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F 000	INITIAL COMMENTS Complaint 1576598/IL81902	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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by:
Based on observation, record review and interview, the facility failed to notify the physician of a significant weight change and pressure ulcer for one of four residents (R1) reviewed for physician notifications in the sample of four.

Findings Include:

1. R1's 12/2015 POS (Physician Order Sheet) documents R1 was admitted to the facility on 11/2/2015 and list the following Diagnoses: Right Great Toe Wound, Sacral Wound, and Coronary Artery Disease.

R1's Weights and Vitals Summary Report dated 12/7/15 documents the following weights: 11/5/2015 - 316 pounds (Mechanical Lift), 11/11/2015 - 315 pounds, 11/25/2015 - 274 pounds, 12/2/2015 - 260 pounds (Mechanical Lift)...12/2/2015: -17.7%, -56 pound change over 30 days.

R1's Progress Notes dated 12/2/2015 by Z4, Restorative Nurse documents, "(R1) reweighed today: Current weight by Mechanical Lift (usual mode of obtaining weight) is 260 pounds. Resident aware and will notify PCP (Primary Care Physician) for any further orders..." There is no documentation that R1's PCP was notified regarding R1's weight loss.

On 12/7/15 at 3:40 pm, Z4 stated, "I did not let (Z6 physician) know about (R1's) weight loss because (E10 LPN (Licensed Practical Nurse) said that (E10) was going to...I guess I should have clarified my documentation."

On 12/8/15 at 9:25 pm, Z2 NP (Z6's Nurse

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F 157	Continued From page 2 Practitioner) stated, "I do not see anything in (R1's) record that we were notified of (R1) having a 56 pound weight loss...I am at the facility doing rounds every week and nobody has verbally told me about his weight loss either... residents are only seen once a month unless we are informed of an problem, I will be seeing him again on 12/9/2015. (R1) was last seen on 11/11/2015." On 12/8/15 at 10:35 am, E7 Dietary Manager stated, "new admissions are to have their weights checked every week... (R1) was weighed after admission and the next week but then he refused to be weighed the following week, so we skipped a week and then weighed (R1)... I observed that (R1) had lost weight {41 pounds in 2 weeks} but the computer did not calculate that it was a significant weight change so (Z6) wasn't notified at that time...On 12/2/15 (R1) lost even more weight {14 pounds} and it was then that it was triggered as a significant weight change... (Z6) should have been notified of (R1's) weight loss." The facility's undated Nutrition/Hydration Reference documents, "Purpose: to monitor each resident's weight consistently and accurately in order to provide ongoing data to facilitate assessment of the resident' nutritional and medical status.... Specific Procedure/Requirements: III) New admissions and re-admissions will be weighed weekly for the first 4 weeks after admission unless otherwise ordered to ensure nutritional stability after admission...VII) In the event there is a significant weight variance that is validated by reweigh, the following actions will be taken by nursing: ... Notification of the physician if the weight change constitutes a significant weight change."	F 157		

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2. On 12/7/15 at 12:20 pm, E6 CNA (Certified Nursing Assistant) provided incontinent care to R1. R1 had been incontinent of stool. During Incontinent Care, R1 was noted to have a two open uncovered sores; one on the left buttocks and one on the coccyx. R1 stated, "I've had them a long time." E6 stated, "(R1) hasn't been on my wing for very long, maybe 5-6 days, but he has had these open areas ever since (R1) was moved over here, (R1) was really red in the groin and buttocks area, the groin is better but as you can see, this area {pointing to buttocks} is more of a purple now... I don't think the nurses ever apply a treatment, we {CNA's} just apply perigaurd {Zinc ointment}.

No documentation of physician notification of the open areas was found in R1's medical record.

On 12/8/15 at 8:57 am E3 stated, "around 7:00 am today I measured (R1's) wounds, they are both a stage III with slough in the wound bed, the left buttocks measures 1.4 cm (centimeters) by 1.5 cm by 0.1 cm, the one on the coccyx measures 1 cm by 2.5 cm by 0.1...last week, (E1) checked on (R1) and saw a blister on (R1's) left buttocks, that was dime size and intact...(Z6) was not notified last week on the blister because we did not consider it a pressure wound because it wasn't open...I updated (Z6) this morning on the pressure ulcers and weight loss."

On 12/8/15 at 9:25 am, Z2 confirmed that neither she or Z6's office were notified of R1's pressure ulcers on 12/7/15 and stated, "they should have called us yesterday on (R1's) wounds, we are very accessible."

