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	145856	A. BUILDING _____ B. WING _____	09/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM L DAWSON NURSING HOME	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

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F 325	Continued From page 55 Per record review, the last intervention regarding R14's weight loss was 6/30/2006. R14's nutritional care plan with a targeted date of 11/2006 indicates that the resident will maintain his weight of 137.5 pounds. On 9/14/2006, R14 refused to be weighed. Per record review, R14's gradual weight loss has not been assessed by E13. R16 has the following record weights: Date (Pounds) Weights 4/2006 115.00 5/2006 113.75 6/2006 100.75 7/2006 113.25 8/2006 113.25 9/2006 94.25 Per record review, R16's care plan states that the resident's Physician should be notified of any significant weight change. R16 had a significant weight change between August and September of 2006. The Physician was not called. E13 did no assessment.	F 325		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.610c)2) 300.1010b) 300.1010h) 300.1210a) 300.1210b)2) 300.1210b)5)	F9999		

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F9999	Continued From page 56 300.3240a) 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. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.1010 Medical Care Policies b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory	F9999		

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F9999	Continued From page 57 committee. 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) The facility must 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 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. Restorative measures shall include at a minimum the following procedures: b) 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	F9999		

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F9999	Continued From page 58 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) Based on observation, record review, staff interviews, review of hospital records and review of the facility's pressure ulcer prevention policy and procedures the facility failed to ensure that the facility was free of neglect in the areas of pressure sores as follows: 1. Failed to ensure that residents are monitored and new pressure sores are identified. 2. Failed to assess pressure sores upon readmission to the facility. 3. Failed to provide treatments to promote healing of pressure sores. 4. Failed to provide services to prevent new pressure sores from developing. 5. Failed to perform an assessment before treating a pressure sore. 6. Failed to obtain a physician's order before treating a pressure sore. 7. Failed to assure that all pressure sores are covered or provided some type of barrier in an effort to prevent contamination/infection of the pressure sores.	F9999		

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F9999	Continued From page 59 These failures occurred for 6 of 13 sampled residents (R3, R4, R6, R7, R17 and R19) identified as high risks for pressure sores and has led to each resident having newly developed pressure sores, and/or worsening pressure sores. The result of the facility's failure to identify, assess, treat and monitor for pressure sores has led to R3 having a pressure sore that has worsened from a stage 2 to a stage 4, as well as R3 developing 11 other pressure sores in the facility that have progressed to stage 3 and stage 4 without being identified, assessed or treated. These failures have also led to R7 developing 2 new pressure sores in the facility, one site having progressed to unstageable without being identified, assessed or treated, as well as R17 receiving treatments to pressure sores without an assessment and/or physician's orders. These failures have also led to R19 developing a pressure sore in the facility that has developed to a stage 4 without being identified, assessed or treated. Although R3, R7 and R17 are identified as high risk for skin breakdown there were no preventive measures implemented by the facility to prevent new pressure sores from developing. Findings include: 1. R3 is an 87 year old resident who was admitted to the facility on February 08, 2006 with diagnoses including Seizure Disorder, Anemia, Dementia and Dehydration. A review of the resident's medical record and MDS (Minimum Data Set) assessment dated 06/09/06 indicates that R3 scores '2' in cognition indicting moderately impaired. Further review of this MDS indicates that R3 requires extensive assist or	F9999		

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F9999	Continued From page 60 total assist in all areas of care. R3 is also identified as Blind. R3 is assessed as high risk for pressure sores again on 08/20/06. On 09/11/06 at approximately 10:05 AM, E2 (Director of nurses) was interviewed regarding pressure sores on the 4th floor of the facility, identified as a Dementia/Intermediate unit. E2 stated, "I think there is only 1 healed pressure sore on this floor." During the initial tour with E8 (nurse) on 09/11/06 at approximately 10:20 AM, R3 was lying in bed on her right side with a contracture noted to the left hand. The head of R3's bed was elevated and both side rails were in a raised position. R3's eyes were closed but R3 responded to the calling of her name by briefly opening her eyes, staring at the ceiling and closing her eyes again. Upon prompting by surveyor, E8 removed the covers of R3 and repositioned her. R3 grimaced and groaned with pain upon this movement, both knees were also noted to be contracted with a pillow between them, and there were heel protectors in place to both of R3's heels. Surveyor with E8 observed 4 open areas and 1 necrotic area on R3 as follows: **right hip - open area with black in the middle and surrounding pink/red area, **right lateral foot/heel - open area with black in the middle and surrounding pink/red area, **left heel - a large black soft area covering the entire heel, **left shoulder - open area with black center and surrounding pink/yellowish area, and **left hip - open area with black center and surrounding pink/yellowish area. There were no treatments or dressings on these pressure sores and R3 was not on any pressure relieving	F9999		

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F9999	Continued From page 61	F9999		

mattress even though she was assessed as high risk for pressure sores since August 20, 2006. There was no incontinence pad in place and a small amount of soft brown stool was noted on R3's sacral area at this time.

