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	145309	A. BUILDING _____ B. WING _____	01/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 444	Continued From page 64 side and reached between R11's legs and wiped mid peri area towards the buttocks and then threw the wipe into the trash can. E5 then picked up another wet wipe and standing behind wiped the buttocks in a circular motion and then again flipped the wipe to the back side and wiped between R11's legs from anus to vagina. E5 did not change her gloves after cleansing R11 of feces or before cleansing the vaginal area. A review of the facility perineal care policy indicated the following: 3. Wash hands before and after perineal care, 4. Wear gloves, 5. Work from cleanest area to dirtiest, therefore cleanse from urethra to anus. The perineal policy did not address staff need to change gloves after touching feces or between cleansing feces and then moving to urethral area, or to take gloves off after performing care and before doing other care with the resident as redressing, brushing hair or transfers. In an interview with E2 on 1/25/08, no further information was given regarding staff not changing or removing gloves when doing peri care on residents. E2 stated "I don't know why they (CNA's) are doing care like that, they've all been trained how to do care properly."	F 444		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)2)3)5) 300.1220b)2)3) 300.3240a)	F9999		

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F9999	Continued From page 65 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 b) The DON shall supervise and oversee the	F9999		

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F9999	Continued From page 66 nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by: Based on observation, record review, and interview; the facility failed to ensure three of thirteen residents were free from neglect and failed to obtain changes in treatment for pressure ulcers in a timely manner (R7, R14 & R20). The facility failed to follow their pressure ulcer policy and wound care protocol. The facility failed to	F9999		

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F9999	Continued From page 67 timely notify physicians of worsening pressure ulcers, and failed to obtain changes in treatment for pressure ulcers in a timely manner for three of thirteen residents with pressure ulcers. The facility failed to accurately and consistently assess skin condition for two of thirteen residents (R7, R14); failed to prevent formation of facility-acquired pressure ulcers for five of thirteen residents (R10, R5, R12, R7 & R14); failed to provide pressure relieving devices for one of thirteen residents identified as high risk for pressure ulcers (R12); and failed to timely turn and reposition residents with pressure ulcers for three (R11, R10 & R7) of thirteen residents. The facility failed to follow their pressure ulcer policy and wound care protocol. This neglect and failures resulted in a facility-acquired infected, unstagable pressure sore on the coccyx for R14; hospitalization for an unstagable pressure ulcer with exposed bone for R20; progression of pressure ulcer from Stage II to Stage IV, with hospitalization for debridement for R7 and development of new pressure areas for R10, R7, R5 & R14. Findings include: 1. R14 acquired a stage II pressure ulcer in the facility on 10/21/08. The pressure ulcer worsened to stage IV on 1/4/08. R14 is 90 years old with diagnoses from January 2008 Physician's Order Sheet (POS) of: weakness, delirium, dementia, depression with psychotic features, Diabetes Mellitus Type II, hypertension, lumbar degenerative disc disease, gastroesophageal reflux disease and osteoporosis. R14's Initial Nursing Assessment dated 9/20/07 assessed R14 as having no	F9999		

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F9999	Continued From page 68 pressure ulcers or blisters on admission. R14's skin was intact except for a scabbed area on her left knee. R14's Minimum Data Set (MDS) dated 10/8/07 assessed her as having no pressure ulcers. R14's Braden Scale dated 9/20/07, which is used to assess potential risk for pressure ulcers, assessed R14 as low risk for pressure ulcer. R14's Nurse's Notes dated 10/21/07 identifies two fluid-filled blisters on R14's coccyx, one 3 cm. (centimeters) and one 1 cm. Both blisters are described as intact. The facility applied a barrier cream to the coccyx area. The coccyx blisters are documented on the weekly wound report dated 10/25/07 as 3.0 cm x 1.4 cm. Weekly wound report dated 11/1/07 report increasing size of blisters to 3.0 x 2.0. Physician's orders dated 11/9/07 documented a change in treatment from barrier cream to Xeroderm to coccyx due to "opened blisters." There was no change in treatment from 11/9/07 until 12/2/07 despite the wound report documentation of increasing size. The area is described on 3.0 x 2.4 on 11/23/07. There is no description of the depth of the wound at this time. The area continued to be described as "blisters" and followed on the weekly wound report instead of the pressure ulcer report. On 12/2/07, the treatment changed to Panafil to wound bed, cover with 4 x 4 and secure with Tegaderm. The measurements on 12/13/07 again show the size to be increasing to 3.5 x 3.8. There is no measurement of the depth of the wound. The treatment was not changed. On 12/20/07, R14's wound began to be documented on the pressure ulcer report instead of the wound report. The area is described as 4.0 x 3.6-the depth of the	F9999		

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F9999	Continued From page 69	F9999		

wound is not measured or described. The treatment remained unchanged. Weekly measurements obtained on 12/28/07 described the area as stage II, measuring 4.1 x 3.2. There is no measurement of depth of the wound. On 1/4/08, the area is described as 4.3 x 3.6 x 1.6. There is no documentation that the treatment was changed or physician notified of changes until 1/7/08.

