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F 000	INITIAL COMMENTS Complaint #0741045/ IL27684 - F314, F324 Complaint #0741113/ IL27748 - No deficiencies Complaint #0740907/ IL27537 - No deficiencies A partial extended survey was conducted	F 000		
F 314 SS=J	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the Facility failed to identify and evaluate risk factors, implement interventions and modify interventions as appropriate, for the development of pressure sores for 2 residents on the sample, R1 and R7. This failure resulted in R1 developing 3 new pressure areas on her right foot and R7 redeveloping Stage 4 pressure sores on her right and left heels. This failure resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 3/23/07, the Facility remains out of compliance at severity level two, while the Facility continues to educate staff on the use of braces and reducing	F 314		3/28/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 314	Continued From page 1 skin breakdown and monitoring their understanding of the importance of skin assessment and correctly fitting braces. Findings include: 1. R1, has diagnoses, in part of Epilepsy due to History of Brain Cancer, History of Pelvic Fracture, Osteoporosis and Hypothyroidism. R1 experienced a fracture of her right femur in the Facility on 12/12/06. R1's physician and family made the decision not to surgically repair R1's right femur fracture due to R1's medical status. R1 was transferred back to the Facility from the hospital on 12/18/06, with a brace on her right leg. E2, Director of Nursing, stated that the family and physician decided to place R1 on Hospice upon her return to the Facility due to her condition. Review of Facility "Weekly Infection Control Report", on which they track decubitus, shows that on 3/6/07, R1 developed 3 unstaged pressure sores on her right outer heel (2.4 centimeters by 2.6 centimeters), right lower achilles (1.4 centimeters by 0.5 centimeters) and right upper achilles (0.6 centimeters by 1.0 centimeters). All 3 pressure sores were covered with eschar. R1's plan of care, dated 1/25/07, has a goal of "resident will have no skin breakdown during this quarter". Approaches include: "Hospice will assess resident skin every visit. Avoid shearing resident's skin during positioning, transfers and turning. Pressure reducing devices in bed". On 3/15/07, E3, LPN, was observed changing the dressing on R1's right foot. It was noted that R1 was wearing a brace on her right leg which is secured with Velcro straps. The brace had a stiff metal stay which ran along the back of the brace.	F 314		

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F 314	Continued From page 2 When E3 removed the brace, it was noted that the area of the 3 pressure sores on R1's right foot corresponds directly to the metal stay in the back of the brace. The only padding between the brace and metal stay and R1's skin was a folded up pillow case. E3 said that R1's leg brace kept sliding down and would rub against R1's skin. The surveyor then noted that the nail was missing from R1's right little toe and the little toe was blackened in the area where the toe nail had been. E3 confirmed that the Facility had not noted the problem with R1's little toe until the surveyor brought it to their attention. E1, Administrator, and E2, stated during an interview on 3/15/07, that they had telephoned R1's physician "a few days ago" about the brace and he said he did not want a different type of brace. However, the Facility ordered a new brace for R1 on 3/16/07, after the sliding of the current brace was brought to the attention of the Facility. The new leg brace, which E1 stated should reduce pressure and rubbing, was placed on R1's leg on 3/26/07. On 3/26/07, E2 stated that R1's pressure sores had now been Staged as the eschar had sloughed off of the wounds. E2 said that the pressure sore on the right outer heel is a Stage IV and the other two pressure sores on R1's feet are Stage II's. The Facility failed to prevent avoidable pressure sores and failed to implement interventions for R1 when pressure sores did develop, to ensure that existing pressure sores did not worsen and additional pressure sores did not develop. 2. R7 has diagnoses, in part, of Renal Failure, Gout and Hypertension. R7's most recent Minimum Data Set (MDS), dated 2/19/07, shows	F 314		

