STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146101	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS HEALTH CENTER	4054 ALBRIGHT LANE ROCKFORD, IL 61103

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F 000	INITIAL COMMENTS	F 000		
F 314 SS=D	Annual Certification Survey 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	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 implement pressure reducing measures for a resident (R7) who is at high risk for skin breakdown by not repositioning and not applying pressure reducing devices on the heels.
This applies to 1 of 4 residents (R7) reviewed for pressure ulcers in the sample of 11.
The findings include:
On 9/8/14 at 12:10 PM, R7 was in bed on her back with the head of the bed elevated. On 9/8/14 at 1:20 PM, R7 was in bed on her back with the head of the bed flat and the lower part of her bed elevated, so the knees were bent with her heels directly resting on the mattress. On 9/8/14 at 2:20 PM, R7 was in bed on her back with the head of the bed flat and the lower part of her bed elevated, so the knees were bent with her heels directly resting on the mattress. R7 was in her bed, on her back from 7:50 AM until 11:35 AM on

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

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F 314	Continued From page 1	F 314		

9/9/14. On 9/9/14 at 7:50 AM, R7 ' s breakfast tray was brought to her room and put on her bedside table. R7 was in bed on her back sleeping with the head of the bed elevated and the lower part of her bed elevated, so the knees were bent with her heels resting directly on the mattress. R7 ' s cloth pressure relieving boots were on her chair that was in her room. On 9/9/14 at 7:55 AM, E4 (certified nursing assistant-CNA) entered R7 ' s room to feed her breakfast. On 9/9/14 at 8:45 AM, R7 was in bed on her back with the head of the bed elevated and the lower part of her bed elevated, so the knees were bent with her heels resting directly on the mattress. R7 ' s pressure relieving boots were on the chair. R7 was repeatedly yelling " Oh my god, I ' m afraid. " On 9/9/14 at 9:00 AM, E6 (CNA) went into R7 ' s room and turned on the radio and asked R7 what was wrong, R7 did not respond. E6 left the room and went and talked with E5 (registered nurse). R7 was in bed with the head of the bed elevated and the lower part of her bed elevated, so the knees were bent with her heels resting directly on the mattress. R7 ' s pressure relieving boots were in the chair. On 9/9/14 at 9:12 AM, E5 went into R7 ' s room and gave her morphine. R7 was in bed on her back with the head of the bed elevated and the lower part of her bed elevated, so the knees were bent with her heels resting directly on the mattress. R7 ' s pressure relieving boots were on the chair. On 9/9/14 at 10:00 AM, R7 was in bed on her back with the head of the bed elevated and the lower part of her bed elevated, so the knees were bent with her heels directly resting on the mattress. R7 ' s pressure relieving boots were in the chair. R7 was awake and playing with the blankets of her bed. R7 was no longer yelling. On 9/9/14 at 10:30 AM, E5 entered R7 ' s room and gave R7

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F 314	Continued From page 2	F 314		

her nutritional supplement. R7 was in bed on her back with the head of the bed elevated and the lower part of her bed elevated, so the knees were bent with her heels directly resting on the mattress. R7 ' s pressure relieving boots were in the chair. On 9/9/14 at 11:34 AM, E4 entered R7 ' s room and performed peri-care, turned her to the left side and pulled blankets up. R7 was calm and did not seem to be in pain while E4 performed care. R7 did not resist care. R7 ' s pressure relieving boots were still in her chair. On 9/9/14 at 8:45 AM, E4 stated " she usually eats in bed in her room, she has not been eating much lately. " On 9/9/14 at 9:04 AM, E4 said that she has been declining lately and has been yelling out on a daily basis. On 9/9/14 at 10:30, E5 said that R7 will not take her nutritional supplement if she is too worked up but when she calms down, she can usually get her to drink them. On 9/9/14 at 11:35 AM, E4 stated " I check her and turn her every two hours. I checked her before breakfast this morning. " E4 also stated " She does not have a preference to how she lays. " E4 was asked about R7 ' s pressure relieving boots and she stated " Sometimes we leave them off to air out during the day because she wears them all night. I can put them on if you want me to. " E4 said that R7 only gets up in the broda chair when her daughter comes to see her. On 9/10/14 at 11:10 AM, E9 (RN) said that she talked with E4 and she said that she checked R7 before breakfast (7:50 AM) and at 11:30, before lunch.
R7 ' s medication administration record dated 7/1/14 documents diagnoses include: right thalamic infarct, difficulty walking, weakness, Lupus, peripheral neuropathy and depression. R7 ' s physician ' s progress note dated 6/5/14 documents diagnoses of dementia and status

