM, E10 was asked about cleaning of the front perinea area, abdominal creases and groin area during the bath. E10 stated she felt those areas were cleaned when, "

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F 312	Continued From page 4 I reached through from the back to wash her front " . On 1/14/14 at 1:15 PM E4 (Assistant Director of Nursing - ADON) stated proper peri care would include washing the front side of a resident ' s groin, abdominal creases and labia. R9 is a 92 year old female with a history of Cerebral Vascular Accident, Anxiety, Dementia and left sided weakness. R9 is aphasic and receives total food and fluid requirements through a gastric tube. R9 ' s care plan dated 9/13 states R9 has functional incontinence related to a Cerebral Vascular Accident. The Minimum Data Set of 9/13 shows R9 to totally dependent on staff for hygiene and toileting. The facility policy for Perineal Care dated 2002 states for a female resident to first wash the perineal area wiping from front to back, separate the labia and wash area downward from front to back. Then assist the resident to turn on her side and wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks.	F 312		
F 314 SS=G	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	F 314		

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F 314	Continued From page 5 by: Based on observation, interview and record review the facility failed to identify a pressure ulcer prior to progressing to Unstageable. The facility failed to identify the resident ' s risk and predisposing factors, and put interventions in place to reduce the resident's potential to develop pressure ulcers. These failures resulted in R55 developing an unstageable pressure ulcer. This applies to 1 of 3 residents (R55) reviewed for pressure ulcers in the sample of 15. The findings include: The Physician Order Sheet shows R55 was admitted to the facility on 10/29/13 with diagnoses to include: GI Bleed, Hyponatremia, Anemia. The skin assessment for R55 dated 10/30/13 states, " Bottom is intact, without redness or breakdown " . The Nursing note on 11/9/13 at 9:20 PM for R55 states, " Patient noted to have a pressure ulcer on coccyx; open skin with yellow drainage, surrounding skin red and non-bleachable, skin crease between buttocks is also red with open skin. 5 x 5 aqua cell dressing applied " . No wound measurements or staging was documented. On 11/10/13 the nursing notes for R55 states " New order - utilize aqua cell dressing and barrier cream to coccyx, keep off coccyx as much as possible, utilize foam or air cushion when in chair." No wound assessment was documented. The Wound Summary document for R55 shows a wound assessment was initiated on 11/12/13. (3 days after the wound was found). The wound on 11/12/13 measured 7.00 cm x 3.5 cm x 0.10cm. The tissue is identified as Granulation tissue - bright red 40% with moderate serous exudate. The PUSH score was 16 and it was listed as Unstageable and facility acquired.	F 314		

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F 314	Continued From page 6 The Wound Care specialist Initial Evaluation completed by Z3 (Wound Physician) on 11/12/13 documents the wound size is 7.0 cm x 3.5 cm with 30% thick adherent devitalized necrotic tissue. Z3 documents, "The wound is acquired in house, likely started off as moisture associated breakdown due to increased loose stools last week per staff." Z3 performed surgical excisional debridement of the tissure to remove necrotic tissue and establish the margins of viable tissue. The November 2013 treatment record shows by nurse initials that skin checks for R55 were performed daily. No exception charting regarding R55's coccyx was found in the medical record prior to 11/9/13. On 1/15/14 at 1:15 PM, E2 (Director of Nurses) states the nursing staff chart by exception, meaning if there is something unusual or abnormal it should be recorded. R55 ' s care plan dated 11/13/13 states R55 acquired an unstageable pressure ulcer to the coccyx identified on 11/12/13. The risk factors and predisposing factors for R55 are not identified. Pressure relief interventions were not identified or intiated prior to 11/8/13. The Minimum Data Set of 11/5/13 shows R55 requires staff assistance for bed mobility and transfer, hygiene and toileting. R55 was identified as occasionally incontinent of bowel and uses a urinary catheter. R55 was assessed as being at risk to develop pressure ulcers, and did not have any unhealed pressure ulcers on admission. The Skin and Ulcer treatments included a turning and repositioning program.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to position and secure a resident ' s urinary catheter and drainage tubing to avoid tension and failed to assess and monitor skin irritation related to urinary catheter use. This applies to 2 of 3 residents (R55, R7) reviewed for urinary catheters in the sample of 15.
The findings include:
The Physician Order Sheet shows R55 was admitted to the facility on 10/29/13 with diagnoses to include: GI Bleed, Hypnatremia and Anemia.
The nursing note for R55 dated 10/30/13 shows a urinary catheter was inserted after the resident complained of abdominal pain and distention. A 1600 ml urine return was obtained. The nursing note does not identify any skin irritation at the catheter-urethral junction.
The nursing note dated 11/8/13 at 12:19 PM for R55 states, " Urinary catheter discontinued per order. New 16 Fr. Catheter inserted. Nurse Practitioner notified of purulent drainage and scant blood from penis. " An antibiotic was prescribed. No additional skin assessment was available.
The nursing note dated 11/9/13 at 2:58 PM for

