STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. BUILDING _____ B. WING _____	C 04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS CHR VILLAGE	P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924

(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
F 314	Continued From page 57 by the physician on 3/18/07. R1's feet were on a pillow.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)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 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	F9999		

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F9999	Continued From page 58 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: 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 neglect a resident. (Section 2-107 of the Act) These regulations are not met, as evidenced by the following: Based on interview and record review the facility neglected R5, R2 and R1 in that they failed to follow policies in place to provide services to prevent and promote healing of pressure ulcers for 3 of 5 sampled residents. Specifically the facility neglected to identify residents at risk for skin breakdown(R5,2,1); neglected to implement pressure relieving measures prior to skin breakdown(R5,2,1); neglected to monitor and measure pressure ulcers(R5,2,1); neglected to notify the Physician of the developement and deterioration of pressurer ulcers(R5,2,1); neglected to notify the Physician of the Certified Wound Specialist's recommendations(R5);	F9999		

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F9999	Continued From page 59 neglected to follow the Physician's treatment orders for pressure ulcers(R5,2,1); and neglected to assess for nutritional needs, notify the Physician of nutritional recommendations of the Registered Dietician(RD), and implement the nutritional interventions in a timely manner(R5). This neglect to follow policies to assess and implement measures to prevent and promote healing of pressure ulcers resulted in R2 developing 7 new pressure ulcers and R1 developing 3 pressure ulcers. This neglect to follow policies to assess and implement measures to prevent and promote healing of pressure ulcers resulted in the deterioration of R5's pressure ulcer, requiring repeated hospitalizations. R5 died from Septic Shock as a consequence of the Sacral Ulcer. Findings include: 1. The facility neglected to implement and follow the following policies for R5: a. The facility policy titled "Pressure Ulcer Prevention" states the following: "A standarized pressure ulcer risk assessment will be used to identify residents who are at risk for the development of pressure ulcers. This standardized assessment will be completed as follows: On admission, Weekly for the first four weeks after admission for each resident at risk; Quarterly; and Whenever clinically indicated." "An individual plan of prevention will be developed to meet the needs of the resident. It will include, but is not limited to: consideration of	F9999		

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F9999	Continued From page 60 mechanical support surfaces, nutrition, hydration, repositioning, rehab/restorative program to maintain or improve mobility/activity status, skin condition and overall clinical condition." "Individualized interventions to prevent the developemnt of pressure ulcers will be implemented as defined in the plan of care. Evaluation of the effectiveness of the individualized resident plan of care will include, but is not limited to: Daily and weekly skin assessments conducted by licensed staff; The assessment and valuation conducted weekly by the skin team." b. The facility policy titled " Pressure Ulcer Documentation" states the following: "A thorough assessment of wounds that develop or are identified on admission will be completed and documented." "Documentation of interventions, notifications and residents response will be completed." "Daily monitoring will be recorded on the resident's treatment administration record. When a complication or change is identified, the nurse will place an asterisk by their initials and document pertinent information in the nurses notes. The information will include, but is not limited to: untoward leakage around dressing, signs of increasing areas of ulceration or soft tissue infection, and pain. Documentation of interventions for any identified complication, interventions and notifications." "Assessment/Evaluation of pressure ulcer wounds will occur weekly at a minimum.	F9999		

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F9999	Continued From page 61 Documentation will include, but is not limited to: Location of the wound; Stage of the pressure ulcer wound; Size of the pressure ulcer wound....; Type and amount of exudate; Odor; Pain; Periwound skin condition; and Documentation of intervention for any identified complications, interventions and notifications." c. The facility policy titled "Weekly Pressure Ulcer Documentation Progress Sheet" states the following: "The Weekly Pressure Ulcer Healing Assessment should be started immediately upon identification of a pressure ulcer..... The form should be completed at least weekly. After completion , assess the progress of the wound. Apply appropriate interventions/changes as necessary and notify appropriate interdisciplinary team members." d. The facility policy titled "Referral of Residents for Interview by Dietician/Consultant" states the following: "The Nutritional Screening Form....will be completed by the Dietary Manager and be provided to the Dietician/Consultant at the begininng of the consulting visit. The Nursing Department(Care Plan Coordinator) wil provide timely input to the Food Service Supervisor regarding residents due for annual review, change of condition assessments, pressure ulcers...." "Between consulting visits, staff should contact the Dietician/Consultant to address nutritional conserns in a timely manner. These concerns might include:new admission with significant	F9999		

