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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. (Section 2-107 of the Act)	S9999		

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These Regulations were not met as evidenced by:

Based on observation, record review and interview, the facility failed to identify, assess, timely treat, and reposition residents for pressure ulcer prevention and healing for 4 residents (R3, R5, R7, R8) reviewed for pressure sores.
This failure resulted in R8 developing a pressure ulcer which deteriorated to a Stage IV.
This failure resulted in R3 developing an unstageable pressure sore/deep tissue injury to the left heel and the right outer ankle and a stage II to the coccyx that were avoidable.

Findings include:

1. The MDS, dated 12/20/16, documents R8 requires extensive assist of two staff for bed mobility, transfer, toileting and extensive assist of one for bathing and hygiene.

R8's labs, dated 5/16/16, document a low albumin at 3.1 (normal 3.5-5.5).

R8's January 2016 POS documents an order for a treatment to her right heel for an in house acquired pressure ulcer, float heels off bed with pillows when in bed.

R8's Care Plan, dated 12/24/16, documents under Skin, that R8's heel ulcer has deteriorated from when it was first identified as a stage II on 3/4/16 to a stage IV 10/6/16. The goal is for the ulcer to heal without signs/symptoms of infection

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by next review. Interventions include: assess/document wound size, depth, color and drainage weekly, float heels with pillows when in bed, wound care practitioner to see her, heel/elbow protectors on when in bed, monitor/record skin status weekly, monitor for lack of healing and report to physician, monitor for pain due to wound, obtain/monitor labs, position resident off affected area as much as possible, turn & reposition every 2 hours and PRN to maintain body alignment and try to maintain adequate circulation to all pressure points.

Quarterly Dietary Notes written by E11, Dietary Manager, dated 1/12/17, document no pressure ulcers and under "abnormal labs" has "n/a" (not applicable) written. R8 has no supplemental support for low albumin ordered or prescribed even though the Annual Registered Dietician assessment, dated 5/16/16, documents a right heel wound with a Braden score of 14.

On 1/17/17 at 11:10 AM, R8 was in her high back wheelchair at bedside. Her feet dangled off the floor and were extremely edematous. R8 told E8 and E9, Certified Nurse's Aides, CNAs, that she had stool all over her pants and requested to lie down. R8 was transferred to bed and had on a saturated disposable brief and was soiled with stool. R8 had deep red/white creases across her upper thighs, buttocks and hips. R8 repeatedly stated her bottom hurt as incontinent care was provided. At that time, E8 and E9 stated they had gotten R8 up between 7:30 AM and 8:00 AM earlier that morning.
At 11:50 AM, R8's skin was still deeply creased. Her heel dressing was intact and dated 1/17/17 and her feet remained extremely swollen.

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S9999	Continued From page 4 On 1/18/17 at 1:07 PM, E10, Licensed Practical Nurse, LPN, undressed R8's heel. The wound was oblong and irregular shaped, deeper in the center. The surface of the wound was pale pink and the dressing had moderate serosanguinous drainage on it which was slightly pink in the center. No odor was noted. E10 stated the wound is chronic and while she acknowledged the extreme swelling of R8's feet, stated she really isn't up much. E10 confirmed the wound deteriorated then has gotten slightly better. Skin Reports, dated 3/4/16 when R8's heel ulcer was first identified, documents the wound to be 4 centimeters (cm) long by (x) 3.5 cm wide with 0.1 depth recorded and identified as a stage II. Exudate was documented as serosanguinous. There is no documentation present on the assessment that documents why R8's ulcer was not identified earlier considering the size of the wound on 3/4/16 and her need for staff assistance for all bathing and hygiene. The most recent skin report, dated 1/12/17 written by Z1, Nurse Practitioner/Wound Specialist, documents R8's right heel as being a chronic stage IV Pressure Injury which measurements of 0.4 cm x 0.9 cm x 0.1 cm with no undermining noted. The report documents a moderate amount of serosanguinous drainage with no odor. The report fails to document any information or identify the edema of R8's feet. On 1/19/17 at 3:25 PM, Z1 stated R8's wound is chronic, but healing very slowly. Z1 stated they hesitate to order protein supplements without current labs and stated she was not sure about when R8's last had labs taken. Z1 stated R8's foot edema could have an impact on the heel healing.	S9999		