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R55 states, " Patient has a reddened glans penis, with small amount of exudate noted at the urethral opening. " The nursing noted for R55 dated 11/9/13 at 7:57 PM, states, " Reddened glans penis, with small amount of exudate noted at the urethral opening. "
The next nursing note related to the penis is recorded on 11/14/13 at 9:30 PM for R55 and states, " Reddened glans penis, no exudate from urethral opening noted this shift. "
The November 2013 treatment record shows skin checks were performed daily. Other than the 4 entries list previously no assessment is documented regarding the penis and catheter.
On 1/15/14 at 1:15 PM, E2 (Director of Nurses) states the nursing staff chart by exception, meaning if there is something unusual or abnormal it should be recorded.
The physician note dated 11/30/13 documents R55 had received recent antibiotic for urethritis. No additional information is recorded regarding penile skin irritation.
On 1/15/14 at 11:15 AM, E6 (Licensed Practical Nurse - LPN) provided catheter care for R55. E6 opened the incontinence brief on R55 and a pungent odor was noted from the perineal area. The catheter was pulled tight under the edge of the incontinence brief. The catheter was not secured to R55 ' s thigh to prevent tension and the drainage tubing was coiled outside the brief on his lap before the tubing was threaded through the leg of his pants. The glans penis was swollen and very sensitive to touch. R55 winched when E6 picked up the catheter to relieve the tension. The urethral opening was abnormally large, approximately 1 inch in diameter. The catheter did not come out through the tip of the penis, but rather from the side of the glans. E6 stated, he was not sure what caused the unusually large

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opening or how long it has been this way. E6 stated catheter care was the only current treatment.
The Nurse Practitioner notes dated 11/8/13 at 9:AM to offer lidocaine gel 5% to tip of penis three times a day for comfort. The Nurse Practitioner on 1/7/14 ordered a follow up appointment with Urology ASAP related to the trauma wound to penis.
R55 ' s care plan dated 10/29/13 states to secure the catheter and drainage tubing to the thigh, and perform catheter care. The plan does not identify or list interventions to address R55 ' s skin irritation/wound at the catheter-urethral junction.
The facility policy dated 8/3/10 states to properly secure the indwelling catheter after insertion to prevent movement and urethral traction. The policy for Perineal care dated 2002 states after completion of catheter care any discharge, odor, bleeding, skin care problems or irritation, complaints of pain or discomfort should be recorded in the resident medical record. The policy states any problems noted at the catheter-urethral junction during perineal care such as drainage redness, bleeding, irritation, crusting or pain should be documented.
2. The January 2014 Physician's Order Sheet showed R7 has diagnoses to include: Urinary Tract Infection (UTI), Benign Prostatic Hyperplasia (BPH), Anxiety and Left-sided Cerebrovascular Accident.

The Minimum Data Set (MDS) assessment reference date of 12/6/13 documents R7 has a indwelling catheter. The assessment shows R7 is continent of bowel and requires extensive assistance of 1 staff for transferring, dressing and toilet use.

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F 315	Continued From page 10 R7's Physician's Progress Note dated 9/6/2013, Z2 (Nurse Practioner) documents, "Pain at head of penis due to frequent tears from foley being pulled. UPDATE: R7 was seen today for UTI and increased weakness." The note further documents, R7's urine culture report showed a large amount of E. Coli (fecal) contamination that required invasive administration (IM-Intramuscular or IV- Intravenous). R7's current skin integrity care plan showed a problem of incontinence of BM (bowel movement) at times and skin tear to penis. The approaches include: "Monitor skin tear to penis for further damage. The care plan does not address the origin of the skin tears to the penis, how to prevent further occurence nor does it show the indwelling catheter as a possible risk factor. On 1/14/14 at 2:15pm E13 (LPN) verified R7's catheter was not anchored. E12 (CNA) said, "Some days [R7] has it [catheter secured] and some days he doesn't."	F 315		
F 441 SS=E	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;	F 441		

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F 441	Continued From page 11 (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. (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 verify the infectious status of a residents wound. The facility failed to provide hand hygiene to residents before eating, and failed to ensure resident care equipment was dedicated to residents in isolation. This applies to to 3 of 13 residents (R26, R24, R10) reviewed for infection control practices in the sample of 15 and 4 residents (R23, R33, R57, R60) in the supplemental sample.	F 441		

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The findings include:

1. R26's Face Sheet shows his diagnoses include Sacral Decubitus. The same sheet shows that R26 was readmitted to the facility on 1/7/14.

