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S9999	Final Observations Complaint #1640169/IL82645 Statement of Licensure Violations : 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 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	S9999	Attachment A Statement of Licensure Violations	

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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.
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:
2) All treatments and procedures shall be administered as ordered by the physician
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. (A, B) (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview, observation and record review, the facility failed to accurately and consistently assess/evaluate and treat pressure ulcers for 3 of 3 residents (R1, R2 ,R3) reviewed for pressure ulcers in a sample of 3. This failure resulted in no treatment in R1's coccyx pressure

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ulcer which declined to unstagable and a decline in R3's coccyx pressure ulcer from from scratches to an unstageable ulcer.

Findings include:

1. The Admission Record documents R1 was readmitted to the facility on 12/24/16 with Hospice services.

R1's Care Plan, dated 12/24/15, documents R1 was admitted to the facility with skin breakdown. The Care Plan interventions document staff to treat as ordered, assess and measure wounds weekly and PRN (as needed), evaluate for additional calories, vitamins, minerals for healing, notify MD (Medical Doctor) if condition worsens or if no improvement of wound over time with current treatment, monitor site for infections, assess for pain and medicate as ordered.

R1's December 2015 Treatment Administration Record (TAR) note, dated 12/24/15, documents "several dried scabbed areas on buttocks c (with) a 1.5 x 1.5 cm (centimeter) stage I pressure ulcer on coccyx." R1's TAR documents on 12/29/15 "coccyx open area .5 x .5 x .1 no odor or drng(drainage)" indicating a decline from admission.

R1's Hospice Notes dated 12/29/15 documents R1 had a stage I pressure ulcer on her coccyx.

R1's December 2015 Physician's Order Sheet (POS) includes an admission order, dated 12/24/2015, for Skin Prep to R1's coccyx and upper right buttocks area every shift and Zinc cream to coccyx and A&D to coccyx and buttocks daily and PRN (as needed). R1's December TAR documents the Zinc was first applied on 12/30/15.

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There is no documentation on R1's TAR from 12/24 through 12/28/2015 that staff applied Skin Prep as ordered. R1's TAR documents staff applied Skin Prep only on the 6-2 shift on 12/29/2015.

R1's Hospice Note, dated 1/5/16, documents R1's coccyx pressure ulcer as "unstageable 2.8 x 1" with a note "referral made to wound specialist" added. Hospice Note dated 1/11/16 documents R1's coccyx pressure ulcer as unstagable with a newly developed in house acquired pressure ulcer on R1's hip on 1/11/16. No treatment change or notification to the physician or family is documented in the Hospice notes regarding the decline in the coccyx pressure ulcer and newly acquired pressure ulcers to R1's hip.

R1's January 2016 TARs do not include any documentation regarding R1's hip ulcer which was identified by Hospice on 1/11/16. R1's TAR documents on 1/6/16 R1's coccyx wound as "coccyx .5 x .5 x .1 stage 2" even though Hospice documented R1's pressure ucler as Unstageable on 1/5/16.

On 1/13/16 at 12:00 pm, R1's coccyx pressure ulcer was uncovered, irregular shaped, bigger than a quarter in size and dark black/grey in the center with white/beefy red edges surrounding. The periwound of the coccyx pressure ulcer was deep purple. There was minimal drainage on the incontinent pad under R1. R1 also had a golf ball size unblanchable deep purple Stage I pressure ulcer on her left hip. R1's heel protectors were off both her feet and her feet were lying directly on the mattress. She had no pressure relieving device between her knees. E4, Facility Wound Nurse, stated she did not know about R1's hip pressure ulcer and that the Hospice Nurse had

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been there earlier in the day. E4 stated the Hospice nurse "probably removed the dressing from the coccyx wound." E4 also stated Hospice had made a Wound Clinic recommendation "last week" and they were waiting for consent from the facility before seeing the Wound Specialist. E4 stated the order for Zinc ointment was from the Hospice, however, there was no evidence of zinc on the wound at that time. R1's medical record contained no documenation regarding a dressing to R1's coccyx pressure ulcer. At this time, E4 did not assess R1's pressure ulcers or document any description of the pressure ulcers.