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F9999	Continued From page 62 nutritional concerns(Stage III or IV pressure ulcer...) The Dietician/Consultant shall complete a fax assessment or give verbal suggestions." e. The facility policy titled, "Change in Condition-Physician Notification states the following: "A licensed staff member will notify the attending physician of a change in the resident's condition. Physician notification is to include but is not limited to: Symptoms of an infectious process and Onset of pressure ulcers." The hospital Discharge Summary dated 10/19/06 states that R5 had a primary diagnosis of Fractured Pelvis and Acetabulum on 10/6/06 with secondary diagnoses of Pulmonary Embolism, Hypertension, history of Congestive Heart Failure and Degenerative Joint Disease. The Admission face sheet documents that R5 was admitted to the nursing home on 10/19/06. The assessment dated 11/1/06 states that R5 had no cognitive problems, required extensive assist with transfer, dressing, bed mobility, total assist with personal hygiene, had an indwelling urinary catheter, occasional incontinence of bowel and a Stage 2 pressure ulcer. The nurses note dated 10/19/06 at 1:50 pm documents that R5 has a "1cm[centimeter] diameter stage 2[pressure ulcer] to inner right buttock and .5cm blister intact on inner right buttock." The Patient Transfer Form dated 10/19/06 includes physician orders for medications, physical/occupational therapy and diet, but does not have an order for a treatment to the right	F9999		

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F9999	Continued From page 63 buttock. The facility assessed R5 on 10/29/06 as moderate risk for skin breakdown. E3, Registered Nurse(RN), Care Plan Coordinator(CPC), stated in interview on 3/27/07 at 1:30pm that she does not do the skin risk assessments on admission but waits until the 14 day assessment is due. E3 confirmed in interview on 4/3/07 at 12:35pm that R5's skin risk assessment was done on 10/29/06 and no assessment was done prior to that date. The Wound Care Evaluation and Treatment Plan dated 10/30/06 done by Z6, RN, Independent Certified Wound Specialist, contains the following information: The wound is identified as the "right buttock" measuring "1.5cm by 1cm, unable to determine the depth, 100% eschar" and peri wound appearance documented as intact. The "depth of tissue destruction is full thickness" and the etiology is "pressure." The recommended treatment plan is as follows: Clean with normal saline, apply Panafil with a Hydrogel gauze bordered composite dressing daily. There is no documentation in the nurses notes or Physician orders that the Z6's recommendation for treatment to R5's right buttock pressure ulcer was ever communicated to Z4, Attending Physician. The nurses notes dated 11/3/06 state the left side of the buttock is "very red and some bleeding." The note documents a dressing and cream was applied to the buttock with Duoderm intact to the middle of the coccyx. The nurses notes dated 11/4/06 states, "Cream on buttock due to some bleeding on L[left] buttock. [R5] stated 'That hurts a lot.' Looks like a rug burn." E7, LPN, confirmed in interview on 4/3/07 at 12:35pm that she did not	F9999		

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F9999	Continued From page 64 measure the area on the left buttock. There is a telephone Physicians's order dated 11/3/06 for Xenaderm to buttocks and to discontinue the Duoderm. The Treatment Record dated 11/2006 documents that Xenaderm was applied to the right buttock every shift starting 11/3/06. The Treatment Record documents that the Duoderm and barrier cream were discontinued. The progress note by E13, Registered Dietician(RD) dated 11/3/06 documents that R5 weighed 185.7 pounds in the hospital and is "137% of her Ideal Body Weight(IBW)." The RD states R5 "may benefit from [increased] protein for healing." The RD recommends "yogurt twice a day(bid) for healing and prevention of ATB[antibiotic] diarrhea." The RD assessment of R5's nutritional needs was not done until 12 days after admission. There is a Physician's order dated 11/7/06 okaying the RD recomendations for R5, which is a delay of 4 days. The nurses notes dated 11/5/06 at 3:00am state, "[R5] has stage 2[pressure ulcer] on right side buttock with stage 3 or 4 on coccyx area. DuoDerm applied to cover both areas...." When asked if he remembered anyone faxing him the Certified Wound Specialist recommendation for 10/30/06 or notifying him that R5's wound was necrotic, Z4, Attending Physician, stated in interview on 4/10/07 at 1:10pm that he "could not remember a fax or telephone call 6 months ago." Z4 stated, "I think if I had been told there was a great problem I would have wanted [R2] to be seen by [Z2,Wound Surgeon]. When asked if he was aware of R2's	F9999		