Z1 (Physician) was interviewed by telephone on 1/24/08 at 1:45 PM. Z1 was asked about notification of the worsening pressure ulcer on R14. Z1 stated that she was not notified of the pressure ulcer until 1/7/08. When she was asked about changes in treatment for R14 noted in the physicians orders, Z1 stated the nursing home was probably following a standard wound protocol. Z1 stated she was not informed of the initial formation of blisters on 10/21/07, stating she had talked to the facility on 10/22/07 but not about blisters or areas on R14's coccyx. On 10/23/07 Z1 saw R14 in the facility. There is no mention of the coccyx area in the 10/23/07 progress note. Z1 documented she was seeing R14 regarding left knee pain, and lower extremity edema, ordered Lasix and labwork for the edema.

Z1 stated she saw the wound on 1/8/08, following notification on 1/7/08. Z1 stated the wound was infected, looked "pretty bad," and that R14 was currently receiving Levaquin for the infection in the wound. Physician's progress report and orders by Z1 on 1/8/08 state (in part), "Pt (patient) c/o (complaining of) buttock pain. No other complaints. ....Skin: Stage III/IV wound to coccyx. Decub: Wound Care per protocol.....Orders: Supercereal at breakfast,

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mighty shakes TID (three times daily), daily multivitamin." Z1 also ordered labwork, prealbumin and albumin level related to delayed wound healing. Z1 ordered Juvin, a nutritional supplement, twice daily related to delayed wound healing. Tramadol 50 mg four times daily was ordered for the pain in R14's coccyx. Laboratory results dated 1/8/08 showed low albumin level of 3.0 (normal 3.5-5.1). Prealbumin level is low 11, (normal 17-34).

Nurse's Notes dated 1/7/08 at 12:30 PM stated that Z1 was called to update her on the wound appearance. There is no description of the wound appearance in the Nurse's Note. Z1 called back and ordered a culture of the coccyx wound, changed the treatment to santyl and aquacel AG, cover with 4 x 4 and Tegaderm.

E3 (Treatment Nurse) was interviewed on 1/24/08, at 11:30 AM, regarding R14's pressure ulcer. E3 stated that R14's wound started as a "cluster of blisters" on 10/21/07. E3 stated the wound was listed initially on the weekly wound report but was moved to the weekly pressure ulcer report "when the wound worsened" on 12/28/07.

E3 stated that she did not obtain the measurements or administer the treatments for a period of time approximately 5-6 weeks between Thanksgiving and early January, 2008. E3 stated that the facility's Assistant Director of Nursing (ADON) and MDS/Care Plan Nurse both left at the end of November. E3 was asked to assume those duties (ADON & MDS/Care Plans). Treatments and measurements were to be obtained by the PRN nursing staff or the floor nurses. E3 stated the measurements were

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F9999	Continued From page 71 written down by the floor nurses, and she (E3) would enter the measurements into the computer for the weekly wound and pressure ulcer reports. E3 reviewed the wound reports and verified that R14's treatment remained unchanged following measurements on 11/15/07, 11/23/07, 11/28/07 with no improvement noted to R14's coccyx. After the change in treatment on 12/2/07 to Panafil, the treatment remained unchanged despite weekly documentation on 12/6/07, 12/13/07, 12/20/07, 12/28/07, and 1/4/08 that the wound was becoming larger and deeper. On 1/8/08, after Z1 examined R14, the orders were changed to treat the infected, unstagable pressure ulcer on R14's coccyx. E2 stated in an interview on 1/29/08 at 10:15 AM, that the facility became aware of the problem with pressure ulcers in December when she noted an increase in newly-acquired pressure ulcers in the facility. E2 verified that E3 had been pulled out of her role as treatment nurse and that PRN staff was filling in for treatments. E2 stated that as soon as the problem was identified, within five weeks, E3 was placed back in her role of treatment nurse. On 1/24/08, E3 presented the facility's wound care protocol to the surveyors. This protocol is a wound algorithm, outlining treatment, preventative measures, and nursing interventions based on the different stages of skin loss. The Stage II Wound Care Algorithm states (in part) that Stage II is "partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater." The interventions listed for "Blister" included, "1. Place patient on	F9999		

