STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007181	A. BUILDING: _____ B. WING _____	01/22/2016

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 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 300.1010 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 a) Comprehensive Resident Care Plan. A facility,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable 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 observation, interview and record review, the facility failed to monitor, identify, assess and treat for pressure ulcers and failed to turn and reposition timely for 6 of 7 residents (R4,	S9999		

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S9999	Continued From page 2 R3, R10, R1, R6, R8) reviewed for pressure ulcers in the sample of 15. This failure resulted in R4 developing multiple avoidable unstageable pressure ulcers from a pressure relieving boot. Findings include: 1) R4's Physician Order Sheet (POS) dated 12/10/15 documents that R4 has a diagnosis of acute osteomyelitis left ankle and foot, pressure ulcer to left ankle stage 4 and Diabetes Mellitus. R4's Care Plan dated 12/10/15, documents that R4 has pressure ulcer to left lower leg related to immobility and incontinence. R4's Care Plan documents that interventions are to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing. Measure length, width and depth where possible. R4's Care Plan Intervention, initiation date of 12/16/15, documents "Float heels while in bed as tolerated." R4's Care Plan, dated 12/22/15 documents R4 has Diabetes Mellitus with intervention "Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness." R4's Care Plans did not address the use of a pressure releiving boot. R4's Physician's Order (PO), dated 12/17/15,documents that R4 is to have left lateral lower leg cleansed with wound cleanser and apply xeroform and cover with dry dressing every night. The only Braden Scale in R4's medical record documenting pressure ulcer risk dated 12/31/15, documents a score of 12. (10-12 is moderate risk). The facility's Weekly Pressure Ulcer Report dated	S9999		

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S9999	Continued From page 3 1/11/16, documnents that R4 was admitted with a pressure sore on 12/9/15 to the left outer leg stage 2, measuring 3.0 centimeters (cm) X (by) 2.0 cm X 0.3 cm. On 1/20/2016, at 10:35 AM, R4 was at the end of the hall near the nurse's station in her geriatic chair. She was wearing a plastic type boot on her left foot/leg. At 11:35 AM, she was in the dining room and continued to wear the hard plastic boot. At 11:45 AM, she continued to wear the boot. The facility's Skin Check Weekly & PRN form, effective date 1/21/16 at 12:00 PM, documents "No new changes this week." The form documented there were no new areas of skin impairment. This form was signed by E19, Registered Nurse (RN). On 1/21/16 at 1:35 P.M., R4 was lying in bed. R4 was wearing the boot on her left leg and her heels were not floated off the mattress. E19, Registered Nurse (RN) took boot off R4's left leg. The boot was made of hard plastic and had straps which extended around th bottom of the foot. E2, Director of Nursing (DON) and E3 Assistant Director of Nursing (ADON) were present. E19 removed dressing from R4's left leg. E19 stated that she had not seen R4's pressure areas. R4 had an area to the top of left foot that had not been identified the top layer of skin was gone, but scabbed over, E19 stated she would stage the pressure ulcer at a stage 1, there was 2 areas on the bottom of R4's foot that were black with echar. E3 stated that she was not aware that R4 had the areas and stated they looked necrotic. E3 stated that should would expect nursing staff to identify on the weekly skin assessment.	S9999		

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S9999	Continued From page 4 The facility Weekly Pressure Ulcer Report dated 1/21/16 documents that R4 has a pressure sore left outer leg 2.8 cm X 2.1 cm X 0.3 cm that R4 was admitted with on 12/9/16. The report documented a newly acquired pressure ulcer to R4's left inner foot meauring 1.0 cm X 0.4 cm unstagable with 100% eschar, a newly acquired unstageable pressure ulcer to her left top of foot measuring 2.5 cm X 1.0 cm with 50% eschar, a newly acquired unstageable pressure ulcer to R4's middle toe measuring 1.5 cm X 1.0 cm with 100% eschar, a newly acquired unstageable pressure ulcer on R4's left outer foot back measuring 2.0 cm X 3.0 cm with 100 % eschar and a newly acquired Stage II on R4's Left middle outer area of the foot measuring 2.5 cm X 0.8 cm X 0.1 cm. The facility progress notes 1/10/16-1/21/16 did not document any assessment for R4's pressure areas. The facility's Monthly 100% Skin Audit dated January 2016 documents no new areas. The facility Skin Check Weekly and PRN dated 1/10/16, and 1/17/16 documents no new areas. On 1/22/16 at 9:15 A.M. Z1, R4's Physician, was interviewed per telephone. Z1 stated that she would expect nursing staff to identify any new pressure areas on R4 when they are to be doing dressing changes daily. Z1 stated that she had not been made aware of any additonal pressure areas on R4 until her office had recieved a fax on her day off on 1/21/16 reporting 4 new pressure areas. Z1 stated she was not provided any measurements of the areas. Z1 stated she was not aware R4 was wearing any type of boot on her left leg/foot.	S9999		