The facility's undated Prevention of Pressure

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F 157	Continued From page 4 Ulcer Procedure documents, "notification of the physician is required when a new pressure ulcer is identified..." The facility's undated Condition Change of the Resident Procedure documents, "Purpose: to observe, record and report any condition change to the attending physician so proper treatment will be implemented" and documents guidelines of: document the date and time the condition change is identified, provide care and notify the physician and family.	F 157		
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, record review and interview, the facility failed to obtain and follow dietary recommendations for wound healing, and failed to identify, monitor and treat a newly acquired pressure ulcer per care plan pursuant to facility policy for two of three residents (R1, R3) reviewed for pressure ulcers in the sample of four. Findings Include:	F 314		

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F 314	Continued From page 5 1. R1's POS (Physician Order Sheet) dated 12/2015 documents R1 was admitted to the facility on 11/2/15 with the following Diagnoses: Coronary Artery Disease, Right Great Toe Wound, and Sacral Wound. This same POS documents the following orders, "Right Great Toe - Cleanse with Normal Saline, Apply Medihoney 2 by 2, cover with 4 by 4 and wrap with Kerlix daily; Sacral Wound - Clean with Normal Saline, apply Santyl..dressing daily." R1's Hospital Discharge Instructions dated 11/2/15 documents, "Right Foot Wound: cleanse with Saline, pat dry, wipe no sting skin barrier into skin around wound edge, cut Medihoney 2 by 2 to wound size and place in wound avoid overlapping Medihoney onto skin, cover with 4 by 4 and Kerlix daily; Wound to Sacrum x {times} 2 - cleanse with Saline, apply Santyl {debriding agent}, cover with Mepilex {foam dressing} dressing, change daily." R1's Skin Observation Tool dated 11/2/15 documents, "(R1) was admitted with a right great toe ulcer, also admitted with many open areas to buttocks." There were no wound measurements documented. R1's Predicting Pressure Sore Risk Assessment completed on 11/3/15, 11/17/15 and 12/1/15 documents, "moderate risk", and on 11/10/15 and 11/24/15 documents, "at risk." R1's Weekly Wound Evaluation dated 11/6/15{Four days post resident admission} documents, "right lateral 1st metatarsal, 100% slough tissue present, 1.7 cm by 3 cm by 0.1 cm." There is no documentation on R1's Sacral wounds.	F 314		

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F 314	Continued From page 6 R1's MDS (Minimum Data Set) dated 11/9/15 documents, "(R1) is alert and oriented, requires extensive assist of two staff for bed mobility and transfers, and has one unstageable pressure ulcer measuring 1.7 cm (centimeters) by 3.0 cm by 0.1 cm." R1's TAR's (Treatment Administration Record) dated 11/2015 documents the Sacral Wound treatment was discontinued on 11/6/2015. There was no documentation of an order to discontinue this treatment and still shows up as an active order on R1's 12/2015 POS. On 12/7/15 at 12:20 pm, E6 CNA (Certified Nursing Assistant) provided incontinent care to R1. During Incontinent Care, R1 was noted to have a two open uncovered sores; one on the left buttocks and one on the coccyx, both with slough covered wound bases. R1 stated, "I've had them a long time." E6 stated, "(R1) hasn't been on my wing for very long, maybe 5 to 6 days, but he has had these open areas ever since (R1) was moved over here, (R1) was really red in the groin and buttocks area, the groin is better but as you can see, this area {pointing to buttocks} is more of a purple now...I don't think the nurses ever apply a treatment, we {CNA's} just apply periguard {Zinc ointment}. On 12/7/15 at 1:55 pm, E3 QA (Quality Assurance)/Wound Nurse stated, "I know when (R1) was first admitted, we were putting Santyl on the wounds but changed to using Zinc Ointment because when I saw it {R1's buttocks on 12/6/15} there were no open areas with slough, the area was more of MASD (Moisture Associated skin Damage)... I did not do any measurements at that	F 314		

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time because there was no open areas, just red and macerated."

On 12/7/15 at 2:15 pm, E2 DON (Director of Nursing) and E3 observed the open areas to R1's buttock and coccyx and E3 stated, "those are definitely pressure related... I was not aware that (R1) had actual open areas, I will have to start my investigation on it... I will come back later and measure it, and put a dressing on them."

On 12/7/15 at 4:30pm, E3 stated, "I haven't been back into (R1's) room."

On 12/8/15 at 8:40 am, R1 stated, "(E3) never did come back yesterday, she came in early this am and looked at my butt then sent (E11 LPN) into put some ointment on it and a bandaid...the only thing anyone did yesterday was applied the same ointment to my butt that they have been."

On 12/8/15 at 8:57 am, E3 stated, "around 7:00 am today I measured (R1's) wounds, they are both a stage III, due to having slough in the wound bed, the left buttocks measures 1.4 cm by 1.5 cm by 0.1 cm, the one on the coccyx measures 1 cm by 2.5 cm by 0.1... last week, (E2) checked on (R1) and saw a blister on (R1's) left buttocks, that was dime size and intact...(Z6 R1's Physician) was not notified last week on the blister because we did not consider it pressure related, we continued to use Zinc ointment to it... I updated (Z6) this morning on the pressure ulcers."

On 12/8/15 at 9:25 am, Z2 Nurse Practitioner (NP) stated neither she or Z6's office had not been notified of R1's pressure ulcers on 12/7/15 and stated, "it is not acceptable for someone to

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lay from 2:15 pm until 7:00 am with no dressing covering an open wound... they should have called us yesterday on (R1's) wounds, we are very accessible. "

On 12/9/15 at 11:50 am, E2 stated, "I did not actually look at (R1's) blister last week, I was just told about (R1) having one." At the same time, E3 stated, "I did look at or measure (R1's) blister last week when I did wound measurements, we were more concerned with his weight loss than anything else; 12/7/15 was the first time I looked at R1's {buttocks}... the floor nurses can measure wounds and get treatments but we do not want them to stage the wound."

