STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004840	A. BUILDING: _____ B. WING _____	04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSONVILLE SKILLED NURSING & REHAB	1517 WEST WALNUT STREET JACKSONVILLE, IL 62650

(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 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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S9999	Continued From page 1 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 observation, record review, and interview, the facility failed to accurately and timely assess and monitor changes in pressure ulcers for 1 of 4 residents (R2) reviewed for pressure ulcers in the sample of 17. This failure resulted in R2's pressure ulcer progressing / worsening from a Stage 2 to a Stage 3 Pressure Ulcer. Findings include: R2's Admission Braden Scale for predicting pressure ulcer risk, dated 3/4/14, was 11 (Score of 12 or less is high risk). R2's Admission Minimum Data Set (MDS), dated 3/10/14, documented R2 did not have pressure ulcers, but R2 was at High Risk for pressure ulcers. R2's MDS, dated 3/6/15, documented R2 requires extensive assistance, and two plus physical assistance for bed mobility and transfers. R2's Care Plan, dated 3/6/15, documented R2 has a pressure ulcer to coccyx that was facility acquired on 8/17/14. R2's Care Plan documented the pressure ulcer was to be assessed weekly. R2's skin condition report dated 4/17/15, documented R2 had a Stage 2 Pressure Ulcer on her coccyx. On 4/22/15 at 10:50 AM, in an observation with E5, Licensed Practical Nurse (LPN), a dressing was in place on R2's pressure ulcer on	S9999		

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S9999	Continued From page 2	S9999		

her coccyx. Additionally, it was observed the size of the ulcer did not match the measurements on the Pressure Ulcer Log, dated 4/17/15. The Pressure Ulcer Log documents that R2's coccyx pressure ulcer measured 1.0 centimeter (CM) in length X 0.5 CM width X 0.1 CM in depth, and is a stage 2. E5 stated that the night nurse does the dressing changes.

On 4/22/15 at 12:40 PM, E3, LPN/ Wound Nurse measured the pressure ulcer. The pressure ulcer now measured 3.0 CM in length X 1.4 CM in width X 0.3 CM in depth. E3 stated that when she took the dressing off it was macerated, and draining. E3 stated she had not seen this wound since her last weekly measurement done on 4/17/15. E3 stated she does not do the daily dressing changes, as they are done by the night nurse and as needed by day nurse. E3 stated she had not been informed the wound had worsened. E3 stated she would complete a change of condition form and notify the physician. The Change of Condition Pressure Ulcer sheet, dated 4/22/15 at 3:00 PM, documents the ulcer is now a Stage 3 Ulcer.

On 4/24/15 at 9:00 AM, E1, Administrator stated that the facility has already identified a problem in regards to staging of pressure ulcers on 4/8/15, and had been sent through Quality Assurance. E1 stated that E2, Director of Nursing had been at the facility doing training on the weekend of 4/18/15. On 4/24/15 at 9:00 AM, E2, stated that she would expect any nurse caring for R2 to reassess the wound and notify the physician if there is a change in the pressure ulcer.

The facility's Skin Integrity Standard Procedure documented that dependant residents sitting or in bed may need a position change for tissue

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S9999	Continued From page 3 offloading every hour. The procedure documented that weekly head to toe assessment are to be done for all residents by licensed nurse with narrative documentation of findings. Weekly narrative documentation must include: description of skin tissue, color, turgor, rashes, bruising, skin tears, edema, incision lines, and any other skin related issues. The procedure documented that if skin integrity issues are identified post- admission to the facility the following documentation is required: wound specifics, size of the wound including length, width, and depth in centimeters, indicated if undermining or tunneling exists the depth must be measured, the amount of drainage, description of the wound bed, odor, signs/symptoms of infection, description of surrounding tissue, stage of the wound, notification on the 24 hour report indicating the skin condition, incident report completed for in house acquired stage III and/or IV. If the wound has shown no signs of improvement in 2-4 weeks reevaluate interventions and the plan of care. (B)	S9999		