STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003081	A. BUILDING: _____ B. WING _____	C 01/21/2016

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S9999	Continued From page 1 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. 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. 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 are not met as evidenced by: Based on interview, record review and observation the facility failed to notify the physician of a worsening pressure sore, failed to monitor a pressure sore and skin integrity, failed to provide treatment; nutritional and pressure relieving interventions for pressure sores and	S9999		

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S9999	Continued From page 2	S9999		

failed to implement a physician's order for a wound consult for four of four residents (R1, R2, R3 and R4) reviewed for pressure sores in the sample of five. These failures resulted in R1 developing a stage three pressure sore to the coccyx and an unstageable pressure sore to the heel.

Findings include:

1. The Admission History and Physical dated 12/2/15 documents R1 was admitted to the hospital on 12/2/15 with diagnoses of Septic Shock and Left Foot Wound Infection. The Operative Report dated 12/4/15 documents R1 underwent a left below knee amputation on 12/3/15. The Discharge Packet dated 12/10/15 documents that R1 was discharged from the hospital with instructions to follow up with Z3 Urologist in two weeks to monitor penis wound. The Physician's Order Sheet dated 12-10-15 documents an order for R1 to have daily skin checks. The Nursing Admission Assessment dated 12/11/15 documents "pressure areas: distal penis, area of eschar present - was found in hospital". The Nursing Assessment documents one additional wound from R1's left below knee amputation.

Nurses Notes dated 12/10/15 through 1/1/10/16 include no documentation related to pressure sores other that R1's penis wound. R1's Nurses Notes dated 12/10/15 through 1/10/16 document the following regarding R1's penis wound:
12/19/15 9:00 PM "Resident remains on isolation for MRSA (Methicillin Resistant Staphylococcus Aureus) at penis TAO (triple antibiotic ointment) applied."
12/20/15 8:00 PM "TAO ointment applied to necrotic area on penis."

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S9999	Continued From page 3	S9999		

12/24/15 4:00 PM "Penis has open area approximately 2 cm (centimeters) uneven in shape that is raw area 0.25 cm black in center." 12/29/15 10:00 AM "Black area on penis."

R1's Treatment Administration Records (TAR) dated 12/1/15 through 12/31/15 documents no monitoring of R1's penis wound. R1's TAR dated 1/1/16 through 1/31/16 documents one entry regarding R1's penis wound dated 1/6/16 stating only "necrotic area tip of penis".

R1's TAR dated 12/1/15 through 12/31/15 documents "Weekly Skin Checks" and no dates are initialed to indicate a skin check was completed for R1.
R1's TAR dated 1/1/16 through 1/31/16 documents instructions for staff to complete skin checks daily starting 12/10/16. The word "daily" is crossed out and replaced with "weekly". A skin check is initialed as being completed on 1/6/16 and no other dates are initialed.

R1's Skin Assessment for Predicting Pressure Ulcer Risk dated 12/31/15 documents that R1 is at high risk for pressure sore development.

Nurses Notes dated 1/10/16 at 6:10 AM document "(R1) transported to .....hospital for surgery (colon resection)".

Z5's (Hospital Nurse) Nurses Notes dated 1/10/16 at 10:00 AM document the following pressure sores were present on R1's skin at the time of his admission to the hospital:

"Midline Coccyx Stage three"
"Tip of penis"
"Right Heel, Unstageable"

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S9999	Continued From page 4 Z7's (Hospital Nurse) Nurses Notes dated 1/11/16 document "(R1) Pressure Ulcer.....stage indeterminable.....Meatus.....length 2cm, width 1 cm, and depth 0.3 cm" and "(R1) Right heel Pressure ulcer.....unstageable eschar complete.....length 4 cm, width 3cm". On 1/21/16 at 9:40 AM Z6 (Surgeon) stated that it is unlikely that R1 developed the stage three coccyx pressure sore and the unstageable right heel pressure sore while being transported to the hospital and that not completing daily skin checks could have contributed to the development or worsening of the wounds. Z6 went on to state that R1 had a large ulcer on the tip of his penis that appeared to have been caused by pressure from a urinary catheter that was anchored too tightly to R1's leg. R1's Medical Record does not include documentation that R1 followed up with Z3 after being discharged from the hospital (on 12/10/16). On 1/21/15 at 8:25 AM Z4 (Z3's Office Manager) stated that R1 has never had an appointment to see Z3 or any Urologist in the office. On 1/20/16 at 1:10 PM E2 Director of Nurses could not provide documentation that R1 followed up with Z3, that daily skin checks had been completed or that R1's penis wound was appropriately monitored after he was discharged from the hospital on 12/10/15. At that time E2 stated that R1 should have followed up with Z3 and staff should have been completing daily skin checks for R1. The Decubitus Care/Pressure Areas policy dated 5/2007 states "Documentation of the pressure area must occur.....at least once each week on	S9999		