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F9999	Continued From page 65 pressure ulcer on his visit of 11/2/06, Z4 replied, "If there is a problem we would look at the area-do an exam of the area." When asked if it is fair to say that since there is no documentation of the pressure ulcer in the progress note dated 11/2/06, that he(Z4) was not made of aware of the ulcer, Z4 responded, "Yes." The Wound Care Evaluation and Treatment Plan dated 11/6/06 done by Z6, Certified Wound Specialist, contains the following information: The first wound location is identified as the "mid coccyx", measuring "2cm by 1cm, unable to determine depth, 100% eschar and the periwound appearance ,reddened." The "depth of tissue destruction is full thickness, the etiology, pressure." The recommendation was to clean with normal saline, apply Accuzyme with a bordered foam dressing daily. The second wound location as identified as the "right buttock," measuring "6 by 5cm with less than 0.3cm depth and minimal drainage." "Area has a 2cm by 2cm, 100% yellow slough with a reddened periwound. The depth of tissue destruction is full thickness and the etiology is pressure." The recommendation is to clean with normal saline, Accuzyme on the yellow area and apply a bordered/nonbordered foam composite dressing daily. Z6, RN, Certified Wound Specialist, stated in interview on 3/30/07 at 12:50pm that she recommended Accuzyme to debride R5's pressure ulcers's on 11/6/06 because it "eats away the eschar, lowering the colonization of bacteria." Z6 stated, "I wanted to prevent infection,that's why I recommended Accuzyme."	F9999		

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F9999	Continued From page 66 Z6 stated the pressure ulcers had no signs of infection on 11/6/06. When asked how the recommendation is communicated to the Physician, Z6 replied, "My understanding is they(staff) fax the recommendation to the Physician." Z6 stated she would expect the recommendation to be faxed to the Physician that same day(11/6). When asked what her opinion was about using DuoDerm on necrotic tissue, Z6 replied, "DuoDerm would increase the chance of infection because of the warmth and moisture. That's one reason I would not use DuoDerm on necrotic tissue." Z6 also stated DuoDerm does not allow the wound to be assessed, as the wound is unable to be seen through the dressing. The nurses notes dated 11/7/06 at 6:50pm state "Air mattress applied to bed." E8, LPN, confirmed in interview on 4/3/07 at 11:50am that R5's air mattress was applied on 11/7/06. The nurses notes dated 11/8/06 at 1:30am state, "Cream and DuoDerm applied to buttocks as ordered." The nurses notes dated 11/5 and 11/8 document DuoDerm being applied to R5's pressure sores, even though the Physician had discontinued the treatment on 11/3/06. The nurses notes dated 11/8/06 at 1:00pm state "new orders faxed to [Z4] for buttock. [Z4] signed and faxed back. E7, LPN, confirmed in interview on 4/3/07 at 12:35 pm that she faxed to Z4 the Certified Wound Specialist recommendations dated 11/6/06 for R5 on 11/8/06, which is a delay of 2 days. E7 stated that Z4 faxed the recommendation right back(11/8) with his okay to follow the recommendations. The Treatment Record for November 2006 fails to document that the recommendations were implemented.	F9999		

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F9999	Continued From page 67 The nurses notes dated 11/8/06 at 9:00pm state R5's temperature was 103.3 F(Fahrenheit). R5 was sent to the Emergency Room to be evaluated and was admitted to the hospital. The Report of Operation by Z2 dated 11/10/06 states, "[R5] has had a foul smelling wound over her sacrum of an unknown period of time, at least several weeks." The section titled Gross Pathology states, "[R5] with a stage 3 necrotic pressure ulcer over the sacrum. Findings at the time of the procedure revealed extensive undermining as well as tunneling down to the deep musculature." The section titled Postoperative Diagnosis states, "Necrotic stage 3 pressure ulcer over sacrum. Initial measurements 5 by 3.5cm with undermining with final measurements after procedure 1.5cm by 8cm by 3.5cm in depth." When asked in his opinion what underlying condition did R5 have or what in his opinion would cause a 1cm Stage 2 pressure sore to go to a Stage 3, foul smelling, necrotic area in a short time, Z2, Wound Surgeon replied, "It could be several things--If not being monitored close enough, if not on an air mattress or any type of preventative precautions being used, if general wound care is not being done or if there was a leaking indwelling catheter." Z2 stated at one point R5 had a leaking catheter with urine bathing the sacral area. When asked if R5 should have had an air mattress on when she first had the 1cm open area, Z2 replied in his opinion "yes." Z2 stated "when [R5's] pressure ulcer was first debrided in November 2006, it was initially treated here at the hospital, it was looking good when [R5] was sent back to the nursing home".	F9999		

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F9999	Continued From page 68	F9999		

Z2 stated within a couple of weeks R5 was back in the hospital, had necrosis with the area looking bad. Z2 stated he questioned whether R5 was getting the wound vac dressing changed and whether she was being turned etc. Z2 stated when R5 came back the second time with heel and a lateral malleolus ulcer--"You know that if she broke down they weren't using heel protectors".

The nurses notes dated 11/29/06 at 6:30pm state R5 was readmitted to the facility with a wound vac dressing on the coccyx.

The RD(E13) progress note dated 12/5/06 states R5 was recently admitted from the hospital for a sacral infection and debridement. The RD states that R5 currently has a wound vac, the most recent weight was the November weight of 174.6 pounds and the family is bringing R5 Ensure three times a day. The RD recommended: "Yogurt bid for [increased] protein and calories, healing and prevention of ATB diarrhea; Vitamin C and Zinc for healing; Arginaid bid due to the size of the wound and drainage."