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F 314	Continued From page 3 that she has short and long term memory problems, is non-ambulatory, requires the extensive assistance of two or more people for transfers and has 2 Stage 4 pressure sores. Facility plan of care shows that R7 was admitted to the Facility on 5/31/06 with a Stage 2 decubitus to her right buttock and Stage 4 decubitus to her left and right heels. E2, in an interview on 3/15/07, stated that the pressure sores on both of R7's heels were healed but, recently reopened. Facility "Weekly Infection Control Report" shows that the pressure sore on R7's right heel was healed on 9/11/06 and the left heel was healed on 10/6/06. Facility "Weekly Infection Control Report" shows that on 12/9/06, R7 developed a 0.3 centimeter x 0.9 centimeter x 1.0 centimeter pressure sore on her right heel, and on 1/30/07, R7 developed a 0.3 centimeter x 1.2 centimeter x 1.5 centimeter pressure sore on her left heel. Both are Stage 4 pressure sores. During observations of R7 on 3/15/07, it was noted that R7 was sitting in a wheelchair with a leg support which ended at R7's mid-calf area, and was wearing splints on both of her feet. R7's feet and lower legs were dangling down over the edge of the support about 6 - 8 inches below the height of her knees. E9, CNA, laid R7 down at approximately 3:30 PM and her leg braces were removed. It was noted that R7's leg were very swollen and edematous above where the splints had been. There were very deep, red creases in the back of R7's calves where they had rested against the edge of the wheelchair support. During an interview of E2 on 3/15/07, it was stated that Physical Therapy had placed the leg support on R7's wheelchair as the wound nurse told them that nothing should be touching R7's heels. E2 stated that the leg support should be longer to prevent R7's feet from dangling.	F 314		

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F 314	Continued From page 4 The Immediate Jeopardy was identified on 3/26/07. The Immediate Jeopardy began on 3/6/07 when R1 developed three new pressure sores. On 3/26/07, at 10:15 AM, E4, Assistant Administrator, was informed of the Immediate Jeopardy at the Facility. The Facility took the following steps to remove the Immediate Jeopardy: 1. On March 12, 2007, a new 20 inch brace was ordered for R1. 2. On March 15, 2007, nursing and CNA staff were inserviced regarding the proper application of the brace. 3. On March 16, 2007, all residents with orders for braces and/or splints were evaluated to ensure that they had not experienced skin breakdown. Revisions were made to care plan as necessary. 4. On March 21, 2007, R1's pressure sore was stage, measured and evaluated by the wound care nurse. R1's care plan and treatment sheets were updated. 5. On March 21, 2007, an order was added for the application of Accuzyme daily and PRN to R1's pressure sores. 6. On March 23, 2007, the nursing staff and CNA staff were inserviced on their responsibilities under the facility skin care protocol and reminded of their responsibility to note any changes in skin condition and report such changes to the nursing staff.	F 314		

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F 314	Continued From page 5 7. On March 23, 2007, nursing staff were reminded of their responsibility for following up on all reports of skin breakdown and that they are to initiate a full assessment and to communicate the information to the resident's physician and family so that appropriate orders can be entered.	F 314		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Facility failed to safely transfer one resident on the sample, R1, from her bed to a wheelchair. This failure resulted in R1 sustaining a fracture of the distal shaft of the right femur, which has subsequently led to R1 becoming bed bound and developing pressure sores. Findings include: 1. Facility investigation shows that on 12/12/06, E4 and E5, Certified Nurses Aides (CNA's), proceeded into R1's room to transfer her from her bed to a wheelchair in order to take R1 to dinner. E6's, Assistant Administrator, investigation states "On 12/12/06, E4 and E5 were in R1's room. E5 transferred this resident by self without the use of a gait belt. When E5 was pivoting R1 to the chair, R1 complained that her knee popped. E5 immediately went and reported it to the shift coordinator. On 12/13/06, I (E6) was called down to R1's room by E7, CNA, who had reported that when she put R1 into bed that she said that her	F 324		3/28/07

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F 324	Continued From page 6	F 324		

leg hurt. When she removed clothing she found a discolored area and what looked to be some swelling. E7 immediately came and got me. At that time, E4 was in the room and stated that it happened last night when she and E5 got R1 up". There is nothing in the nurses notes regarding the incident on 12/12/06. The next entry in the nurses notes is dated 12/13/06 which states "3:49 PM, CNA stated that resident said her right knee made a popping noise when being transferred. (2 person) I went to assess resident and she told me it did not pop. I moved both knees and they both popped. No complaint of pain or discomfort. No swelling or bruising noted. Did note what looked to be a small amount of fluid to kneecap. Noted old light green bruising to right side of knee. 6:15 PM, call back from x ray company, oblique fracture to right femur with separation of fracture fragments. Call out to physician at this time, awaiting call back".

Facility staff did not use a gait belt or two staff to transfer R1 on 12/12/06. The Facility investigation into the incident includes a statement written and signed by E4 on 12/15/06, which states "On 12/12/06, at approximately 4:30 - 5:00 PM, E5 and I was getting residents up for dinner. E5 was getting R1 up. I offered to help but she said she had it. When E5 was sitting R1 up, R1 said "Oh, my knee popped". E5 checked her knee and then transferred into chair. E5 did not use a gait belt. The next day I came into work and R1's knee was swollen".

