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PINECREST MANOR	**414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054**

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F 000	INITIAL COMMENTS Annual licensure and certification survey Validation Survey for Subpart U: Alzheimers Unit Pinecrest Manor is in substantial compliance with Subpart U, 77 Illinois Administration Code 300.7000.	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 identify a pressure ulcer before it was an unstageable wound and failed to document weekly measurements and assessments. The facility failed to seek a change in treatments for wounds showing no signs of progress toward healing. This applies to 2 of 6 residents (R10,R16) reviewed for pressure ulcers in the sample of 22. The findings include: 1. The chart face sheet for R16 documents she was admitted to the facility on June 30, 2015. The admission MDS (Minimum Data Set) documents R16 to have multiple diagnoses including Alzheimer ' s disease and dementia.	F 314		3/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/22/2016

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F 314	Continued From page 1 The MDS documents R16 to have no skin issues and requires extensive assistance with two persons for bed mobility and transfers. The December 9, 2015 quarterly MDS documents R16 to have a BIMS (Brief Interview for Mental Status) score of 5 (severe cognitive impairment). R16's July 16, 2015 Braden Scale for predicting pressure sore risk score was 16 (low risk for pressure ulcer). On February 4, 2016 at 8:45 AM, E4 LPN (Licensed Practical Nurse) stated upon admission each resident has a full skin assessment. E4 said after the initial assessment if the resident is at a low risk for pressure ulcers the aides will do the skin check.The nurse will perform skin checks for the residents at high risk for pressure ulcer development. E4 said (R16) was at a low risk for pressure ulcers so the nurse's aides would have done the weekly assessments. On February 4, 2016 at 9:45, E6 CNA (Certified Nursing Assistant) stated (R16) was a stand lift transfer with two people. E6 said a full skin check is done on residents during their shower. E6 said (R16) is a weekly shower on Tuesday evening. E6 said (R16) would use her feet and her hands to propel herself in the hallway. On February 4, 2016 at 9:00 AM, E4 said (R16) began ambulating with physical therapy after she was admitted and she had hard inserts in her shoes. E4 stated in her opinion the hard inserts were the cause of skin breakdown for (R16). The August 22, 2015 skin assessment form documents an unstageable wound measuring 2.5 cm x 2.3 cm with necrotic/Eschar (blackened dead tissue). The nurses note document the wound is located on the right medial heel. On February 4, 2016 at 9:00 AM, E4 stated the new open area was reported to E2 DON (Director of Nurses) and she makes recommendations for	F 314		

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treatments. E4 could not recall if the wound was a blister prior to becoming unstageable. No documentation was located identifying the area as a blister. E4 stated E2 advised her to use a Betadine swab and dress the wound.
On February 4, 2016 at 9:00 AM, E4 stated she would expect the nurses to assess and measure the wound weekly and document their findings. E4 said the documentation should include any drainage, tissue type and appearance of the wound. The weekly wound assessments for October 16, 2015 document the wound remains at 2.5 cm (centimeters) x 2.0 cm and is blackened. The next documented skin assessment of November 6, 2015 stated, " unable to measure wound." The November 13, 2015 skin assessment form documents an approximation of the wound. The November 21, 2015 assessment documents measurements unknown- approximately a little smaller than the size of a quarter. The December 6 and 11th assessments do not document measurements.
On February 4, 2016 at 9:30 AM, E5 stated all pressure areas are measured by width and length, and the facility has tape measures and wound measurement tools available. The December 19, 2015 skin assessment is documented to be 3 cm around.
The August 2015 POS (Physician order sheet) documents an order for betadine wipe, and then cover with gauze/kling-change daily and as needed. The physician orders showed no further treatments had been ordered for the heel.
On February 4, 2016 at 9:00 AM, E5 RN (Registered Nurse) removed the gauze dressing from R16's right foot. The right heel had a quarter size very dry raised blackened area. A sign above R16's bed dated August 22, 2015 reads for heels to be floated when the boot is not