There is a Physician Order dated 12/12/06 okaying the dietary interventions recommended by the RD on 12/5/06. E6, RN, confirmed in interview on 4/3/07 at 1:00pm that RD's dietary recommendations for R5 did not start until 12/12/06, seven days after the recommendation was made.

The nurses notes dated 12/23/06 at 11:00am state, "Observed red area on left outer ankle-Note new order for protective ointment." There are no measurements or staging documented in the note or on the pressure ulcer

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F9999	Continued From page 69 measuring records. The nurses notes dated 12/27/06 at 2:00pm state, "[R5] complained left ankle-noted unstageable wound measure 2 by 2 on outer ankle necrotic tissue on wound, small amount of purulent drainage, dressing applied, note nonblanchable erythema right medial heel 2 by 1.5, dressing applied." The nurses note documents the Physician was notified and new orders were received. There is a Physician's order dated 12/27/06 for a treatment to the left ankle. On 12/29/07 there is an order to apply a cushioned egg crate bootie to the left foot at all times. There also is an order dated 12/29/06 to keep R5's feet floated on a pillow up off the bed. There is a Physician order dated 12/8/06 for the wound vac dressing to be changed every Monday, Wednesday and Friday. The Treatment Record dated 1/2007 documents that the wound vac dressing was not done on 1/1/07 on the 7-3 shift as the nurse's initial is circled. There is no documentation in the nurses notes or the Treatment Record that the treatment was done. E5, LPN, confirmed in interview on 4/3/07 at 1:10pm that she did not change R5's wound vac dressing on 1/1/07 as scheduled per the treatment record. E5 stated she ran out of time on 1/1/07 and asked E8, LPN, to do the dressing change. E5 stated that E8 agreed to do R5's dressing change for her. When asked if she did R5's wound vac dressing change on 1/1/07, E8, LPN, replied in interview on 4/3/07 at 1:25pm, "No." E8 stated that when E5 asked her to do R5's wound vac dressing for her, she(E8) told E5 that she could not do the	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS CHR VILLAGE	P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924

(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 70 treatment as she had never been trained in the procedure. E8 confirmed that she did not do the wound vac dressing change for R5 on 1/1/07. The nurses notes dated 1/3/07 at 9:00am stated the "coccyx wound measure 7.2 by 6.7, depth 2.6. 11-12 o'clock has 1cm undermining, from 9-11 o'clock has 1.5cm undermining, from 9-11 o'clock is necrotic tissue on edges-wound bed red with areas of dark gray tissue. [Z1,RN] from wound clinic here-recommend wet/dry dressing at this time. Right heel non blanchable 1 by 2cm, left ankle 1.1 by 1.7cm slough present in wound bed." The nurses note documents an appointment with the wound clinic on 1/4/07. The Consultation Report dated 1/4/07 states that R5 was admitted to the hospital for "Hyponatremia and a worsening sacral ulcer. The patient[R5] underwent extensive debridement back in November of 2006, was being treated with a wound vac. [R5] was overall doing well until recently when we started noticing on the last visit a necrotic edge on the left border of the wound and there was some undermining. It was noted [R5] had developed a grade 2 pressure ulcer over the lateral malleolus on the left ankle and also a grade 1 pressure ulceration on the right heel. Reportedly [R5] has been on an air mattress at the nursing home, but there have been questions as far as appropriate dressing changes and so forth." The Report of Operation dated 1/5/07 states debridement of the sacrum and left ankle was done. The area titled Final Measurements states, "Width 11cm, height 9cm, depth 3cm of the sacral wound; Left lateral malleolus 3 by 3cm with 2mm(millimeters) depth."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. BUILDING _____ B. WING _____	C 04/13/2007

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F9999	Continued From page 71 The nurses notes dated 1/19/07 at 1:40pm document that R5 was readmitted to the nursing home. There is a Physician's order dated 1/26/07 for Arginaid bid(protein supplement). E6, RN, stated in interview on 4/3/07 at 1:00pm that R5's Arginaid did not restart until 1/26/07. When asked if anyone clarified with the Physician on 1/19/07 if he wanted the Arginaid which was ordered for R5 prior to her discharge to the hospital continued E6 replied, she could not remember if anyone had or not. R5 did not receive the Arginaid from 1/19 to 1/26/07 which is a delay of 7 days. RD progress note dated 1/29/07 states R5's weight is 169.6. The RD documents that R5's weight is down 4 pounds since the initial January weight, but her intake is good. The RD did not assess R5 for 10 days after admission. The nurses notes dated 2/2/07 at 12:30pm document that R5 was sent to the Emergency Room for an evaluation related to vomiting and loose stools. The Discharge Summary dated 2/9/07 states that R5's diagnosis while in the hospital was Enteritis/ileus which was resolved. R5 was readmitted to the nursing home on 2/9/07. There is a Physician's order dated 2/9/07 for Arginaid bid. The hand written Medication Record for February 9, 2007 has the Arginaid written in to be given bid. The typed Medication Record for 2/9-2/28/07 fails to document the Arginaid as being given until 2/16/07. E6, RN, confirmed in interview on 4/3/07 at 1:00pm that R5's Arginaid	F9999		