E8 who was present during this observation was interviewed regarding these pressure sores and and treatments stated, "I don't know anything about R3 having pressure sores, I'm not working on this side, I usually work on the other side."

Surveyor then reviewed the clinical record of R3 and was unable to locate an order for treatments for these pressure sores or evidence that R3's physician was aware of these pressure sores. There were no assessments for these sites, and pressure sores were not addressed on R3's care plan.

At 1:50 PM on this day, E9 (nurse) was interviewed regarding R3 having pressure sores and receiving treatments. E9 stated, "I didn't know R3 had pressure sores." E9 continued, "I don't know anything about assessments for those sites, I just called Z1 (physician of R3) and he told me to have E5 (treatment nurse) to assess them and call him back."

At approximately 2:10 PM on this day, E5 came to this floor and stated to surveyor in a surprised manner, "I never knew anything about R3 having those areas (pressure sores) until today (09/11/06) ! !" E5 continued, "I just saw those areas you (surveyor) are talking about, I'll assess them, measure them and call Z1."

At approximately 2:30 PM, E5 approached surveyor and stated, "I just spoke with Z1 and he

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F9999	Continued From page 62 ordered treatments for all of those sites. I also put a turn schedule over R3's bed, and I'm ordering a low loss air mattress for her bed." On 09/12/06 at approximately 10:30 AM, R3 was observed sleeping on a low loss air mattress, with bilateral side rails intact. R3 was again observed to be nonverbal. There was a turn schedule posted above R3's bed and there were dressings noted on R3 at various pressure sore sites. On 09/12/06 at approximately 10:30 AM, E5 approached surveyor and stated, "I measured and charted all the pressure sores and I have physician's orders for each." Upon further interview, E5 stated, "I observed 12 new sites on R3 on yesterday (09/11/06)!!" E5 provided surveyor with assessments and the following measurements of newly identified pressure sores: -Right outer ankle stage 3, measuring 2.6 x 1.0 x 0 cm.(centimeters) and Black in color. -Left outer ankle/foot stage 3, measuring 1.6 x 1.3cm and black in color. - Right inner heel (#5) stage 3, measuring 1.4 x 1.2 cm and dark discoloration. - Right outer heel (#6) stage 3, measuring 2.3 x 2.0 cm. and pink around edges red 1/2, black 1/2 in color. - Left outer great toe (#7) stage 4, measuring 2.0 x 3.0 cm. eschar in color.	F9999		

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F9999	Continued From page 63 - Right foot heel great toe (outside #9) stage 3, measuring 1.0 x 3.0x .1cm. and black discoloration. - Left shoulder (#10) stage 3, measuring 3.8 x 3.5 x .1cm and eschar with pink in color. - Right trochanter (bottom #11) stage 3, measuring 0.4 x 0.5cm and 100% pink in color. - Right trochanter (top #11) stage 3, measuring 1.0 x 1.0 x.1cm and pink around edges with yellow slough. -Left trochanter (#12) stage 4, measuring 5.0 x 3.5 x .1cm and black with red in color. - Right outer foot (middle #13) stage 3, measuring 1.6 x 1.5 cm and black discoloration. - Left inner heel (#14) stage 4, measuring 7.0 x 5.5 x .1cm and eschar in color. This review and interview indicated that after prompting by surveyor, E5 identified 7 additional sites in addition to the 5 sites already observed by surveyor. Surveyor again interviewed E5 regarding how pressure sores are communicated to her for assessments and how these pressure sores were missed. E5 stated, "The nurse assistants have to do skin checks on residents when they give them showers and let the nurse know if they find any sores and the nurse then lets me know." E8 was interviewed regarding shower schedules for residents when skin checks are done. E8 stated to surveyor that the CNA's (certified nurse	F9999		

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F9999	Continued From page 64	F9999		

assistants) follow the posted schedule on this wall. Surveyor then observed a room layout with days showers are to be given to residents taped on the wall at the nurses station, however surveyor was unable to locate a shower tracking system on this floor. Upon further interview E8 stated, "The CNA's are suppose to document on the shower form the skin condition of residents and give the form to the nurse."