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2. On 01/17/17, R3 remained in the dining room in her wheelchair with no foot pedals from 11:30 AM to 12:45 PM based on 10-15 minute observation intervals. On 01/18/17, R3 was in her wheelchair without foot pedals from 9:30 AM to 12:50 PM based on 10-15 minute observation intervals. R3's bilateral feet/ankles were edematous and reddish in color on both days. At no time during these observations were R3's feet offloaded or elevated. On 01/17/17 at 11:20 AM, during a skin check and toileting for R3, the adhesive dressing on R3's coccyx area was rolled up with the wound bed exposed. The dry dressing on R3's right calf was intact on the edges with scant amount of serosanguinous drainage in the middle of the dressing. The dressing on R3's left heel was intact with serosanguinous drainage in the middle of the dressing. R3's right heel dressing was intact with no drainage noted. E21, Certified Nurses Assistant (CNA), stated the wound nurse had already done dressings changes earlier in the day.

On 01/19/17 at 2:05 PM, E10, LPN, performed dressing change and measurements of R3's pressure ulcers. When the dressing to R3's left heel was removed, there was bloody/brown drainage noted on the soiled dressing. The area had a large layer of dead skin at the 12 o'clock region that was removed by Z1, Nurse Practitioner/Wound Specialist, who stated the skin was from the blister that developed. The wound was measured at 2.1 centimeter (cm) x 3.2 cm x 0.1 cm with a large area of black/brown tissue on the upper region of the ulcer. The bottom portion was bloody and reddened with the center being brown/yellow. There was a smaller opened area at the 10 o'clock region that was bloody and measured 0.6 cm x 1.6 cm.

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S9999	Continued From page 6 The Physician Order, dated 01/17/17, for the treatment for the left heel ulcers were ordered as antiseptic agent (Betadine) and gauze to left heel twice per day and as needed (PRN) every day and evening shift for blister. On 01/19/17, Z1 stated the pressure area was unstageable and ordered a collagenase wound debridement ointment (Santyl) with a dry dressing. Z1 also stated that the legs need to be offloaded to keep the edema down and promote healing. The right outer ankle measured 0.5 cm x 0.2 cm and was observed as a deep purple area the surrounding tissue very swollen and hard. It was described as deep tissue injury by Z1 and to treat with skin prep and offload. The right heel and the left inner ankle were observed with closed skin, but were reddened and noted to have tissue loss from previous in-house acquired pressure ulcers that had recently been healed. The right calf had an unstageable vascular ulcer that was open measuring 2.9 cm x 3.0 cm with multiple black, red and yellow areas throughout the wound. The surrounding tissue was hard and reddish/purple. Z1 stated that the depth could not be determined due to the multiple areas of necrotic tissue. The treatment to the right calf was wound cleanser with 4 x 4 gauze, Santyl ointment and cover with dry dressing. Z1 further stated that offloading the leg wound promote healing and decrease the amount of edema. The pressure ulcer on the coccyx was not observed. The Pressure Ulcer Wound Sheet, dated 01/06/17, documented R3's left heel ulcer developed in-house measuring 5.0 cm x 8.0 cm with edema and painful during dressing change and staged at a level II. There was no causative factor listed. Z1 stated that the wound measurements significantly changed due to the	S9999		

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blister had erupted and would change due to the areas of necrotic tissue.

The Pressure Ulcer Wound Sheet, dated 12/07/16, documented R3 developed a stage II pressure ulcer to the right buttock/coccyx measuring 1.5 cm x 7.0 cm x 0.1 cm with scant serous drainage. The treatment ordered was for a hydrocolloid dressing to be changed every three days and prn.

The Weekly Nursing Skin Assessment, dated 01/11/17, documented newly developed pressure areas to the right ankle measuring 0.5 cm x 0.5 cm and to the left ankle measuring 1.0 cm x 0.5 cm. The left ankle was resolved as of 01/19/17.

The Minimum Data Set (MDS), dated 12/27/16, documented R3 requires extensive assist of at least one staff for bed mobility, locomotion, dressing, hygiene and bathing; and extensive assist of at least two staff for toilet use and transfers.

The Care Plan, dated 01/06/17, documented R3 requires assistance with turning and repositioning. There was no documentation of encourage offloading in the Care Plan.

The Physician's Order Sheet (POS), dated 01/01-31/17, documented R3 was not on any protein supplements or any other dietary supplements to aid in wound healing.