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F9999	Continued From page 72 did not get restarted until 2/16/07 even though it was ordered by the Physician on 2/9/07, 7 days earlier. The RD progress note dated 2/15/07 states that R5 weighed 164.6 pounds on 2/11/07. "Weight is [down] 9 [pounds] in 1 month, 5.1% [significant decrease in] 1 month. May be [related] decubitus,wound vac, hospitalization." The note documents that R5 has the wound vac to the coccyx and left ankle decubitus ulcer. The RD note dated 3/9/07 R5's March weight is 156.8 pounds which is down 7.8 pounds in 1 month or 4%. The RD recommends adding 8 ounces of milk to all meals and fortified pudding at lunch and supper for increased protein needs. The Nutrition Recommendations form dated 3/9/07 documents that the form was not faxed to the Physician until 3/12/07, a delay of 3 days. The nurses notes dated 3/13/07 at 1:45pm document that R5 was sent to the Emergency Room for evaluation for a low blood pressure and vomiting. The Emergency Physician Record dated 3/13/07 states that R5 was airlifted to another hospital. The progress note dated 3/15/07 documents that R5 expired on 3/15/07 at 6:11pm. Z3, Hospital Physician, stated in interview on 4/4/07 at 10:30 am that "Septic Shock related to the Sacral Decubitus" was the cause of R5's death. Z3 stated at first they thought it was either the urine or the decubitus was the cause of the Septic Shock, but the urine culture was negative. Z9, Deputy Coroner, stated in interview on 4/10/07 at 9:15am that the cause of death for R5	F9999		

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F9999	Continued From page 73 is "Septic Shock as a direct consequence of the Sacral Decubitus". 2. The facility neglected to implement and follow the following policies for R2: a.The facility policy titled "Pressure Ulcer Prevention"states the following: "A standarized pressure ulcer risk assessment will be used to identify residents who are at risk for the development of pressure ulcers. This standardized assessment will be completed as follows: On admission, Weekly for the first four weeks after admission for each resident at risk; Quarterly; and Whenever clinically indicated." "An individual plan of prevention will be developed to meet the needs of the resident. It will include, but is not limited to: consideration of mechanical support surfaces, nutrition, hydration, repositioning, rehab/restorative program to maintain or improve mobility/activity status, skin condition and overall clinical condition." "Individualized interventions to prevent the development of pressure ulcers will be implemented as defined in the plan of care. Evaluation of the effectiveness of the individualized resident plan of care will include, but is not limited to: Daily and weekly skin assessments conducted by licensed staff; The assessment and valuation conducted weekly by the skin team." b. The facility policy titled " Pressure Ulcer Documentation" states the following: "A thorough assessment of wounds that develop	F9999		

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F9999	Continued From page 74 or are identified on admission will be completed and documented." Documentation of interventions, notifications and residents response will be completed." "Daily monitoring will be recorded on the resident's treatment administration record. When a complication or change is identified, the nurse will place an asterisk by their initials and document pertinent information in the nurses notes. The information will include, but is not limited to:untoward leakage around dressing, signs of increading areas of ulceration or soft tissue infection, and pain. Documentation of interventions for any identified complication, interventions and notifications." "Assessment/Evaluation of pressure ulcer wounds will occur weekly at a minimum. Documentation will include, but is not limited to: Location of the wound; Stage of the pressure ulcer wound; Size of the pressure ulcer wound....; Type and amount of exudate; Odor; Pain; Periwound skin condition; and Documentation of intervention for any identified complications, interventions and notifications." c. The facility policy titled "Weekly Pressure Ulcer Documentation Progress Sheet" states the following: "The Weekly Pressure Ulcer Healing Assessment should be started immediately upon identification of a pressure ulcer..... The form should be completed at least weekly. After completion , assess the progress of the wound. Apply appropriate interventions/changes as necessary and notify appropriate interdisciplinary team	F9999		