On 09/12/06 at approximately 11:00 AM, E10, CNA, (certified nurse assistant) was interviewed regarding showers and daily skin checks on residents and documentation regarding it. E10, E8 and E9 all attempted to locate shower forms for residents. After approximately 10 minutes of search, E8 pulled out a large stack of unorganized shower forms from a drawer which dated back to 04/06. There was no current documentation that residents were receiving showers and there was no forms indicating that R3 were receiving showers or daily skin checks.

E10 (CNA) was again interviewed regarding documenting showers given to residents. E10 stated, "We really don't write down the baths."

Review of R3's hospital records indicates that R3 was discharged from the facility to a local hospital on 07/30/06. On 08/02/06 while still a patient at this hospital, R3 was observed by hospital staff as 'having 2 small stage 2 superficial sacral ulcers and all other skin intact."

Record review indicates that R3 was readmitted to the facility from this hospital on 08/04/06 with a stage 2 pressure sore to the left hip. There has been no assessment done, nor any treatment ordered, for this pressure sore even though it

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F9999	Continued From page 65 was identified by facility staff upon readmission on 08/04/06. The facility has a Pressure ulcers, Prevention and Treatment policy and procedures which includes: 5. a. Charge nurses are to check all residents at risk for skin condition. Frequency is documented in residents' plan of care. b. Certified Nurse Assistants are to check all residents skin condition daily and report any changes. 8. Individualized pressure ulcer prevention plan is developed and documented in care plan. Policy 1. All residents are assessed for pressure ulcer risk upon admission, quarterly and as needed. 2. Preventive measures are instituted immediately for residents at risk. With the exception of heel protectors, none of the above policy and procedures were followed for R3. 2) R19 was observed on 9/12/06 sitting in the 2nd floor dining room. Surveyor observed open reddened areas and blisters to R19's right upper arm and elbow area. On 9/13/06 at 10:30 AM surveyor observed R19 sitting in the dining room with a dry gauze dressing to the right elbow area. Surveyor requested E6 (RN) to do a skin check	F9999		

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F9999	Continued From page 66 on R19. At 10:45 AM R19's diaper was removed and surveyor observed a dry 4 x 4 dressing to R19's sacral area. As E6 removed the dry dressing, pieces of R19's skin came off with the dressing. Surveyor observed multiple (8) open reddened areas to R19's left buttock, 2 open reddened areas to the right buttock, 2 reddened areas to the right posterior thigh, and an open area to the sacral area. Surveyor asked E7 (CNA) to remove the stocking from R19's left foot. Surveyor observed a large blackened closed area to the left outer heel. E7 was asked if she had observed the blackened area to the left heel during AM care or on the previous day. E7 stated "no." Surveyor asked E7 if she had removed R19's sock during AM care and E7 stated "no." E6 stated R19 came in with a rash and no pressure sores. R19's record was reviewed by surveyor on 9/13/06 at 10:15 AM, and revealed R19 was admitted to the facility on 9/8/06 with diagnosis that includes status post (s/p) right below the knee amputee, Diabetes Mellitus, Pneumonia, and Pernicious Anemia. Review of R19's admission and assessment record for nursing dated 9/8/06 revealed R19 was admitted to facility with "multi blisters all over her body with multiple decub also Stage II to sacral area Rt. (right) and Lt. (left) buttock, Lt. and Rt. arm and elbow. Further documentation revealed R19 had a rash secondary from antibiotics (Vancomycin). An order for Triamcinolone lotion 0.1% to body rash was carried over from the hospital. Review of R19's treatment administration record and current physician order sheet lacked documentation of any orders for the pressure ulcers. Nurses notes dated lack documentation of an ongoing assessment of R19's multiple	F9999		