On 1/13/16, at 2:40pm , E4 stated she was planning on measuring R1's wounds later that evening. E4 stated the wound specialist hadn't seen R1 yet as the facility had yet to get a consent signed from the family member.

On 1/14/16 at 10:40 am, wound documentation completed by E4 on 1/13/15 was reviewed. E4 assessed R1's coccyx pressure ulcer as "2 x 1.5 x .1 stage II c mild drainage + no odor". E4 documented R1's hip pressure ulcer as a "fluid filled blister 1 x 2.5 surrounding skin slightly red, scab noted to edge of blister 0.4 x 0.3." There was no documentation in the nurse's notes that the family and/or physician were notified of decline in the coccyx pressure ulcer and the newly developed hip pressure ulcer.

On 1/14/16, at t 10:55 am, E3 Registered Nurse (RN) caring for R1 looked at R1's coccyx pressure ulcer and said "That is not a stage II. It's unstageable" and also noted the hip ulcer which was now dry and deep red in color. No Zinc cream was evident at the coccyx area and R1. E3 stated she was going to call Z2, Physician, and get a treatment order. At 11:53 am, E3 stated she

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called Z2 and got an order for R1's coccyx pressure ulcer. When asked about an order for R1's hip ulcer and if she notified Z2 of that ulcer, E3 replied, "I didn't know I was suppose to get one for that ulcer." After looking at the TAR, E3 stated "I'll have to call the Doctor back and get an order for her hip ulcer." E3 also stated a consent for Wound Management had been signed the night before and they would be notified to see R1. This was nine days after Hospice requested the referral to a wound specialist.

On 1/14/16, at 11:35 am , Z1, Hospice Nurse, stated she identified the coccyx ulcer as unstagable on 1/5/16 and the hip pressure ulcer on 1/11/16 which she discussed with E4, Wound Nurse and the other staff nurses at the time she noted it. Z1 stated the facility was aware of both and should have notified the physician and gotten orders at the time they were identified. Z1 also stated she questioned why the facility staff didn't see it before her since neither wound was new when she saw it and they should have been applying the Zinc Oxide ointment to it. Z1 also stated she is not real familiar with pressure ulcers and made the recommendation for the Wound Specialist on 1/5/16 when she first noticed the coccyx ulcer as unstageable. Z1 stated whether the resident is Hospice or not, it is the responsibility of the facility's nurses to follow thru with appropriate notification to the physician for treatment orders.

On 1/15/16, 10 days after Z1 recommended the referral to the Wound Specialist, the wound specialist evaluated R1's coccyx wound and measured it to be 3 cm x 3 cm x 0.1 cm, necrotic/unstageable, with 51-75% adherent yellow slough and 1-25% granulation. The left hip measured .4 x .5 necrotic/unstageable and right

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S9999	Continued From page 6 hip 1.9 x 2cm, suspected deep tissue injury. On 1/15/16 at 10:10 am, Z2 stated he was not made aware that R1's pressure ulcer had decline to an unstageable ulcer until yesterday and that he would have expected the facility's nurses to contact him with that information promptly. Z2 stated had he been notified when the ulcer declined, he would have ordered a dressing to cover but not an aggressive treatment since she was overall deteriorating. Z2 stated he would expect the facility to be accurately assessing the wounds periodically and take actions accordingly. The facility policy entitled "Decubitus Care/Pressure Areas", dated 5/07, documents it is the policy of the facility "to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing on any pressure ulcer, once identified." Under procedure, the policy documents that "Upon notification of skin breakdown, a 'Newly Acquired Skin Condition' report will be completed and forwarded to the Director of Nurses. The Pressure ulcer will be assessed and documented on the TAR with documentation to include size, stage, site, depth, drainage, color, odor, and treatment." The policy documents the physician will be notified for treatment orders and documentation will occur upon identification, at least once weekly on the TAR, and response to treatment. The policy documents nursing personnel are to notify dietary personnel to seek nutritional support and monthly reviews by the Registered Dietician (RD.) 2. R2's Admission Sheet documents R2 was admitted to the facility on 12/30/15 from the hospital.	S9999		