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post fracture of left ankle.
R7 ' s MDS dated 8/8/14 documents a BIMS score of 0 (severely impaired cognition). R7 had no rejection o f care behaviors exhibited. R7 is an extensive assist of one for bed mobility and an extensive assist of two for transfers. R7 is non-ambulatory. R7 is an extensive assist of one for dressing and eating. R7 requires total dependence for bathing. R7 has impairment of both sides of upper and lower extremities for Range of motion. R7 is always incontinent of bowel and bladder. R7 is at high risk for Pressure ulcers.
R7 ' s Braden skin assessment dated 8/8/18/14 shows that she is at great risk for skin breakdown. R7 ' s Nutrition risk assessment dated 8/18/14 documents R7 is at risk for pressure ulcers and shows a care plan goal to maintain good skin integrity. R7 ' s care plan dated 8/25/14 shows under the category Pressure ulcers: Preventative skin program. On the Preventative skin program sheet, R7 was identified as being high risk. Interventions for high risk include: pressure reducing mattress, reposition every two hours, apply supportive devices as indicated and peri-care after incontinence. R7 ' s treatment sheet dated 7/1/14 shows an order for " spenco boots (pressure relieving device) while in bed. " R7 ' s kardex dated 9/8/14 shows a supportive intervention as Spenco boots while in bed. R7 ' s kardex also shows to reposition every two hours with one assist. R7 is marked for high risk for skin break down on kardex. R7 ' s nursing notes showed no documentation of a refusal to turn or of increased agitation from turning.
The policy and procedure for Positioning revised 8/21/14 states " Resident who cannot reposition themselves will be repositioned by staff every two

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F 314	Continued From page 4 hours or per care plan. "	F 314		
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		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to wear gloves when administering IV antibiotic medication through Central Line. The facility failed to remove contaminated gloves after pericare.
This applies to 3 of 3 residents (R9, R7, R6) reviewed for infection control in the sample of 11.
The findings include:
1. Physician order sheet dated September 2014 shows R9 has been an antibiotic since August 5, 2014-Vancomycin-Intravenous-(IV) 1500 mg reconstitute to 500 milliliters of Normal Saline through Peripherally Inserted Central Catheter-(PICC line) administered daily. The same Physician Order Sheet shows R9 has diagnoses including Osteomyelitis- (Bone Infection.)
On 9/9/14 at 11:30 AM, E3-Registered Nurse was administering the IV antibiotic medication to R9. E3 was flushing the picc line of R9 without wearing gloves. After flushing the Picc line, E3 connected the tubing to the IV bag that contains the antibiotic. E3 ran the IV tubing thru the machine, programmed the machine and connected the other end of the IV tubing to R9 ' s PICC line. (All without gloves.)
E3 said I should have worn gloves when doing this.
On 9/10/14 at 10 AM, E2-(Director of nursing-DON) said, nurses should wear gloves when working with the picc line... flushing and or administering medications.
A document entitled The Nurses Infusion Manual for Long Term Care Facilities dated January 2004 states: Considerations,..4. Licensed nurses

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caring for residents receiving infusion therapies are expected to follow infection control ...Procedure, 6. Don Gloves.
2. On 9/9/14 at 11:34 E4 (certified nursing assistant-CNA) performed peri-care on R7. R7 had an incontinence brief on that was saturated with urine. E4 put gloves on and performed peri-care to R7. E4 applied an incontinence brief to R7. With E4 ' s contaminated gloves still on, E4 removed R7 ' s pants, turned her to her left side, pulled her blankets up and attached her call light. E4 then took the incontinence pad that was on her bed and the towels that she used and opened R7 ' s door to dispose of the linens in a basket that was outside of the room.
On 9/10/14 at 2:30 PM, E4 stated, " I should wash my hands after cleaning the front and then I would wash my hands and change my gloves after doing the back and before I touch everything. Sorry, I know I didn ' t do that. "
The facility ' s policy and procedure for handwashing revised on 8/2014 shows that all staff should wash hands: F. after handling used dressings, specimen containers, contaminated tissues, linen, etc., G. After contact with bodily fluids, blood, secretion, excretions, mucous membranes, or broken skin, H. After handling items potentially contaminated with a resident ' s blood, body fluids, excretions, or secretions.
3. The September 2014 Physician Order Sheet lists R6 ' s diagnoses to include Dementia, Osteoporosis, Valvular heart disease, Glaucoma, and Seizures.
On 9/08/2014 at 2:00 PM, E8 (Certified Nurses Assistant- CNA) placed R6 on the toilet. R6 urinated in the toilet. E8 provided peri-care to R6 and continued to pull pants up and put R6 into bed. E8 did not remove her gloves or wash hands after providing peri-care to R6.

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F 441	Continued From page 7 On 9/10/2014 at 1:00 PM, E7 said, " You wash your hands before you put gloves on then you do treatment (peri-care), change them (gloves) in between and wash hands. You can repeat this as needed and wash your hands at the end of the treatment (peri-care) " . The facility ' s handwashing policy dated 5/24/2001 shows, handwashing must be performed after contact with body fluids, blood, secretion, excretions, mucous membranes, or broken skin.	F 441		