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F9999	Continued From page 67 pressure ulcers and wounds. Wound assessment book on 9/13/06 lacked any wound assessment sheets done on R19. Treatment note section of R19's chart lacked documentation any assessment for R19's multiple wounds and lacked documentation of R19 physician was notified for treatment orders. There was no care plan addressing R19's pressure ulcers or wounds or pain assessment completed for R19. E5 (treatment nurse) stated in interview on 9/13/06 she had done an initial assessment on 9/9/06 but was unable to find it in the chart. On 9/13/06 at 1:00 PM, E5 provided surveyor with the following new wound assessments: -Left outer heel- wound type-pressure ulcer, unstageable, 5.0 length, 3.0 width, 0 depth,black wound base. -Sacral pressure ulcer-Stage III, 4.0 length, 2.0 width,4 depth, pink with black yellowish wound base, with not drainage -Lt buttock (top) pressure ulcer- Stage 2, 3.0 length, 2.0 width, 4 depth, pink wound base, no drainage -Lt buttock (bottom) pressure ulcer-Stage 2, 2.0 length, 1.0 width, 0 depth, pink wound base, no drainage -(R) inner arm antecubital-blister Stage 2, length 4.0, 6.0 width, 0 depth, pink in color -(Lt) inner arm-blister-Stage 2, length 1.0, width 2.8, depth 0, pink in color On 9/13/06, E5 stated R19's physician was notified and orders for a topical occlusive dressing was obtained for the sacral pressure ulcer, and to leave left ankle open to air. Heel protectors were also ordered and E5 stated R19 had been placed in a low air mattress bed.	F9999		

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F9999	Continued From page 68 Assessments, preventive devices and physician orders were implemented only after prompting by surveyor on 9/13/06, 4 days after R19's admission. 3. During pressure sore treatment with E5 (Treatment Nurse) on 09-12-06 at 12:20 PM, R7 was observed lying in bed. R7 was observed with bilateral heel protector in place. Upon prompting E11(Certified Nurse Aide) to removed the heel protector, surveyor observed the left heel was noted to be discolored and surrounded by a fluid filled blister. The left heel size was 4 X 3 cm. R7 was also observed with a redness area on the left bunion. R7 was observed total dependence on staff for activity of daily living. Review of the medical record revealed R7 was admitted from hospital on 09-08-06 with diagnosis that included Failure to Thrive, Dementia, Hypertension, Degenerative Joint Disease of the Left Hip and Depression. During Interview with E11on 09-12-06 at 12:25 PM in R7's room, surveyor asked E11 if checked the heel of the resident during morning care. E11 stated, "No, I did not see the discoloration on the heel. I did not take the heel protector off until now when you (Surveyor) came in. The boots were already on when I came to work." Interview with E5 on 09-12-06 at 12:30 pm in the room stated, "R7's left heel has a bruise. The nurses are suppose to assess the resident on the floor. I am the treatment nurse for the 2nd floor. If they have a problem pressure sore, they will call me. The left bunion is a stage 1." Interview with E9 (Nurse) on 09-12-06 at 12:40	F9999		

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	145856	A. BUILDING _____ B. WING _____	09/20/2006

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F9999	Continued From page 69 pm, the nurse stated," I did not know anything about left heel or bunion pressure sore. The left heel is unstageable. The left bunion is stage 1." Interview with E6 (Medicare Nurse) on 09-12-06 at 12:50 PM at the nurse station, E6 stated, "It is beginning to have fluid in it. It is a blister with fluid. It is a new pressure sore. It is unstageable. The left bunion pressure sore is a stage 1." Surveyor asked who does the skin check? E6 stated, "The Certified Nurse Aide does the daily skin check. There is no skin check for this resident. There is no assessment, treatment or care plan for the pressure sores. Also, the physician and family was not notified about the new pressure sores." Review of the Minimum Data Set dated 08-03-06 stated, "Section: M: Pressure ulcer (a). Stage 1/0 (b). stage 2/0, (c) stage 3/0 and Stage 4/0." Review of the Wound Assessment Flow Sheet confirm there were no orders for the pressure sore. Review of the Norton Plus Pressure Ulcer Score Scale - For predicting pressure sore - R7 was score a risk high." Review of the physician order sheet date 09-01-06 confirmed there were no treatment orders for the left heel and bunion pressure sore. R7 was also observed on 09-12-06 at 12:20 PM with a sacrum pressure sore with an occlusive dressing heavily soiled with a large amount of drainage. Review of the Treatment Record confirms that the dressing was changed on 09-09-06. Surveyor did not observe the staff changing sacrum ulcer dressing on 09-12-06. Further review of the treatment sheet confirmed	F9999		

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F9999	Continued From page 70	F9999		

the sacrum ulcer dressing should have been changed on 09-11-06. There was no signature the dressing was changed. The treatment record dated 09-12-06 was blacked out. The sacrum ulcer was to be done on 09-14-06. The treatment sheet confirmed the sacrum ulcer was not treated in 5 days.

Review of the Physician Order dated 09-09-06 stated, "Cleanse sacrum left and right buttock with normal saline solution and apply occlusive dressing every 72 hour (PRN) whenever necessary."

According to interview with E9 stated, "The sacrum and buttock topical dressing is heavily soiled and needed changing."