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F9999	Continued From page 75 members." d. The facility policy titled, "Change in Condition-Physician Notification states the following: "A licensed staff member will notify the attending physician of a change in the resident's condition. Physician notification is to include but is not limited to: Onset of pressure ulcers." The Physician progress note dated 3/13/07 states that R2 has diagnoses of Carcinoma of the lung, Diabetes, Osteoarthritis, Pressure sores in the gluteal area and a History of Colon Cancer. The assessment dated 3/8/07 states that R2 has cognitive problems, requires extensive assist with transfer, dressing, hygiene, bed mobility and has 2, Stage 2 pressure sores. The nurses note dated 2/28/07 documents that R2 was admitted to the facility on 2/28/07. The note documents "Tx[treatment] started to coccyx area [related to] small reddened/slightly open area." There are no measurements or staging documented in the nurses notes. The nurses note dated 3/2/07 at 8:30 am state, "Dressing [changed] coccyx. Measured 1.5cm by .5". E6, RN, confirmed in interview on 3/28/07 at 11:00 am that the first measurement of R2's coccyx area was done on 3/2/07. E6 stated she did not call the Physician at that time because R2 was admitted with the open area. The nurses note and Weekly Pressure Ulcer Log dated 3/7/07 state R2 had the following open areas identified: "Right upper buttock--1.5 by 1cm; Right lower buttock--1 by 2.5cm and	F9999		

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F9999	Continued From page 76 Coccyx--1 by .4cm." All three areas were documented as "Stage 2 pressure ulcers." There is a Physician's order dated 3/7/07 to clean right upper/lower buttocks with normal saline, apply Hydrogel and cover with a composite dressing daily. The Treatment Record dated 2/28/07 and 3/2007 documents that the coccyx area is being treated with Hydrogel and a composite dressing daily. E2,DON, confirmed in interview on 3/28/07 that she was unable to find a Physician's order to treat R2's coccyx. The facility skin assessment dated 3/12/07 identifies R2 at moderate risk for skin breakdown. E3, RN, CPC, confirmed in interview on 3/27/07 at 1:30 pm that she does not do the skin risk assessment until the 14 day assessment is due. E3 confirmed that there is no other skin assessment for R2 prior to the one dated 3/12/07. The Weekly Pressure Ulcer Log dated 3/14/07 states R2 now has 4 open areas identified: "Right upper buttock--1 by 1.2cm; Right lower buttock--1 by 2.2cm; Coccyx-- 2 by.2 cm and Left buttock measure 1 by 1cm. An air mattress is written in as a "new Tx[treatment]." The Wound Care Evaluation and Treatment Plan dated 3/16/07 contains the following information: "Right buttocks--10 by 5cm with less than 0.3cm depth, no tunnelling/undermining with minimal drainage." The etiology is "pressure/Shearing." The peri wound appearance is "reddened with multiple open area. The treatment	F9999		

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F9999	Continued From page 77	F9999		

recommendation is to Clean with normal saline, apply Hydrogel with a nonbordered composite dressing daily. The section titled Notes states, "Try to avoid tape to skin."

"Left buttocks--2 by 2cm with less than 0.3cm depth, full thickness, no undermining/tunnelling with minimal drainage." The peri wound appearance is "reddened." The Treatment recommendation is to cleanse with normal saline, apply Hydrogel with a non bordered composite dressing daily. The section titled Notes states, "Avoid tape if possible."

Z6, RN, Certified Wound Specialist, stated in interview on 3/28/07 at approximately 1:00pm that she saw R2 on 3/15/07, not 3/16/07 as the Wound Care Evaluation form is dated. Z6 stated she wanted to avoid tape with R2 and use a non stick telfa with an ABD(Abdominal) pad. Z6 stated, "My logic for that was to lay the ABD pad on it[buttocks]-the [disposable brief] would hold it on. I did not want to put any more tape on it[buttocks]. It could be tape she's allergic to". When asked about using Tegaderm on R2's buttocks, Z6 replied that "Tegaderm is not considered a non-adhesive dressing."

Z8, Physician, stated in interview on 3/28/07 at 3:20pm that he was faxed the Certified Wound Specialist's recommendation, agreed with the recommendations to use the ABD pad etc and faxed them back the same day to the facility(3/15). Z8 stated they usually call him right away to report open areas, but stated he did not know how many open areas R2 had on 3/21/07.

There is no Physician's order written in the Physician Telephone Orders or in the Physician

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F9999	Continued From page 78 Order Sheet(POS) for March 2007. The Treatment Record dated 3/2007 has an entry dated 3/16/07. The entry states, "tx[treatment] [changed] right and left buttock, Cleanse with NS[normal saline], apply Hydrogel gauze cover with ABD pad--[No] tape. Coccyx-clean with NS apply Hydrogel gauze. Change every day." The entry is crossed through with lines and the Treatment Record is not initialed as the treatment ever being implemented. The Treatment Record documents that the coccyx and right lower/upper buttocks were cleaned with normal saline, Hydrogel was applied with a composite dressing from 3/1-3/21/07. The treatment was done every day to the buttocks and every third day to the coccyx. E6, RN confirmed in interview on 3/28/07 at 11:20am that she did talk to the Z8, Physician, about the Wound Specialist's recommendations. E6 stated they did try to use the non adherent pad with the Hydrogel for R2, but it wouldn't stay on in bed. E6 stated the ABD pad would only work if R2 was up. E6 stated she did pass on in report to not use tape for R2's dressings. E6 confirmed that she did not call the Physician between 3/15-3/21/07 about R2's treatment orders. E6 stated that the composite dressing continued to be used as documented in the Treatment Record until 3/21/07, when the order was changed to Tegaderm. E6 stated the Tegaderm did not work and on 3/24/07 the order was changed to protective barrier cream to the areas. The Weekly Pressure Ulcer Log dated 3/21/07 states R2 has the following open areas identified: "Right upper buttock--1.5 by .5 cm; Right lower	F9999		