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R2's Nursing Admission Assessment, dated 12/30/15, documents R2 had a Stage II pressure ulcer on her coccyx and nothing on her heels.

R2's Nurse's notes document R2 went to the hospital for cardiac issues on 1/2/16 and returned to the facility on 1/4/15 on Hospice.

The first assessment on R2's coccyx ulcer was documented on 1/4/16 on the back of the January 2016 TAR. It documents R2's coccyx ulcer was a Stage II pressure ucler measuring 0.5 cm x 1cm and "blisters on bil (bilateral) heels. Right heel measured 4 cm x 5 cm and left heel 4 cm x 7.5 cm."

R2's Treatment orders, dated 1/4/16, include "Cleanse left buttocks with wound cleanser and Santyl to wound bed, apply mepilex change daily and PRN." The orders also included to float R2's heels at all times and "monitor bilat (bilateral) heel/apply mepilex drsg" every other day and as needed.

R2's January 2016 TAR had an order for skin prep bil heels every shift. R1's TAR also documents that the treatment for the coccyx wound wasn't done on 1/8/16 due to not having the mepilex and not done 1/10/16 and 1/11/16 due to the resident being "combative." There is no documentation the nurses went back on any of those days in an effort to do the treatment.

On 1/13/15 at 3:14 pm, E3 rolled R2 to her right side. R2's dressing at the coccyx area was bunched up in the middle and just attached on each side. The wound bed was visible. R2's heels were not floated and her heel protector boots were off and laying under the covers at the end of the bed. R2's right heel was black with an

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unattached outer edge between 4 and 7 o'clock which looked scabby with slight drainage. R2's left heel was an intact dusky purple blister.

On 1/13/16, E3 obtained a new order for R2's coccyx ulcer to discontinue the Santyl and cleanse with wound cleanser, apply mepilex dressing every three days and as needed til healed. No orders were obtained for the open heel pressure ulcer even though it was weepy with drainage.

3. R3's Admission Sheet documents R3 as being initially admitted to the facility on 10/24/15 with diagnoses of Dehydration, Chronic heart arrest, congestive heart failure and Tachycardia among others. R3's Admitting Orders, dated 10/24/2015, document R3 to have a gastrostomy tube and a urinary catheter. The Minimum Data Set (MDS) dated 1/1/16 documents R3 to have cognitive impairment and require total assist of all activities of daily living.

The Nursing Admission Assessment, dated 10/24/15, documents R3 had no opened areas identified on the skin except the g-tube insertion site. The Progress notes dated 10/24/15 at 9:00 pm document R3 had a skin check completed with identified bilateral heels as dry crusted skin. There was no other documentation of R3's heels regarding the description of these areas.

On 10/31/15, the progress notes document R3 was sent back to the hospital. R3's Progress notes documented she was readmitted on 11/7/15 with 2 small skin tears on her coccyx.

On the back of the November TAR, a note dated 11/7/15 documented R3 as having small skin tears on middle of her buttocks identified with an

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order to cleanse and apply a gauze dressing. The TAR documented an order for Skin Prep, dated 11/7/2015, was given but not documented as administered until 11/12/15. There is no full assessment of the wounds including size, color, odor, drainage, etc.