2. R1's Progress Notes dated 11/5/2015 by Z7 RD (Registered Dietician) documents, "RD Initial Assessment: 60 year old male with Diagnoses noted to include Hypertension, Diabetes Mellitus type II, Coronary Artery Disease, Obesity and Peripheral Vascular Disease... Per Skin Integrity Assessment dated 11/3/15, (R1) with wound to right great toe and sacral wound. Labs reviewed... Recommend change... in an effort to support wound healing, recommend add daily multivitamin with minerals; recommend ProStat SF (Sugar Free) AWC (Advanced Wound Care) {supplement} 30 ml (milliliters) BID (twice a day) for 6 weeks."

R1's 11/2015 POS and MAR (Medication Administration Record) does not document that R1 was receiving the ProStat SF AWC.

R1's 12/2015 POS documents an order received on 12/4/15 for "ProStat AWC 30 ml BID" but not the recommended multivitamin with minerals.

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On 12/7/15 at 1:55 pm, E2 stated, "(Z7) gives a copy of the recommendations to (E1, E2, and E7)..the floor nurses then send them to the physician for signature and once the physician signs it, the floor nurses implement the order and let (E7) know {about the order}... I expect a turn around in a couple of days, and if not, the nurses should follow up with the physician again." E2 also stated, (E2) did not know why it took 1 month for R1 to get an order for the ProStat or why the multivitamin was not ordered.

On 12/8/15 at 9:25 am, Z2 NP stated, "normally the facility puts the RD (Registered Dietician) recommendations into our box, there at the facility for us to sign, I'm at the facility every Monday and the other NP is there on Thursdays. I'm sure it {the recommendation} would have been signed right away and should have been started, I can only think of one time I did not agree to an RD recommendation, but I don't recall every seeing a recommendation for (R1) and there is nothing in our scanned records of a recommendation. Had the RD recommendations been put into place, (R1) might not have developed these new wounds {stage III}."

On 12/8/15 at 1:10 pm, E3 and E4 (Restorative Nurse) both stated, that the facility had come to the conclusion that R1's recommendations were never sent to the physician and that is why there was a delay in starting the ProStat AWC and why the multivitamin was never started. E3 stated, "it was during (R1's) care plan meeting with the family on 12/4/15 that we decided to start the ProStat, not because it had been recommended by (Z7)."

3. On 12/7/15, R3's Electronic Medical Record

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F 314	Continued From page 10 documents diagnoses of Peripheral Vascular Disease and Diabetes Mellitus. On 12/7/15, R3's Electronic Medical Record documents R3 has a stage two pressure ulcer on her coccyx that was acquired on 9/16/15. R3's Electronic Weekly Wound Evaluation dated 11/6/15, 11/13/15, 11/20/15, 11/27/15 and 12/4/15 document R3's Pressure Ulcer on her coccyx as measuring 0.2 centimeters (cm) by 0.1cm by 0.1cm and "RD (Registered Dietician) to eval (evaluate)." There is no documentation of evaluation of R3 by a dietician since 10/1/15. On 12/8/15 at 10:55am, E7, Dietary Manager stated, "(Z7) RD comes twice a month." E7 also stated that if there is a weight loss or wound referral there is an on-call dietician the facility can call. On 12/8/15 at 11:30am, E3, Quality Assurance (QA)/Wound Nurse stated, "There is an on-call RD we (the facility) can fax if we (the facility) need (Z7) before she comes back." E3 also stated (Z7) should be following (R3) for her wound. On 12/8/15, E3, QA/Wound Nurse stated she was unable to find documentation on Z7's assessment for R3's pressure ulcer on R3's coccyx and that it had been over a month since Z7 had seen or evaluated R3. The facility's undated Investigation procedure for pressure ulcers documents, "Frequency Monthly for residents who have a current treatment for pressure ulcer... Special Instructions... 5. Pressure Ulcer Investigations may be completed by the QA Coordinator... Input to complete the	F 314		

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F 314	Continued From page 11 comprehensive investigation is to be obtained from involved parties, including, but not limited to: resident... dietary... physician... 9. If the pressure ulcer fails to show some evidence of progress towards healing within two weeks, the pressure ulcer... and the residents overall clinical condition should be reassessed..." The facility's Prevention of Pressure Ulcer Policy dated 2006 documents, "Purpose To prevent skin breakdown and development of pressure sores. Assessment Guidelines... general condition of skin, nutritional status, weight... Procedure... Use pressure reducing or relieving devices as necessary...Establish a turning and positioning schedule in bed and chair to meet the resident's needs. 11. Position with appropriate surfaces to protect bony prominences... Monitor nutritional status... Documentation Guidelines... If a pressure ulcer is present, the licensed nurse is responsible to record the condition of the skin... as well as the treatment provided..."	F 314		