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	146037	A. BUILDING _____ B. WING _____	C 04/13/2007

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F9999	Continued From page 79	F9999		

buttock--1 by 1.5cm; Coccyx--1.5 by .2cm; Left buttock--1 by .5cm; Right lateral buttock--.3 by .2cm; Right middle lateral buttock--2.6 by .3cm ; Right middle lateral buttock--.5 by .2cm; Right lower lateral buttock--2.4 by .5cm; Right middle buttock--.7 by .7cm; Left middle buttock--.2 by 1cm;Left upper buttock .5 by .2cm." All 11 areas, including the 7 new open areas are staged as Stage 2 pressure ulcers being treated with Hydrogel covered with Tegaderm.

There is a Physician's order dated 3/21/07 to Cleanse coccyx and open areas on buttocks with Normal Saline, apply Hydrogel gauze, cover with Tegaderm, change daily.

The nurses notes dated 3/24/07 at 9:30am state, "Buttock has small open areas where tegaderm and composite located. Pulled off tegaderm gently with [water], continue to pull skin. Complained of heels painful."

There is a Physician's order dated 3/24/07 to Discontinue the Hydrogel and Tegaderm; Begin Protective Barrier Cream to buttocks three times a day and as needed ; Booties to both feet while in bed. The Physician's order dated 3/16/07 states, "[R2] needs to be positioned from side to side when in bed to keep off buttock. May be on back for meals only."

On 3/27/07 at 11:30 and 11:40am R2 was observed sittting in the wheelchair without a pressure relieving cushion. At 11:50am R2 was transferred back to bed by E11 and E12 Certified Nurse Aide'(CNA's). There was no pressure relieving cushion in the wheelchair. R2 had been sitting on the sling bottom of the wheelchair. R2 was positioned on her back with no heel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 80 protectors in place(booties). E11, CNA, stated in interview on 3/28/07 at 12:20pm that she can't remember what time R2 got up on 3/27/07, but knows R2 was up for breakfast which is served at 10:15am. On 3/28/07 from 9:40 to 11:10am at regular intervals R2 was observed sitting in the wheelchair without a pressure relieving cushion. At 11:25 am E10, CNA was repositioning R2 in the bed. At the time E10 confirmed there was no pressure relieving cushion in R2's wheelchair. E10 stated on 3/28/07 at 12:15 pm that R2 had gotten up in the wheelchair between 9:00 and 9:30am that morning. 3. The facility neglected to implement and follow the following policies for R1: a.The facility policy titled "Pressure Ulcer Prevention"states the following: "A standarized pressure ulcer risk assessment will be used to identify residents who are at risk for the development of pressure ulcers. This standardized assessment will be completed as follows: On admission, Weekly for the first four weeks after admission for each resident at risk; Quarterly; and Whenever clinically indicated." "Individualized interventions to prevent the development of pressure ulcers will be implemented as defined in the plan of care. Evaluation of the effectiveness of the individualized resident plan of care will include, but is not limited to: Daily and weekly skin assessments conducted by licensed staff; The assessment and valuation conducted weekly by the skin team."	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 81 b. The facility policy titled " Pressure Ulcer Documentation" states the following: "A thorough assessment of wounds that develop or are identified on admission will be completed and documented." "Documentation of interventions, notifications and residents response will be completed." "Daily monitoring will be recorded on the resident's treatment administration record. When a complication or change is identified, the nurse will place an asterisk by their initials and document pertinent information in the nurses notes. The information will include, but is not limited to:untoward leakage around dressing, signs of increading areas of ulceration or soft tissue infection, and pain. Documentation of interventions for any identified complication, interventions and notifications." "Assessment/Evaluation of pressure ulcer wounds will occur weekly at a minimum. Documentation will include, but is not limited to: Location of the wound; Stage of the pressure ulcer wound; Size of the pressure ulcer wound....; Type and amount of exudate; Odor; Pain; Periwound skin condition; and Documentation of intervention for any identified complications, interventions and notifications." c. The facility policy titled "Weekly Pressure Ulcer Documentation Progress Sheet" states the following: "The Weekly Pressure Ulcer Healing Assessment should be started immediately upon identification	F9999		