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On 1/22/16 at 9:15 A.M. E2 stated that she would expect nursing staff to have identified any new pressure areas on R4's left foot when doing scheduled daily dressing changes. E2 stated that she was aware that R4's heels were not floated on 1/21/16 during observation of skin check. E2 stated that the R4 has a pressure ulcer on R great toe that is a stage 1, A stage 1 pressure ulcer on the top of R foot, A stage 2 pressure ulcer on the top of Left foot. E1 DON stated they were not refuting that R4 had black necrotic areas on the bottom of her Left foot. E2 stated that the facility had identified that the necrotic areas on the left foot were caused from the boot, because the areas were at the area of the straps and from the boot straps being too tight. E2 stated the boot had been removed.

On 1/22/16 at 12:35 P.M., E3 ADON stated that she does a monthly head to toe assessment facility wide. E3 stated that she would have done the January asssessment on 1/10/16.

The facility's Policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated February 2014, documents the the nursing staff and attending physician will assess and document and individual's significant risk factors for developing pressure sores: for example, immobility, recent weight loss and a history of pressure ulcers. The policy documents the nurse shall describe and document/report a full assessment of pressure sore including location, stage, width and depth, pressence of exudates or necrotic tissue, pain assessment, resident's mobility status, current treatment, including support surfaces.

The facility's Policy Pressure Ulcer Prevention

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S9999	Continued From page 6 revised August 2015, documents that a standardized pressure ulcer risk assessment (Braden Scale) will be used to identify residents who are at risk for the development of pressure ulcers. This assessment will be completed upon admission, weekly X 4 weeks, quarterly and when a significant change in the residents conditon is noted. The policy documents interventions for the prevention of pressure ulcers will be individualized to meet the specific needs of the resident. Interventions will consider the assessment of risk and skin condition of the resident. The policy documents that for residents identified as moderate risk; individualized turning and repositioning , toileting, incontinent vare and hydration per individual resident needs, restorative mobility programming as needed, protect heel, float if possible, manage nutrition, RD to assess as needed for additional interventions, monitor weight and food consumption, manage friction and shear, by utilizing positioning and repositioning. The policy documents that assessment and documentation includes weekly skin checks for all residents, monthly skin checks during the 100% Monthly Skin Audit for all residents, daily observation of skin and identification during routine care given by CNA's, any findings will by documented in Point of Care by the CNA which generates an alert for the Licensed Nurse for assessment and further follow up. (B) 300.610a) 300.1210d)6) 300.3240a)	S9999		

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S9999	Continued From page 7 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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 record review and interview, the facility failed to use safe transfer techniques to prevent falls for 1 of 8 residents (R6) reviewed for falls in a sample of 15. This failure resulted R6 falling	S9999		

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S9999	Continued From page 8 and sustaining a left leg fracture and laceration. The findings include: R6's Minimum Data Sets (MDS) dated 11/28/15 documents that R6 is totally dependent for transfers with assist of 2 staff members. R6's Care Plan dated 12/31/15 documents that R6 is at risk for falls and is to be transferred per mechanical lift. The Facility's Occurrence Report, dated 1/25/15, documents that E12 Certified Nurse's Aide (CNA) attempted to perform a mechanical lift transfer without assistance on R6 on 1/25/15 at 1:36 PM. The report documents that the mechanical lift tipped over, E12 lowered R6 to the floor hitting R6's leg on a wheelchair. Report documents that E12 reported the mechanical lift may have caught on the floor mat. Subsequently R6 obtained a left leg laceration and complained of left leg pain due to the fall. R6 was sent to an emergency department and subsequently was diagnosed with left femoral neck fracture (hip fracture) and received sutures to the left leg laceration. Emergency Department report dated 1/26/15 documents that "Patient (R6) presents from nursing home via EMS (Emergency Medical Services) after a fall, patient (R6) has severe skin tear below the knee level (left)-bleeding controlled...Patient has left femoral neck fracture...Since (R6) is non-ambulatory, (R6) will not require surgical interventions...sutured laceration...pain control...discharge back to extended care facility." The facility's policy titled (Mechanical) Lift (8/10/01) documents that "Clear your path of	S9999		

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S9999	Continued From page 9 obstacle or hazards before you move the resident." On 1/21/16 at 9:30 AM E3, Assistant Director of Nursing, stated, "(R6's) fall was due to human error. (E12) attempted a mechanical transfer without assistance. Two staff members are to do mechanical transfers." On 1/22/16 at 9:30 AM, E18, CNA stated, "We are required to do a mechanical lift with two staff members." (B)	S9999		