R1 was sent to the hospital on 12/13/06 and hospital records show that R1 sustained an oblique fracture of the distal shaft of the right femur. Hospital History and Physical shows that R1 had a previous fracture of the right hip, with a metallic prosthesis replacing the head and neck of the proximal right femur and a total

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replacement of the right knee with a prosthesis. Osteoporosis was present.

Z1, R1's responsible family member, was interviewed on 3/15/07, regarding the incident on 12/12/06. Z1 stated that due to R1's medical condition, R1's physicians decided that R1 would not be a candidate for surgical repair of the femur fracture. A brace was placed on R1's right leg for immobilization in hopes that R1's femur would heal straight.

R1's Facility "Plan of Treatment for Outpatient Rehabilitation", dated 8/24/06, shows that R1 required Maximum Assistance for transferring. E8, Care Plan Coordinator, stated that whenever maximum assistance is required, two people should be transferring the resident.

A review of R1's Facility plan of care shows that she was at increased risk for falls related to a history of Epilepsy due to brain cancer, fracture of the pelvis, fracture of the femur, Osteoporosis, Deep Vein Thrombosis and a history of falls. The Approach for this Problem, with an original date of 6/28/05, states "transfer with 2 person assist". However, the Facility plan of care dated 10/26/06 has the same Problem listed but the approach, with the same date of 6/28/05, states "transfer with 1-2 person assist". E8 was interviewed on 3/15/07 and stated that she did not know why the approach for falls was changed for R1 - it should have stated that R1 was a two person transfer. E8 said that it may have been changed in error as she was new in her job at the time and did not understand the Facility computer system.

The Facility policy for Two Person Pivot Transfer states "1. When two people are required to perform the transfer, the first person stands in front and the second in the small area between the two chairs (or between the bed and the chair). 2. Position yourself in front of the

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F 324	Continued From page 8 resident in such a way that you can block the resident's foot and knee nearest to the chair with your foot and knee. 3. Place both hands on the gait belt with one hand guarding the buckle from the resident's skin. 4. The second person will hold on to the gait belt and assist by lifting and guiding the resident into the chair or bed." R1's current Facility plan of care, dated 12/22/06, states "(R1) has a fracture of the right femur and is dependent upon staff with bed mobility. She is bed bound at this time. She has a brace to right leg. 1/18/07, resident now has (indwelling) catheter". Observation of R1's right leg and foot on 3/15/07, shows 2 pressure sores near her right heel, on the outside of the foot exactly where the stay in the brace hits R1's skin. It was also noted that the smallest toenail on R1's right foot had fallen off and the area was black. The area on the R1's fourth toe, where the little toe touches, was also turning black. According to Facility documentation, these pressure areas developed in the Facility on 3/6/07. During an interview by telephone with E2, Director of Nurses, on 3/19/07, it was stated that R1 is now on Hospice. E2 stated Hospice decided that R1 required an indwelling catheter since she is bedfast, turning R1 causes pain and they wish to keep R1's leg brace clean and dry.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)5) 300.1220b)7) 300.1420 300.1420a)	F9999		

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F9999	Continued From page 9 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) 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. 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 300.1220 Supervision of Nursing Services	F9999		

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F9999	Continued From page 10 b) The DON shall supervise and oversee the nursing services of the facility, including: 7) Coordinating the care and services provided to residents in the nursing facility. Section 300.1420 Specialized Rehabilitation Services If physical therapy, occupational therapy, speech therapy or any other specialized rehabilitative service is offered, it shall be provided by, or supervised by, a qualified professional in that specialty and upon the written order of the physician. a) In addition to the provision of direct services, any such qualified professional personnel shall be used as consultants to the total restorative program and shall assist with resident evaluation, resident care planning, and in-service education. These regulations are not met as evidenced by the following: Based on record review, interview and observation, it was determined that the facility failed to identify and evaluate risk factors, prevent avoidable pressure sores, implement interventions, and modify interventions as appropriate when pressure sores did develop, to ensure that existing pressure sores did not worsen and additional pressure sores did not develop. This affects 2 residents on the sample, R1 and R7. R1 developed 3 new pressure areas on her right foot and R7 ' s previously healed Stage 4 pressure sores on her right and left heels reopened. Both residents had orthopedic devices in place. R1 was on hospice services.	F9999		