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	146037	A. BUILDING _____ B. WING _____	C 04/13/2007

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PLEASANT MEADOWS CHR VILLAGE	P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924

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F9999	Continued From page 82 of a pressure ulcer..... The form should be completed at least weekly. After completion , assess the progress of the wound. Apply appropriate interventions/changes as necessary and notigy appropriate interdisciplinary team members." d. The facility policy titled, "Change in Condition-Physician Notification states the following: "A licensed staff member will notify the attending physician of a change in the resident's condition. Physician notification is to include but is not limited to: Onset of pressure ulcers." The undated Transfer Form states R1 had a Fractured Right Hip with repair on 3/9/07. The nurses note dated 3/12/07 state R1 returned to the facility from the hospital. The skin assessment dated 2/10/07 states that R1 is at mild risk to develop pressure ulcers. E3, RN CPC, confirmed in interview on 3/27/07 at 1:30pm that she had not done a skin risk assessment for R1 since his return from the hospital. E3 stated that when R1 returned from the hospital he had no open areas, except for the tape burns on the hip. The assessment dated 3/22/07 states R1 has cognitive problems, requires total assist with transfers, extensive assist with bed mobility, toilet use, dressing, hygiene and has two Stage 2 pressure ulcers. The nurses note dated 3/18/07 states R1 "has Stage 2 to R[right] inner coccyx-0.5cm in diameter with reddened center." E5, LPN, stated in interview on 3/27/07 at 2:10pm that R1 only	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS CHR VILLAGE	P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924

(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 83 had 1 open area on the right buttock on 3/18/07. The Physician's order dated 3/18/07 states "[after] cleaning Stage 2 decubitus apply Xenaderm tid[3 times a day]. [Alternating] air mattress to bed... Blue booties on both feet while in bed." The Treatment Record dated March 2007 has an entry dated 3/18/07 that states, "[after] cleansing Stage 2 decubitus apply Xenaderm tid." The tid portion of the entry is crossed out, with "qd[every day], [check] tid" written in. Z8, Attending Physician, confirmed in interview on 3/28/07 at 3:30pm that he ordered just the Xenaderm tid to R1's open area, not the composite dressing. Z8 did state that he was "okay with them using the composite also." The Weekly Pressure Ulcer Log dated 3/21//07 states R1 has "3-Stage 2, facility acquired, site buttocks." There are no measurements documented on the log, only an entry stating "skilled." E6, RN, stated in interview on 3/27/07 at 12:20pm that she uses Xenaderm cream and covers the open area with a composite dressing daily, not tid as ordered by the Physician. E6 stated she has not measured R1's open areas since he moved from the intermediate unit over to the skilled unit. The nurses note dated 3/23/07 at 6:00pm states "Booties to feet-blister to L[left] lateral edge of foot intact." There is no documentation of any measurement of the blister in the nurses notes.	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MEADOWS CHR VILLAGE	**P O BOX 375 400 W WASHINGTON CHRISMAN, IL 61924**

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F9999	Continued From page 84 On 3/27/07 at 12:20pm E6,RN, was observed to do the treatment to R1's pressure ulcers. E6 removed the composite dressing from the buttocks. There were 2 open areas present. E6 measured the area on the right buttock as .8 by .7cm and the left buttock as 1 by .5cm. E6 stated both areas were Stage 2's. E6 stated the third area was now closed. E6 cleaned the open areas with normal saline, and applied Xenaderm with a composite dressing. E6 stated in interview on 3/27/07 at 2:10 pm, last Thursday(3/22)R1 had 3 open areas on the buttocks. E6 stated she did not notify the Physician as she did not know what open areas R1 had before. On 3/27/07 at 11:40am, 12:30pm and 1:30pm, R1 was observed lying in bed on his back with no "blue booties(heel protectors)" on his feet, with his feet resting on the bed. At 1:30 pm the surveyor asked E9, CNA, to take R1's socks off so the surveyor could look at R1's feet. E9 removed R1's socks and lifted his feet off the bed so the heels were visible. An intact blister was observed on the lateral part of the left foot and an open area was present on the left posterior heel. The surveyor asked E6, RN, to look at R1's feet. E6 stated at the time that R1 had nothing open on his feet. E6 confirmed that the open area on the left posterior heel was new. E6 measured the area as 1cm by 1cm. E6 staged the area as a Stage 2, and stated the area did not feel hard or callused, but there was "dark tissue in the center, it may be unstageable." E9, CNA, asked E6 at the time if R1 should have his "booties" on. E6 told E9 "not to put the heel protectors/booties on with the air mattress to "just float [R1's] heels." R1 was observed at 2:10pm, 2:55 and 3:15 pm in bed with no booties/heel protectors on as ordered by the physician on 3/18/07. R1's feet were on a	F9999		

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F9999	Continued From page 85 pillow. (A)	F9999		