The Braden Scale for Predicting Pressure Ulcer Development, dated 12/30/16, documented R3 was a moderate risk for developing pressure ulcers.

On 01/19/17, E10, LPN, stated R3 had developed

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the bilateral heel ulcers and the right ankle ulcer from the foot pedals on the wheelchair. She stated that the coccyx ulcer developed from non-compliance and sitting in the wheelchair for extended periods of time. E10 stated that the ulcer on the right calf could have been caused by rubbing on the foot pedal as well, even though Z1 stated it appeared to be a vascular wound. E10 further stated that was the reason R3 did not have foot pedals on now. Z1 stated that the legs needed to be offloaded in order for the ulcers to heal.

The Facility's Pressure Ulcer Treatment Policy, revised 10/20/05, documents, "Purpose: To assure each resident that has a pressure ulcer receives the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing;" and continues "#7. Weekly weights will be obtained on all residents with stage III, stage IV or multiple stage II pressure ulcers. Weights and food consumption will be reviewed weekly to address need for supplementation or nutritional enhancement."

3. On 01/17/17 at 11:15 AM to 12:45 PM, R5 was in the dining room in a wheelchair with no foot pedals and no positioning cushion, leaning to the left side. R5's feet were edematous with no support socks on or shoes. On 01/18/17, R5 was asleep with her head slumped forward while sitting in a high back wheelchair with a positioning cushion that came up between her legs (pommel cushion) and bilateral foot pedals on the wheelchair from 9:20 AM to 12:20 PM without benefit of repositioning based on 10-20 minute observation intervals. Multiple staff walked by R5 during this period of time.

The POS, dated 01/03/17, documented R5's

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diagnoses, in part as, Diabetes Mellitus, Obesity, Dementia with Behavioral Disturbances, Parkinson's Disease, Restless Leg Syndrome and History of Falls.

The MDS, dated 11/15/16, documented R5 was moderately cognitively impaired and required extensive assist of at least two staff for transfers, dressing and toilet use.

The Care Plan, dated 01/18/17, documented R5 was identified as having potential for impaired skin integrity due to decrease mobility, incontinence and Diabetes Mellitus. It documented R5 required assistance with turning and repositioning every two hours and as needed to maintain body alignment. It also identified R5 as requiring a positioning device in wheelchair to maintain proper sitting position.

4. R7's undated admission sheet documents R7 diagnoses, in part of, Dementia, lack of coordination, abnormal posture, osteomyelitis, and major depressive disorder. R7's Medical Diagnosis Sheet, dated 4/18/16, documents a nondisplaced fracture of the medial malleolus of the left tibia, closed fracture.

R7's MDS, dated 10/25/16, documents a Brief Interview Mental Status(BIMS) score of 12, indicating moderately impaired cognition.

R7's Braden Pressure Ulcer Risk Assessment, dated 10/24/16, documents a score of 14, indicating moderate risk for developing pressure ulcers.

R7's Care Plan, initiated 4/27/2012, and revised on 11/02/2016, documents in part, R7 needing assistance to reposition every 2 hours and as

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S9999	Continued From page 10 needed to maintain body alignment and to maintain adequate circulation to all pressure points. On 01/17/17, R7 remained seated in the wheelchair in her room without benefit of repositioning from 10:50 AM until 1:00 PM based on 10 to 15 minute observation intervals. At 1:00 PM, E4 and E6, CNAs, transferred R7 from the wheelchair to the toilet. E6 stated R7 had been up in the wheelchair since 7:45 AM. On 1/18/17, R7 remained seated in the recliner in her room without benefit of repositioning from 9:05 AM until 11:25 AM based on 10 to 15 minute observation intervals. At 11:25 AM, E5, CNA, wheeled R7 to the dining room. During the noon meal from 11:25 AM until 12:41 PM, R7 continued to sit in the wheelchair. At 12:43 PM, R7 was transferred from the wheelchair to the recliner. On 1/20/17 at 2:00 PM, E3, Assistant Director of Nursing (ADON), stated that it is the expectation of staff to reposition residents every 2 hours and as needed. The Facility's undated Positioning Policy documents, in part, "The most effective means of pressure relief in positioning residents is the change of position. Pressure over extended periods of time results in tissue destruction." (B)	S9999		