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S9999	Continued From page 5 the TAR. The assessment must include.....size, shape, depth, color....." Pressure Sore Prevention Guidelines dated 4/2006 states "The following guidelines will be implemented for any resident assessed at a .....high risk for skin breakdown.....daily skin checks." 2. The Weekly Wound Tracking sheet dated 1/13/16 documents that R3 acquired a stage two pressure sore on her coccyx on 1/12/16. Z1's (Hospice Nurse) Clinical Note dated 1/14/15 documents "(R3) has a stage two pressure ulcer that measures 4.5 (centimeters (cm)) by 3 (cm) that is 100% slough on her sacrum.....spoke with (Z2 Physician).....ordered a dressing change: cleanse wound with wound cleanser, pat dry. Apply calcium alginate to wound and cover with adhesive foam dressing. Change daily." The undated TAR documents that R3's coccyx wound dressing is scheduled to be completed by the 6:00 PM to 6:00 AM shift and that the treatment was completed by E5 Licensed Practical Nurse (LPN) on 1/15/16, 1/16/15 and 1/17/15. R3's pressure sore treatment is not initialed as being completed on 1/18/16 on the undated TAR. R3's Medical Record does not document that E4 Dietician was notified of R3's pressure sore or include a nutritional assessment related to R3's pressure sore. On 1/19/16 at 2:10 PM E5 LPN confirmed that she completed R3's daily pressure sore treatment on 1/15/16, 1/16/16 and 1/17/16. At that time E5 stated she noticed that tunneling was present at the base of R3's coccyx pressure sore on 1/17/16. E5 stated she did not notify the on coming nurse, Z2 Physician or Z1 Hospice Nurse	S9999		

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S9999	Continued From page 6	S9999		

about the development of tunneling in R3's pressure sore. On 1/19/16 at 2:00 PM E3 LPN stated she was R3's nurse on 1/18/16 (6:00 PM to 6:00 AM). E3 stated she did not see R3's coccyx pressure sore during her shift and she did not remember changing the dressing to R3's pressure sore.

On 1/19/16 at 10:30 AM Z1 stated that a dressing was not in place over R3's coccyx pressure sore when she observed it this morning. Z1 stated that R3's pressure sore had worsened from a stage two pressure sore (on 1/14/16) to a stage three pressure sore with tunneling and that the wound bed had deepened to a depth of 1.5 cm to 2 cm. Z1 stated facility staff did not notify her that R3's pressure sore was worsening.

On 1/20/16 at 10:40 AM E2 Director of Nurses stated she would have expected the nursing staff to notify the dietician of R3's newly developed pressure sore and that E5 should have notified E2, Z1, Z2 and the next shift nurse of R3's worsening pressure sore.

The Decubitus Care/Pressure Areas policy dated 5/2007 states "Nursing personnel are to notify dietary personal of any pressure areas to seek nutritional support....." The Skin Care-Wound Care Teaching Protocols dated 4/2007 states "notify the physician of any changes in skin integrity of lack of progress".

3. The Minimum Data Set dated 10/30/15 documents R4 is severely cognitively impaired and requires total assistance with with eating. The Skin Assessment dated 10/30/15 documents that R4 is at high risk for skin break down. The Physician's Order Sheet (POS) dated 1/1/16 through 1/31/16 documents an order for R4 to

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S9999	Continued From page 7	S9999		

have double protein at breakfast and lunch. E6's (Registered Dietician) Note dated 12/20/15 states "(skin) Tx (treatment) continues for stage two pressure ulcer on coccyx including.....double protein at breakfast/lunch....."

On 1/19/16 at 12:40 E7 Activity Director fed R4 100% of a pureed lunch including a single serving pureed bread, fruit, chicken fried steak, greenbeans and mashed potatoes. On 1/19/16 at 12:50 PM E7 confirmed that R4 ate 100% of her lunch and stated that she received a single serving of each item.

On 1/20/16 at 8:30 AM E8 Social Services Director fed R4 100% of a pureed breakfast including a single serving of pureed eggs. On 1/20/16 at 9:05 am E8 stated R4 ate all of her breakfast. E8 stated R4 did not receive an extra serving of eggs and stated she did not offer R4 a second serving of anything. On 1/20/16 at 9:15 AM E9 Dietary Manager reviewed R4's POS for double protein at breakfast and lunch and stated (R4) should have gotten an extra serving of eggs this morning. E9 stated the cook must have made a mistake.

4. The MDS dated 10/26/15 documents that R2 is severely cognitively impaired. The Weekly Wound Tracking sheet dated 1/18/16 documents that R2 has a right hip stage two pressure sore. The POS dated 1/8/16 documents orders for R2 to wear bilateral heel protectors and whole milk to replace menu milk. E6's RD (Registered Dietician) Note states "PU (pressure ulcer) referral.....recommend whole milk with each meal rather than bid (twice daily)....."

On 1/19/16 at 12:45 PM E10 Certified Nurses Aide fed R2 lunch. R2 had a glass of juice, a

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S9999	Continued From page 8 glass of water and a cup of coffee in front of him at the table. R2 did not have a glass of milk. On 1/19/16 at 1:10 PM E10 stated R2 had water, juice and coffee to drink at lunch. On 1/20/16 at 9:10 AM E9 stated that R2 only receives milk twice daily at breakfast and dinner. On 1/19/16 at 12:45 PM and 1:20 PM R2 was seated in a high back wheel chair with his feet resting on the floor and no heel protectors on his feet. On 1/19/16 at 11:40 AM R2 was in bed with no heel protectors on his feet. On 1/20/16 at 8:40 AM, 9:20 AM and 11:15 AM R2 was seated in a high back wheel chair with his feet resting on the floor and no heel protectors on his feet. On 1/20/16 at 1:00 PM R2 was lying in bed with no heel protectors on his feet. On 1/20/16 E11 Certified Nurses Aid confirmed that R2 was not wearing heel protectors. At that time E11 stated that R2 had heel protectors when he returned from the hospital (1/8/16) and she does not know why R2 has not been wearing them. (B)	S9999		