STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146021	A. BUILDING _____ B. WING _____	C 07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATURE TRAIL HEALTH CARE CENTER	**1001 SOUTH 34TH STREET MOUNT VERNON, IL 62864**

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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	Complaint #1653577/IL86566 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the Care Plan for one resident (R1) out of 3 residents reviewed for Care Plan in a sample of 6. Findings Include: According to R1's Care Plan with Initiation date of 6/24/16 he has a stage 3 pressure ulcer to left buttock related to immobility and the goal is the pressure ulcer will show signs of healing and remain free from infection by/through the next review every 90 days with a target date of 8/11/16. Interventions include: LAL(Low Air Loss Mattress) and resident to lay down after each meal to offload pressure to buttock. 1.) On 6/29/16 at 10:35 AM and at 11:20 AM R1 was in the dining room at the table in his wheelchair with his eyes closed and head forward. On 6/29/16 at 11:30 AM E12 CNA(Certified Nursing Assistant) was questioned if she worked with R1 and she stated she was his regular CNA. When questioned E12 if R1 had been to bed or was going to bed E12 stated that	F 282		

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

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F 282	Continued From page 1 R1 had not been to bed yet but he wouldn't be going to bed this morning because it was almost lunch time now and there really wasn't enough time to lay him down. 2.) On 6/29/16 at 1:30 PM R1 was in bed on his LAL (Low Air Los Mattress) and between the resident and the mattress was a fitted sheet, flat sheet folded in half, blanket and 2 cloth incontinent pads and the LAL mattress was set on static not alternating pressure. On 6/30/16 at 11:35 am, R1 was in bed and between the LAL mattress and the resident was a fitted sheet, flat sheet, blanket, double flat sheet, blanket and an incontinent cloth pad at this time the LAL mattress was set on static not alternating pressure. On 6/30/16 at 11:45 am E12 CNA stated that they usually put R1 to bed like this after meals because he was only down in bed for short period usually only an hour. E12 confirmed she was the regular CNA for R1 on day shift. On 6/30/16 at 2:00 PM, E6 LPN(Licensed Practical Nurse) stated R1 should not have multiple layers on his LAL (low air loss mattress) and should be laid down after all meals. On 7/1/16 at 12:15 PM, Z2 (Manufacturer Representative) for LAL stated there should not be multiple layers of padding between the resident and the mattress of the LAL mattress or it defeats the purpose and can even be more detrimental to the resident because it actually makes the mattress harder rather than softer and if the resident is on the LAL mattress for a pressure area it should be put on alternating pressure not static.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 2	F 314		

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 follow the residents Care Plan, manufacture guidelines, policy and procedures and physician orders/recommendations to prevent pressure ulcers or the deterioration of pressure ulcers for one resident (R1) in the sample of 3 reviewed for pressure ulcer in a sample of 6.

Findings Include:

1.) On 6/29/16 at 10:35 AM and at 11:20 AM R1 was in the dining room at the table in his wheelchair with his eyes closed and head forward. On 6/29/16 at 11:30 AM E12 CNA(Certified Nursing Assistant) was questioned if she worked with R1 and she stated she was his regular CNA. When questioned E12 if R1 had been to bed or was going to bed E12 stated that R1 had not been to bed yet but he wouldn't be going to bed this morning because it was almost lunch time now and there really wasn't enough time to lay him down.

2.) On 6/29/16 at 1:30 PM R1 was in bed on his

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LAL (Low Air Los Mattress) and between the resident and the mattress was a fitted sheet, flat sheet folded in half, blank and 2 cloth incontinent pads and the LAL mattress was set on static not alternating pressure. On 6/30/16 at 11:35 am, R1 was in bed and between the LAL mattress and the resident was a fitted sheet, flat sheet, blanket, double flat sheet, blanket and an incontinent cloth pad at this time the LAL mattress was set on static not alternating pressure. On 6/30/16 at 11:45 am E12 CNA stated that they usually put R1 to bed like this after meals because he was only down in bed for short period usually only an hour. E12 confirmed she was the regular CNA for R1 on day shift.

On 6/30/16 at 2:00 PM, E6 LPN(Licensed Practical Nurse) stated R1 should not have multiple layers on his LAL (low air loss mattress) and should be laid down after all meals. On 7/1/16 at 12:15 PM, Z2 (Manufacturer Representative) for LAL stated there should not be multiple layers of padding between the resident and the mattress of the LAL mattress or it defeats the purpose and can even be more detrimental to the resident because it actually makes the mattress harder rather than softer and if the resident is on the LAL mattress for a pressure area it should be put on alternating pressure not static

3.) According to R1's communication note with Z2 (Primary Care Physician) dated 6/14/16 done per E6 LPN(Licensed Practical Nurse) she received orders to apply zinc barrier cream to buttock three times a day for abrasion to buttock.

