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	145714	A. BUILDING _____ B. WING _____	C 09/07/2004

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OAK PARK HEALTHCARE CENTER	**625 NORTH HARLEM OAK PARK, IL 60302**

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F9999	FINAL OBSERVATIONS Complaint #0493670/IL12070: no findings	F9999		

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F9999	Continued From page 17 Complaint #0493866, #0493926 and #0493944: see F224 and F309 STATE VIOLATIONS ASSOCIATED WITH THESE COMPLAINTS: 300.610 a) 300.1010 h) 300.1210 a) 300.1210 b) 300.1210 b) 3) 300.1210 b) 5) 300.1220 b) 300.1220 b) 6) 300.1220 b) 8) 300.3240 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 there under. 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. Facility staff shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health,	F9999		

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F9999	Continued From page 18	F9999		

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.

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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.

General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

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F9999	Continued From page 19 services to promote healing, prevent infection, and prevent new pressure sores from developing. The DON shall supervise and oversee the nursing services of the facility, including: Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility training programs. This person may conduct these programs personally or see that they are carried out. An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met based on observations, clinical record review, staff interviews, resident interview, other interviews, review of facility documents and review of hospital records, the facility failed to ensure that one resident (R3), was free from neglect as evidenced by the facility's: 1. Failure to identify changes in R3's bilateral lower leg wounds caused by maggot infestation 2. Failing to provide timely treatment to eradicate this infestation that further resulted in the formation of numerous clusters and layers of maggots in these wounds putting R3 at risk for further damage to the remaining healthy tissue.	F9999		

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F9999	Continued From page 20 3. The facility treatment nurses, who were inexperienced and licensed-pending, were assigned to provide care and treatment for R3, who had extensive and complicated wound care without the direct supervision of a licensed nurse. This practice placed R3 and other residents, who depend on facility staff for treatments and wound care, at risk due to the potential for lack of timely and correct assessment and treatment of wounds . 4. The treatment nurses failed to note that resident was not responding to current treatment. 5. Failure to notify physician of a wound condition that was worsening between 8/12/04 when R3 was re-admitted to the facility and prior to his hospital admission on 8/17/04. R3 was found to have a gross infestation of maggots in these wounds that consisted of multiple layers and clusters of maggots. R3 was admitted to hospital on 8/17/04 after facility identified the infestation. R3 had both legs amputated and was readmitted to the facility. Findings include: R3 was admitted to the facility on 7/1/04 with diagnoses including hypertension, peripheral vascular disease, congestive heart failure, and cellulitis of the bilateral lower extremities with wound drainage. According to the most recent comprehensive resident assessment dated 7/13/ 04, R3 has modified independence with cognitive skills for decision-making and has no memory deficits. R3's long term and short-term memory are intact. The resident requires supervision with activities of daily living and personal hygiene. The resident assessment documented that R3 had stasis ulcers to the lower extremities and	F9999		

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F9999	Continued From page 21 daily pain. During an interview on 8/26/04, R3 stated that he was admitted to the facility with ulcers to both lower legs. R3 stated that the ulcers were "really bad" and he had pain daily that made treatments painful. According to the resident, there was so much drainage, that the dressings were always soiled and the wounds had an obvious foul odor. R3 stated that the wounds were large and covered most of the right and left lower legs. R3 further stated, "Towards the end, the wounds got worse"; that 3-4 days before he was hospitalized on 8/17/04, he saw that the wounds were covered with maggots; that the treatment nurse (E3) would "clean the maggots out" of the wounds and reapply clean dressings on the bilateral leg wounds. R3 told surveyor that, by her actions, he believed that the nurse was aware of them and recognized that they were in the wound. R3 said the maggots were visible; he had identified them and assumed that the staff knew this also. On review of the facility's Weekly Skin Report, dated 8/13/04, R3 had multiple ulcers. It was documented that R3 had a Stage 4 pressure ulcer to the sacral area (4 cm x 2.5 cm); Stage 1 pressure ulcers to the left and right buttocks (2.5 cm x 2 cm and 2 cm x 1 cm, respectively); and a Stage 1 pressure ulcer to the left hip (2.5 cm x 1. 5 cm). The Weekly Skin Report also documented that R3 had two non-stageable ulcers to the left and right lower legs. According to the report, the non-stageable wounds covered 90% of the resident's left lower leg; and 80% of the right lower leg. It was also documented that the wounds were red, yellow and green in color, with a large amount of serosanguinous drainage	F9999		

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and a foul odor. R3 had massive wounds to the bilateral lower extremities requiring daily treatment and monitoring. There was no documentation in the chart that the treatment staff assessed the wound, recognized that it was worsening and sought referral either with licensed staff or the physician.

