STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009435	A. BUILDING: _____ B. WING _____	C 02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA HEALTHCARE AND REHAB	176 THOMAS COURT WAUCONDA, IL 60084

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements were not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess, monitor and	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 update physician timely in order to obtain immediate medical intervention for the treatment of the skin excoriation, hydration and a critical potassium blood level result. This failure resulted in R1 being admitted to local hospital with diagnosis of dehydration, hypotension and clostrium difficille infection. This applies to one resident of three residents (R1) reviewed for skin alteration and hydration. The findings include: According to the Physician order sheet (POS) R1 was admitted to the facility 12/23/14 with diagnosis that included Atrial Fibrillation, Dermatophytosis of groin and perianal area, Hypertension, and Pneumonia. Admission nursing notes dated 12/23/14 showed R1 with sheering and ecchymosis to bilateral lower extremities, dressings to bilateral heels and rashes to perineal area. There was no identified issues with R1's coccyx on admission according to R1's admission assessment to the facility on 12/23/2014. R1's admission nursing assessment dated 12/23/14 showed R1 needed extensive assistance with transfer, dressing, toileting, hygiene and bathing. On 2/18/15 at 9:50am, Z1 (Family member) stated she was in R1's room on 12/30/14 when she noticed the excoriation to R1's buttocks. Z1 stated the nursing staff informed her R1 had a bad rash from her diarrhea. Z1 stated she was not informed of R1's diarrhea. The facility failed to document the persistent diarrhea episodes R1 had at the facility but the report from the hospital records showed R1 had persistent diarrhea for	S9999		

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S9999	Continued From page 2	S9999		

few weeks at the facility.

Review of R1's best practices wound care consultation note dated 12/30/14 failed to show a treatment order for R1's coccyx area.

Nursing notes dated 12/31/14 showed R1 with "bloody stool with mucous and excoriation on buttocks". Neither the wound care nor the nursing notes adequately described the excoriation area on R1's buttocks. There was no measurement of the area in any of the progress notes. The only order in R1's POS was dated 1/6/15, seven days after the initial identification, for "Lotrisone 1%-0.05% topical cream. Cleanse with normal saline and pat dry, apply lotrisone to buttocks/gluteal folds and perineum twice daily for 7 days".

On 2/18/15 at 2:40pm, E3 (Wound nurse) stated R1 got the excoriation of the skin from her constant diarrhea and that she applied barrier cream to the area. E3 stated the wound specialist saw R1's buttocks on 1/6/15 and ordered the Lotrisone.

Review of facility's policy on skin assessment last revised 8/2011 showed to "document findings on skin assessment in electronic medical record (EMR). It also showed that "when a new change in skin condition must be reported to skin care coordinator, physician, and family, and that "a comprehensive assessment is required".

Review of facility's undated policy and procedure on Resident Condition Changes showed when there is a skin breakdown, the facility should write descriptive notes of the sores including size, depth, and drainage if any and complete unusual occurrence report per policy.

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S9999	Continued From page 3	S9999		

On 2/18/15 at 9:50am, Z1 also stated R1 did not look right and she asked the nursing staff to check R1's potassium level on 12/30/14. The potassium critical level result of 6.6 was called back to facility on 12/31/14. Nursing notes dated 12/31/14 showed nursing left message for the Physician at 2:07pm. R1's Nurses notes showed a follow-up call was made to the physician on 1/1/15 at 8:13am. Nurses note showed R1 was not treated for the critical potassium level until 1/1/15 at 7:19pm.

Z1 also stated she kept visiting R1 and found on 1/10/15 that something was very wrong with R1. Z1 stated she insisted R1 should be sent out to the hospital. Z1 stated when R1 got to the hospital she was admitted to the intensive care unit. Z1 stated R1 was dehydrated, and was also put on "isolation for stool infection".

Review of hospital record dated 1/11/15 showed R1 was admitted to the hospital with diagnosis of "hypotension (sepsis related), acute renal failure, dehydration and clostridium difficile and evaluation of persistent diarrhea over the past few weeks".

On 2/19/15 at 12:30pm, E2 Director of nursing (DON) stated nursing staff should have called the medical director if there was no response from the Primary Physician regarding a critical laboratory value.

On 2/19/15 at 1:00pm, Z2 (Medical Director) stated he should have been notified right away about the critical laboratory value. Z2 stated the nurses have full access to him and he should have been notified promptly. Z2 stated he would

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S9999	Continued From page 4 have ordered Kayaxalate right away and also order a repeat laboratory for the next day. (B)	S9999		