4.) According to Head to Skin Checks dated 6/20/16 shows area red to right and left inner

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buttock with no measurement or other information signed by E6. According to E2 DON(Director of Nursing) she stated Z2 had seen R1 on this date and looked at the area and measured it. At this time (7/1/16 at 2:00 PM) E2 provide times line of R1 pressure areas.

5.) According to R1's time line provide by E2 on 7/1/16 on 6/20/16 R1's measurements to his buttock area were 5.4 cm x 4.2 cm x 0.5 cm.

6.) According to facility provided document titled Weekly Pressure Ulcer Log provided on 6/28/16 upon entrance for 6/25/16, R1's area is admitted with. According to corrected Weekly Pressure Ulcer Log with date of 6/25/16, R1's area is facility acquired.

7.) According to R1's communication order dated 6/22/16 shows to refer to Z1 wound specialist.

8.) According to Doctor's Progress Note done per Z1 on 6/23/16 shows recommendations to frequently reposition to reduce pressure to the affected area and low air loss mattress. According to weekly Pressure Ulcer Record dated 6/23/16 whom E6 stated was done by Z1 shows R1 to have on his right buttock a stage 3 pressure ulcer measuring 5.4 cm x 4.2 cm x 0.5 cm. It also indicates the area has deteriorated. Should be noted at this time there is no mention of escar to the area. According to same documents R1 has to his left inner buttock a stage 2 pressure ulcer measuring 1.5 x 1.7 x 0.1. It is designated as a new pressure ulcer

9.) On 6/29/16 at 12:50 PM, R1 was noted to have a stage 3 pressure ulcer to his right buttock his small amount of serousangineous drainage,

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pink to red around the edges with black escar around the inner aspect. The left inner buttock was noted to be pink around the edges with small amount of clear/yellow drainage with small amount of escar moving into left buttock area.

10.) On 7/1/16 at 2:15 PM, E6 stated R1 had a new pressure ulcer on his sacrum.

11.) According to R1's weekly Pressure Ulcer Record dated 7/1/16 shows R1 has an unstageable pressure ulcer to his sacrum that is 6 cm x 1.3 x 0. Shows area to sacrum with yellow wound bed, in the center there is a black area measuring 1.2 cm x 0.5 cm

12.) On 7/1/16 at 3:20 PM, Z3 (Primary Care Physician) stated she had only seen the area to R1's buttock on 6/20/16 and had referred in to Z1 the wound specialist. Z3 stated she had ordered a low air loss mattress to help prevent or at least help decrease risk of pressure ulcers to R1. Z3 stated it was very important that the staff at the facility follow the guidelines on the LAL mattress and be very diligent in following all of her directions in trying to keep R1 clean and dry, turned and repositioned and off his buttock as much as possible because R1 was already at such a high risk for pressure ulcers. Z3 stated that is why that is why she had recommended R1 be laid down after every meal. Z3 stated the pressure ulcers may not be totally prevented but if the staff followed orders and his plan of care it would certainly help prevent more or new pressure ulcers and not cause the one he has to progress any farther. Z3 stated when she had seen the area it was closed

13.) On 6/30/16 at 11:35 am, Z1 (Nurse

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Practitioner/Wound Specialist) stated she had seen R1 on 6/23/16 at at that time the area on his right buttock was a stage 3 pressure ulcer and the area on his left buttock was a stage 2 pressure ulcer. Z1 stated she did not know how the staff had classified R1's original area as an abrasion instead it was probably a stage 2 pressure area and that it had been caused by friction and shearing which is what caused a pressure ulcer. Z1 stated LAL mattress should not have multiple layers and defeats purpose of keeping pressure off the ulcerated area, which is why she and the primary care physician had both made sure this intervention was in place Z1 stated she felt R1's pressure ulcer could have been prevent from going to a stage 2 to a stage 3 because the staff knew he was already a very high risk individual and they should have been extra diligence making sure all his interventions were in place and done correctly according to his care plan. Z1 stated if the facility was doing the intervention according to the physician recommendation/orders and following the manufacture guideline for the LAL mattress and doing the plan of care correctly then Z1 should not be getting any further pressure ulcer either. Z1 stated when she first viewed the areas they were open.

14.) Review of R1's chart, nursing notes, wound notes, skin assessment notes show no evidence where staff identified when R1's area became open from 6/20/16 to 6/23/16.

15.) On 7/1/16 at 3:00 PM E2 and E6 both stated they could not find any documentation where their staff had identified R1's areas to his left and right buttock being open. E6 stated the area was noted as open when it was assessed by Z1 on

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F 314	Continued From page 7 6/23/16 at 4:02 PM. Last time area was documented as closed was when area was assessed by Z3 on 6/20/16 at 4:01 PM 16.) According to the facility document titled Wound Assessment dated 7/10/15 shows a thorough wound assessment should consist of objective criteria and measurements that promote accurate, consistent comparisons to determine the extent of the wound and the effectiveness of wound healing. You should complete a comprehensive wound assessment during every dressing change, and compare the results to previous assessments so that you can monitor, communicate, treat, and document wound healing progression or complications.	F 314		