Review of the Nurse's Notes, Wound Report Notes, Weekly Skin Report and Treatment Administration Record and the Physician's Notes, prior to 8/17/04, revealed no documentation identifying R3 had an infestation of maggots in bilateral lower extremity wounds. There was also no evidence that treatment staff notified the physician of the drainage and odor of these wounds.

The Treatment Administration Record documented that E3 changed the lower extremity dressings on 8/12/04, 8/13/04, 8/14/04 and 8/15/04. There was no evidence that E3, the treatment nurse, identified that the wounds were worse or that E3 sought further guidance from the licensed nurse who was to be supervising E3 during her license-pending status. Changes in R 3's wound condition were not documented in the clinical record between 8/12/04 and 8/16/04 even though drainage and odor was reported as being evident in the wound and R3 was not responding to treatment.

E4 stated, during an interview on 8/26/04, that her responsibilities as treatment nurse began on 8/16/04, when E3 (previous treatment nurse) took time off to prepare to take the state board exam for her nursing license. E4 stated that R3 refused to have his dressings changed on 8/16/

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F9999	Continued From page 23 04. According to E4, several attempts were made to encourage the resident to comply with dressing changes, but the resident continued to refuse. E4 did not notify physician of R3 refusing the treatment on 8/16 or any change in wound especially in view of the previous documentation of drainage and odor indicating infection. E4 stated that R3 was cooperative with the dressing change on 8/17/04. E4 stated that during the dressing change on 8/17/04, R3 had "maggots all over his wounds." E4 , who was sweating profusely and nervous, stated she had never seen maggots in a wound " like that." E4 further stated when she removed the dressings E3 had applied on 8/15/04 she was so shocked to find maggots in the wounds, that she immediately replaced the dressings, and left R3's room to call the physician and inform the director of nursing. E4 stated the wounds were totally covered with maggots. The maggots were cleaned out of the resident's wounds and he was transferred out to the hospital, as ordered by the physician. During a telephone interview with E3, on 9/2/04, E3 stated that she changed R3's dressings on 8/12/04, 8/13/04, 8/14/04 and 8/15/04. E3 further stated that she did not see any maggots in the resident's wounds when she changed the dressings on 8/15/04. However, E3 stated that she has never seen maggot, other than in a book . E3 stated during the dressing change on 8/15/04, she was accompanied by a facility staff nurse (E5), who was a new hire and was also license-pending to practice nursing. On review E3's employee file, it was determined that E3 was hired by the facility on 6/14/04, as a Charge	F9999		

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Nurse. On the date of hire, E3 was a license-pending nurse, as she had not taken her state board for licensure. Upon further review of E3's employee file, it was documented that the facility was unable to obtain a work history, as E3 had never worked in this country.

Although the maggots had been cleaned out of the wounds prior to the resident presenting to the emergency room on 8/17/04, there were still clusters and layers of maggots remaining on the wounds. The hospital Emergency Treatment Record documented that R3 presented with " wounds/ulcers to legs with maggots noted; odor to legs; tendon exposure noted right leg." The Photographic Wound Documentation indicated that R3 presented to the emergency room with massive wounds to the left and right lower extremities. On observation of the wounds, as depicted in the hospital Photographic Wound Documentation, there were visible maggots along the borders of the wounds to the inner and outer areas of the bilateral lower legs. In addition, the wound to the posterior right leg, near the area of the Achilles tendon, shows a large cluster/mound of maggots, which presented as a large, raised area.

During a telephone interview on 8/27/04, Z1 (emergency room physician) stated that R3 presented to the emergency room with multiple layers of maggots in his wounds. Z1 further stated, "I've never seen maggots like that before." Z1 stated that in her career as a physician, she had never seen a patient with maggots that severe. "He had layers, and layers, and layers, and layers... of maggots." Z1 further stated that she was concerned that the maggots would

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F9999	Continued From page 25 cause damage to the remaining healthy tissue. According to Z1, the infestation of maggots to the resident's wounds did not appear within a 24-hour period and would have been visible earlier. Z1 further stated, "This did not happen overnight ." and would have been present in the wound prior to the emergency room admission to hospital. Facility staff utilized license-pending, inexperienced staff to provide treatments and wound care, failing to supervise these staff and ensure that wounds were being properly assessed and monitored. Facility staff failed to identify the maggots in these wounds. In an interview with E1 and E2, it was revealed that the facility policy, related to supervision of license-pending staff, is to watch them do a few treatments and then allow them to do it on their own. This policy does not allow for direct supervision as required by the Illinois Department of Professional Regulation. (A)	F9999		