The hospital microbiology report of 1/4/14 documents MRSA (methicillin resistant staphylococcus aurous) of the coccyx wound. (3 days prior to discharge)

R26's Nursing Admission Note of 1/8/14 documents that R26 returned from the hospital with the following areas of concern: stage II pressure ulcer to the coccyx 2.8 x 1.6 x 1 cm. No documentation was written to indicate the presence of MRSA or colonization.

R26's January, 2014 treatment record shows a treatment order initiated on 1/10/13 to cleanse the coccyx with normal saline and apply a foam dressing.

On 1/14/14 R26's treatment record shows a new order to cleanse the wound with normal saline, apply Santyl (enzymatic debrider for dead tissue) and cover with a foam dressing daily.
The Wound Care Consult Note of 1/14/14 documents that R26's coccyx wound is now a stage III, with light serous drainage.

R26's Risk for Impaired Skin Integrity dated 1/10/14 does not document R26's history of MRSA of the coccyx wound or ongoing monitoring for signs and symptoms of infection.

On 1/14/14 at 1:30 PM, E7 (Licensed Practical Nurse) said that R26 was on an antibiotic for

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	145972	A. BUILDING _____ B. WING _____	01/16/2014

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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 441	Continued From page 13	F 441		

Sepsis and not MRSA of the wound. E7 (LPN) said that another nurse confirmed this, and that E4 (Assistant Director of Nursing) would know about it.

On 1/14/14 at 2:15 PM, E4 (ADON) said that when R26 returned from the hospital he was on an antibiotic for a Urinary Tract Infection and not for MRSA. Someone made an assumption. When I reviewed the chart R28 did not have an order for MRSA treatment and no diagnoses related to MRSA.

According to the facility policy and procedure for Contact Precautions, the facility will assess the following areas to decide if Contact Precautions are indicated:

The condition of infection versus colonization with ARM. (Antibiotic Resistant Organism)
The site of infection or colonization with an ARM.
The ability to contain drainage or feces from a site that harbors an ARM.
The ability to contain drainage, excretions or secretions from a site infected with any organism.

R26 was observed 1/13/14 at 12:30 PM in his bed. No isolation supplies were observed in or near R26's room.
2. On 1/14/14 a sign on the door of Room 26 shows that R24 is currently on Contact Isolation Precautions.
On 1/14/14 at 1:05 PM, E11 (CNA) applied his gait belt around R24 ' s waist and assisted him to transfer into bed. E11 then removed the gait belt and put it in the pocket of his uniform pants. After completing care with R24, E11 left the room with the gait belt and proceeded to provide care for other residents.

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 _____	01/16/2014

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PRESENCE COR MARIAE CENTER	3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114

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F 441	Continued From page 14 On 1/15/14 at 9:00 AM, E4 (ADON) stated, " They should have designated equipment for that room that is left in that room. " The facility policy entitled Infection Control and dated 8/21/13 states, " Dedicate resident-care equipment and items such as thermometers, stethoscopes .... to the use of a single resident. If equipment is to be shared, it must be cleaned and disinfected before use by another resident. " 3. On 1/13/14 at 2:50 PM, a resident group activity was observed in the lounge. E14 (Activity Aide) was playing (beach) ball toss with the residents. Each resident was tossed the ball and attempted to catch it and throw it back to E14. Several times the ball bounced on the floor and rolled about in the lounge. Prior to the ball toss activity, a game of bowling was played. Each resident handled the bowling ball and threw the ball in an attempt to knock over the bowling pins. Upon completion of the 2 ball activities, residents were escorted into the dining room for an afternoon snack. On 1/13/14 at 3:10 PM, R10, R23, R33, R57, and R60 were observed at a group table in the dining room eating chocolate chip cookies and drinks. E14 stated the residents had come from the lounge after the activity into the dining room for a cookie snack. E14 confirmed, the activity staff playing and each resident had had contact with the activity balls. E14 stated the resident hands were not washed after the activity and prior to eating cookies with their hands.	F 441		