4. Surveyor observed R17 on 09-13-06 at 10:10 AM lying in bed. R17 was observed with a dressing on the right upper thigh with large amount of serous drainage. Surveyor observed E5 cleanse pressure sore with wound cleanser, applied tropical medication and dry dressing.

Review of the Physician Orders dated 08-01-06 to 09-13-06 confirmed there was no order for the right upper thigh pressure sore treatment.

Review of the wound assessment flow sheets and care plan dated 08-01-06 to 09-13-06, confirm there are no assessments or care plan of right upper thigh pressure sore. Further Review of the medical record confirms that the physician and family were not notified of the pressure sore.

Upon prompting, E5 checked the physician orders for an order for R17's right upper thigh pressure sore. Per interview with E5 on 09-13 at

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F9999	Continued From page 71 11:00 AM on 2nd floor at nurses station, E5 stated, "There is no physician's order, assessment or care plan for the pressure sores. It is a stage 2 pressure sore." Surveyor also observed R17 with a dressing on the right outer ankle. E5 cleansed with wound cleanser, applied topical medication and dry dressing. Review of the wound assessment flow sheet dated 08-01-06 through 09-13-06 confirm that the right outer ankle was not assessed nor care planned. Interview with E5 on 09-13-06 at 11:00 am at the nurses station state, "There is no assessment or care plan for the right outer ankle." 5. R6 is a 90 year old resident with diagnoses including Dementia, Glaucoma, Depression and left eye enucleation. R6 is moderately cognitively impaired and requires assist from staff in all areas of care. R6 is identified as high risk for skin breakdown. On 09/11/06 at approximately 10:35 AM, R6 was observed on bedrest with bilateral side rails in raised position. R6 was noted with the left eyelid completely closed and looking with the right eye. E8, who was present at this observation, stated, "R6 is blind in the left eye and has a stage 2 to her sacral area. E8 was prompted by surveyor to remove R6's bed linen, so that this pressure sore could be observed. Surveyor, with E8, observed a large open area to R6's coccyx. This coccyx and sacral area was completely covered with a thick white cream. There was no dressing or other barrier in place. E8 stated to surveyor "That's Baza (protective) cream that the CNA applied to her this morning, I haven't had time to	F9999		

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F9999	Continued From page 72 do R6's treatment yet." Record review indicated a current assessment of R6's pressure sore dated 09/06/06 as follows: -Left buttock stage 1, measuring 1 x 1cm and red with pink margin in color. R6 has a current physician's order for pressure sores as follows: "Hydrogel dressing -apply to sacral area after NSS (normal saline solution) cleanse cover with clean dry dressing daily and as needed." "Hydrogel dressing to right lower buttock daily til healed" This order and assessment is in conflict with the observation made by surveyor with E8 when it was directly observed that R6 has a pressure sore to the coccyx/sacral area. E8 could not provide surveyor with an explanation for this discrepancy. There was also no dressing in place to this site per physician's orders, putting R6's at risk for contamination and prevent healing of this pressure sore. 6. R4 is a 75 year old resident with diagnoses including Dementia with psychoses, Seizure disorder, and Cerebral vascular accident. R4 is moderately cognitively impaired and requires assist in all areas of care except eating. R4 is identified as high risk for skin breakdown. On 09/11/06 at approximately 10:45 AM, R4 was observed in bed with both side rails in a raised position. R4 was alert, conversant and with a smell of urine. E8 who was present during this observation stated to surveyor, "R4 has a stage 2	F9999		

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F9999	Continued From page 73 pressure sore to the left buttock." After prompting by surveyor, E8 removed the bed linen of R4 and surveyor observed a large open area to R4s left lower buttock. There was no dressing or barrier in place. The sheets and thick padding below R4 were heavily saturated with yellow liquid having a strong smell of urine. E8 stated, "I haven't done R4's treatment yet," but E8 had no explanation as to why there was no dressing in place to R4's pressure sores. R4 has current pressure sore assessment dated 09/06/06 as follows: -Upper left buttock Left lower buttock, stage 2, measuring 3 x 3Cm and pink/reddish in color. R4 has a current physician's order as follows: "Curasol wound gel- Hydrogel dressing apply to lower left buttock twice daily until healed." The scheduled times for these treatments are between 6am - 2pm and between 2pm - 10pm. Review of R4's TAR (treatment administration record) for the month of September indicated R4 has not been receiving treatments as ordered. R4 did not receive treatments to her left lower buttock sore on the following days: 2pm - 10pm September 4, 5, 6, 7 or 8th. (A)	F9999		