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applied. E6 stated the sign was put up after the wound had appeared.
On February 4, 2016 at 9:00 AM, E5 stated the wound was probably caused by pressure from not having her heels floated. E5 said the treatment for the wound (betadine swab) has not been changed. It is the original treatment from August 2015.
On February 4, 2016 at 9:00 AM, E4 stated if a wound is not healing or showing signs of improvement she would notify the doctor, otherwise the doctor does not assess the wounds unless the staff request. E4 said when the wound first appeared it was flat with the skin and blackened.
On February 4, 2016 at 10:30 AM, E2 stated the wounds should be assessed weekly with measurements and assessment. E2 stated she consults with each new open wound and recommends a treatment. E2 states if a wound is not healing or showing signs of progress then she would call the physician. E2 stated R16's wound is healing, though the assessment for the wound measurements show little reduction in size over 4 months and the bed of the wound remains blackened.
The facility ' s undated Pressure Ulcer Prevention policy documents the goal to ensure that a resident who is admitted to the facility without a pressure ulcer does not develop a pressure ulcer, and a resident who has a pressure ulcer receives care and services to promote healing
.....Evaluation of treatment regimens for existing pressure ulcers for effectiveness/response and any recommendations for treatment regimen changes shall occur at least monthly.

2. On February 4, 2016 at 10:00 AM, E3 DON (Director of Nursing) changed the dressing on

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R10's left heel. The wound was approximately 1.0 x 0.6 x 0 cm. The wound bed was pink with irregular borders.
On February 3, 2016 at 2:30 PM E2 said, on December 16, 2015 a blister was idenfied on R10's left outer heel. R10 had a bump in her shoe that caused the blister. E2 covered the bump to having a cushion with a smooth/slippery surface to reduce pressure and friction. E2 said a change in foot wear may decrease (R10's) mobility. On February 4, 2016 at 3:30 PM, E1 Administrator, and E2 said they don't consider a blister a stage 2 pressure ulcer, and therefore did not do weekly skin checks.
On February 5, 2016 at 9:35 AM, E2 said, if the wounds don't improve I make a recommendation for a new treatment and the physician either orders it or makes another decision. The physician will look at the wound if I ask him to.
On February 5, 2016 at 9:35 AM E2 said she would consider changing footwear if the wound did not improve.

The December 16, 2015 Skin Assessment form shows a blister was identified on December 16, 2015 on R10's left outer aspect of her heel. The dimensions were 3.0x3.5x0 cm. The description shows a blister formation with darker-colored fluid, intact. Treatment shows (a clear adhesive dressing) to the wound, and a (gel/tape) inside of the outer aspect of shoe at the heel. The January 13, 2016 Skin Assessment Form (28 days later) shows the exact same measurement, same treatment, and the description as, area is dark and intact." The January 27, 2016 (42 days from the start of the wound) Skin Assessment Form shows the dimensions of the wound to still be 3.0x3.5x0cm with description and treatment unchanged from last assessment.

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F 441 SS=D	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; (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.	F 441		3/5/16

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F 441	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to wash hands, change soiled gloves after providing care and before touching noncontaminated items to prevent the spread of infection. This applies to 3 residents (R2, R12 & R13) of 19 reviewed for infection control in the sample of 22. The findings include: 1. R13 has diagnoses to include a history of C-Diff (Clostridium Difficile) according to the POS (Physician Order Sheet) dated February 2016. According to the MDS (Minimum Data Set) dated January 21, 2016, R13 requires extensive physical assist (of staff) for the completion of personal hygiene. On February 2, 2016 at 12:07 PM, E7 and E8 CNA's (Certified Nursing Assistants) provided personal hygiene care to R13. E8 cleansed R13's perineal (peri) area. E8 went into the bathroom on two occasions during cares to retrieve more supplies. E8 also obtained a clean incontinent brief, placed it on the bed and touched the inside of the brief to open it while wearing the soiled gloves. After completing the cleansing of R13's genitalia, E8 (still wearing the soiled gloves) touched R13's body, bed and bed linens to assist in turning him to allow E7 to provide peri care to his buttock region. Once R13 was turned to his left side, E8 handed E7 a clean washcloth wearing the soiled gloves. E7 began providing care and noted that R13 was passing gas and leaking liquid stool. E8, returned to the bathroom to retrieve and prepare more	F 441		