On 11/19/15, R3's Progress Notes document R3 was transferred out and returned to the facility on 11/23/15. A hospital transfer form, dated 11/23/15, documents R3 had an unstageable pressure ulcer on her coccyx with a Physician's Order for Medihoney and mepilex (dressing). There was no documentation the facility assess R3's coccyx pressure ulcer at that time to determine size, color, depth, odor or drainage. The 11/2015 TAR documents an "open area on coccyx" with mepilex and medihoney ordered. R3's TAR documents the mepilex was applied for the first time on 11/26/15, two days after readmission.

On 11/29/15, R3's Progress Notes document she was discharged to the hospital and readmitted on 12/3/15. No assessment of R3's coccyx wound is documented until 12/14/15 and reads "coccyx measures: 5 x 5.4 x .1 c (with) no drainage + no odor." There was no staging with this assessment. R3's Physician's Orders dated 12/14/15 document cleanse coccyx c NS (normal saline), apply Santyl to wound bed, cover with gauze and ABD, change daily and PRN. On 12/14/15, wound specialist evaluated R3 and documented the wound as being "necrotic (unstageable), small amount of exudate, sero-sanguneous, no odor or pain. The assessment further documented 51-75% moist black eschar with 1-25% epitheliation and granulation."

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On 12/20/15, the nurse documents R3's treatment not done as "the floor nurse requested to change treatment." On 12/21/15, the dressing again is not documented as done. On 12/21/15, E4 documents R3's pressure ulcer as measuring 2.3 cm x 3.4 cm x 0.1 cm with slight drainage. There is no documentation she completed the treatment at that time on R3's pressure ulcer.

On 12/28/15, E4 documents R3's pressure ulcer measures 5 cm x 4.5 cm x 1.5cm with mild drainage + slight odor. On 12/28/15, R3's wound was debrided and measured 6 cm x 4.5 cm x 1.5cm according to the Wound Specialist note.

On 1/1/16, R3 Progress Notes document she was transferred to the hospital and returned to the facility on 1/11/16. R3's Admissions Orders document she should have Santyl and Calcium Alginate daily to her coccyx pressure ulcer.

The January 2016 TAR documents R3's coccyx wound as measuring 5.5 cm x 5 cm x 2.5 cm with undermining at 10-2 o'clock of 2.3cm, moderate drainage x no odor on 1/11/15. On 1/13/16 at 12:30 pm, no initials were present on the R3's TAR documenting R3's daily treatment of Santyl and calcium alginate had been completed since her admission on 1/11/2016.

On 1/13/15 from 11:30am to 2:50pm, R3 was in the same position in bed. At 2:50 pm, R3's coccyx pressure ulcer dressing was intact only on the top and sides, the bottom of the dressing was loose with the wound bed exposed and bowel movement on the bottom edge of the dressing. Both heels were dark with dry calloused skin. No padding was between her legs and she had a 1/4 folded top sheet and heavy cloth incontinent pad under her. E4 stated at the time that her dressing

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S9999	Continued From page 11 is done by the 2-10pm shift and would be done next shift. E4 did not remove the soiled dressing from R3's pressure ulcer. Dietary Notes show R3 was last assessed by dietary on 12/7/15 and receives Glucerna 1.2 feeding at 65cc/hour for 23 hours a day. However, it does not show R3' gets any other nutritional or supplemental assist besides the Glucerna and a daily multiple vitamin/mineral. The dietary note dated 12/7/15 documents R3 as having a stage III pressure ulcer and no assessment has been done since it's been assessed as unstageable. Albumin lab dated 1/10/16 documents it as low at 3.2 with normal 3.5-5.2. On a Hospital History and Physical dated 11/19/15, R3's Albumin was 3.9. The January 2016 POS also fails to show any nutritional support ordered to aid R3's in the healing process of her coccyx wound. On 1/18/16, the wound specialist evaluated R3's coccyx wound and measured her coccyx wound to be 4.4 cm x 4 cm x 1.5 cm with undermining from 12-2 o'clock at 2.6cm deep. (B)	S9999		