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F9999	Continued From page 11 Findings include: 1. R1, has diagnoses, in part of Epilepsy due to History of Brain Cancer, History of Pelvic Fracture, Osteoporosis and Hypothyroidism. R1 fractured her right femur on 12/12/06. R1's physician and family decided not to surgically repair R1's fracture due to R1's medical status. R1 was transferred back to the facility from the hospital on 12/18/06, with a brace on her right leg. E2, Director of Nursing, stated that the family and physician decided to place R1 on Hospice at this time due to her condition. Review of facility "Weekly Infection Control Report" on which they track decubiti, shows that on 3/6/07, R1 developed 3 pressure sores on her right outer heel (2.4 cm by 2.6 cm), right lower Achilles (1.4 cm by 0.5 cm) and right upper Achilles (0.6 cm by 1.0 cm). All 3 were covered with eschar and could not be "staged." R1's plan of care, dated 1/25/07, has a goal of "resident will have no skin breakdown during this quarter." Approaches include: "Hospice will assess resident skin every visit. Avoid shearing resident's skin during positioning, transfers and turning. Pressure reducing devices in bed." On 3/15/07, E3, LPN, was observed changing the dressing on R1's right foot. It was noted that R1 was wearing a brace on her right leg which is secured with Velcro straps. The brace had a stiff metal stay which ran along the back of the brace. When E3 removed the brace, it was noted that the area of the 3 pressure sores on R1's right foot corresponds directly to the metal stay in the back of the brace. The only padding between the	F9999		

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F9999	Continued From page 12	F9999		

brace and metal stay and R1's skin was a folded up pillow case. E3 said that R1's leg brace kept sliding down and would rub against R1's skin. The surveyor then noted that the nail was missing from R1's right little toe and the little toe was blackened in the area where the toe nail had been. E3 confirmed that the Facility had not noted the problem with R1's little toe until the surveyor brought it to their attention.

E1, Administrator, and E2, stated during an interview on 3/15/07, that they had telephoned R1's physician "a few days ago" about the brace and he said he did not want a different type of brace. However, the facility ordered a new brace for R1 on 3/16/07, after the sliding of the current brace was brought to the attention of the facility. The new leg brace, which E1 stated should reduce pressure and rubbing, was placed on R1's leg on 3/26/07.

On 3/26/07, E2 stated that R1's pressure sores had now been staged as the eschar had sloughed off of the wounds. E2 said that the pressure sore on the right outer heel is a Stage IV and the other two pressure sores on R1's feet are Stage II's.

2. R7 has diagnoses, in part, of Renal Failure, Gout and Hypertension. R7's most recent Minimum Data Set (MDS), dated 2/19/07, shows that she has short and long term memory problems, is non-ambulatory, requires the extensive assistance of two or more people for transfers and has 2 Stage 4 pressure sores. Facility plan of care shows that R7 was admitted to the facility on 5/31/06 with a Stage 2 decubitus to her right buttock and Stage 4 decubitus to her left and right heels. E2, in an interview on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145728	A. BUILDING _____ B. WING _____	C 03/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYVILLE MANOR	**2133 VADALABENE DRIVE MARYVILLE, IL 62062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 13 3/15/07, stated that the pressure sores on both of R7's heels were healed but, recently reopened. Facility "Weekly Infection Control Report" shows that the pressure sore on R7's right heel was healed on 9/11/06 and the left heel was healed on 10/6/06. Facility "Weekly Infection Control Report" shows that on 12/9/06, R7 developed a 0.3 cm x 0.9 cm x 1.0 cm pressure sore on her right heel, and on 1/30/07, R7 developed a 0.3 cm x 1.2 cm x 1.5 cm pressure sore on her left heel. Both are Stage 4 pressure sores. During observations of R7 on 3/15/07, it was noted that R7 was sitting in a wheelchair with a leg support which ended at R7's mid-calf area, and was wearing splints on both of her feet. R7's feet and lower legs were dangling down over the edge of the support about 6 - 8 inches below the height of her knees. E9, CNA, laid R7 down at approximately 3:30 PM and her leg braces were removed. It was noted that R7's legs were very swollen and edematous above where the splints had been. There were very deep, red creases in the back of R7's calves where they had rested against the edge of the wheelchair support. During an interview of E2 on 3/15/07, it was stated that Physical Therapy had placed the leg support on R7's wheelchair as the wound nurse told them that nothing should be touching R7's heels. E2 stated that the leg support should be longer to prevent R7's feet from dangling. (A)	F9999		