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washcloths for cleansing the stool. E8 touched the faucets, bathroom objects, clean wash cloths and retrieved the bed pan while wearing the gloves used to provide personal care. E7 cleansed the leaking stool and placed the bed pan under R13 to allow him to finish having a bowel movement. Both E7 and E8 (without removing the soiled gloves) positioned R13 in bed, touched pillows, bed linens, bed control buttons and other items in the room. Upon making R13 comfortable, E8 removed her gloves and left the room without washing her hands. E8 went directly to the West Dining Room (near kitchen area) and retrieved a rolling cart containing a meal tray for R24. At no time did E8 wash her hands.

On February 3, 2016 at 9:05 AM, E9 RN (Registered Nurse) stated staff are expected to wash their hands before and after providing care and always before leaving a resident's room. E9 said staff should change gloves (and wash hands) between tasks such as "after providing care and prior to touching any items in the room" to prevent cross contamination. E9 stated on February 2, 2016, R24 did receive a room tray for the lunch meal. On February 3, 2016 at 10:10 AM, E10 LPN (Licensed Practical Nurse) also stated R24 did receive a meal tray for lunch on February 2, 2016. On February 3, 2016 at 10:43 AM, E2 DON (Director of Nursing) stated gloves are to be removed and hands washed then new gloves applied after providing personal cares and prior to touching any linens or items in the room.

The facility policy titled Standard Precautions, revised May, 2013 showed gloves are to be changed "between tasks and procedures on the same resident after contact with material that

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may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments." The facility policy titled Hand Washing, dated July 30, 2007 showed "hands should be washed .... after handling items soiled with secretions/excretions (from wounds, urine, feces, etc.) ... and before and after donning gloves, changing dressings, obtaining specimens, providing catheter care (any procedure)." The facility policy titled Perineal Care, dated March 7, 2014 showed staff are to "remove gloves and wash hands" after providing peri care.

2. R12 is a resident with diagnoses to include legally blind to her left eye and macular degeneration according to the POS dated February, 2016.

On February 2, 2016 at 11:53 AM, E7 was observed assisting R12 with peri care after having a bowel movement on the commode. E7 wiped and washed R12's buttocks then pulled up a clean incontinent brief and R12's slacks. E7 assisted R12 to steady her self upon rising and ensured the wheeled walker was in reach of R12. During this time, E7 was wearing the gloves used to provide peri care. E7 assisted R12 out of the bathroom and then removed her gloves and washed her hands. At no time did E7 offer R12 the opportunity to wash her hands after using the commode.

R12's medical record showed her POA (Power of Attorney) had written a note dated August 7, 2015 requesting staff to "Be sure to wash (R12's)

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hands as often as possible and remind (R12) to wash her own hands after using the toilet."

3. The Minimum Data Set (MDS) of December 1, 2015 shows R2 is cognitively impaired, and requires extensive assistance with transfers, dressing, hygiene, bathing, and toileting.

On February 2, 2016 at 1:00 PM, E11 CNA pushed R2 into the bathroom. R2 used the assist bar to stand, and E11 helped R2 pivot to the toilet. E11 removed R2's pants, and soiled incontinence brief. E11 said R2 was incontinent of urine. R2 placed his hands between his legs in his groin area, and E11 asked him to move them so she could provide incontinence care. E11 cleaned R2's peri area, placed an incontinence brief, and transferred him to his wheelchair. E11transferred R2 to the recliner, and covered him with a blanket. E11 did not offer to wash R2's hands after toileting, and did not ask R2 if he would like to wash his hands.

On February 4, 2016 at 2:40 PM, E3 (Assistant Director of Nursing-ADON) said staff should offer to wash residents' hands after toileting, or should wash a resident's hands after toileting if they need assistance.

The July 30, 2007 facility "Handwashing" policy states "Hands should be washed...after eating, coughing, sneezing, bathroom use..."