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F9999	Continued From page 72 air mattress or overlay. 2. Leave blister open to air. 3. Keep clean and dry. 4. No direct pressure on blister." On 1/24/08 at 9:20 AM, R14 was observed in her room. She was on a pressure relief air mattress. E2 was asked when R14 was placed on the pressure relief mattress. E2 stated that the facility had "just acquired" four pressure-relieving mattresses several days ago and R14 was placed on the air mattress "several days ago." E2 was asked why R14 was not placed on the air mattress or overlay after the blisters were first observed on 10/21/07, as per the facility wound care policy. E2 stated, "That's not the policy we currently use. We use the hospital's 'Wound Risk Assessment/Prevention/Management Policy.'" The facility's "Wound Risk Policy" was reviewed. This policy states (in part) that staff will "Adopt wound care protocols by stage of wound (1-4) and for skin tears. Include indications for assistive devices including wound VAC and air flow mattress...." The policy also has interventions based on Braden Assessment Score. The interventions for Moderate to High Risk (14 or less per Braden Scale) include, "H. Utilize pressure relieving devices including air mattress or overlay, elbow and heel protectors." 2. R7 assessed at low risk for pressure ulcer development, developed a facility acquired, Stage 2 pressure ulcer to her right coccyx on 11/26/07. R7's Physician was not kept informed of the status of R7's right coccyx pressure ulcer which worsened to a Stage 4 pressure ulcer on 12/28/07. On 11/21/07 the facility's assessment, Braden	F9999		

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F9999	Continued From page 73 Scale identified R7 to score a "16. This assessment identified R7 to be at low risk for pressure ulcer development. The assessment form identified the following: Low Risk: Total score 15-16 if under 75 years old or 15-18 if over 75 years old." R7 is 86 years old. R7's quarterly MDS dated for 11/29/2007 identified R7 to not have had any pressure ulcers during the seven days prior to the assessment date; and identified R7 to not have had an ulcer that was resolved or cured in the 90 days prior to the assessment date. Review of R7's MDS's identified R7's last pressure ulcer was during the 90 days prior to MDS assessment date of 12/21/06. R7's Pressure Ulcer Record dated for 11/26/07 and 11/28/07, identified R7 to have an "abrasion" that was 1.0 cm x 1.0 cm x 0.1 cm. This record identified the treatment of DuoDerm to this "abrasion." This record also identified "Stage 2="Partial thickness skin loss involving the epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater..." On 12/06/07, the above Pressure Ulcer Record identified R7's Stage 2 pressure ulcer had increased in length to 1.4 cm. On 12/13/07, this record identified R7's Stage 2 pressure ulcer had increased in length to 1.5 cm, and had increased in width to 1.2 cm. On 12/20/07, this record identified R7's Stage 2 pressure ulcer was 1.4 cm x 1.2 cm; R7's Stage 2 pressure ulcer remained larger in length, and larger in width, than R7's initial measurements on 11/28/07 of 1.0 cm x 1.0 cm.	F9999		

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R7's nurses notes dated for 11/26/07 identified nursing staff notified Z2, R7's Physician, of the 1.0 cm by 1.0 cm skin shear to R7's right coccyx area. These nursing notes identified this area was noted to have scab formation starting, and periwound erythema (redness) was also noted. R7's POMT dated for 11/26/07, identified Z2 had ordered DuoDerm to be applied to R7's right coccyx area, with a change every seven days, and as needed until healed.

R7's nurses notes and POMT dated for 12/2007 identified Z2 had not been notified on 12/06/07, when R7's Stage 2 pressure ulcer was identified to have increased in length; identified Z2 had not been notified on 12/13/07, when R7's Stage 2 pressure ulcer was identified to have increased in length and width; and identified Z2 had not been notified on 12/20/07, when R7's Stage 2 pressure ulcer was identified to be larger in length and width than on 11/26/07, when nursing staff had notified Z2 initially of R7's pressure ulcer. On 01/25/08, at approximately 11:30 AM, and at 12:30 PM, interviews of E3 confirmed Z2 had not been notified on 12/06/07, on 12/13/07, nor on 12/20/07 when it had been identified on R7's Pressure Ulcer Record on these respective dates that R7's Stage 2 pressure ulcer to R7's right coccyx had increased in length and width. E3's interview identified Z2 had not been notified of the change in R7's pressure ulcer until 12/28/07.

Facility reassessed R7 on 12/28/07 using the Braden Scale identified R7 now was at moderate risk for pressure ulcer development. R7 scored a "13", and this assessment form identified a total score of 13-14 to be moderate risk.

R7's Pressure Ulcer Record dated for 12/28/07,

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F9999	Continued From page 75 identified R7's Stage 2 pressure ulcer to R7's right coccyx had increased in length to 2.0 centimeters, had increased in width to 1.4 centimeters, depth remained at 0.1 centimeters, redness remained around the ulcer; and this record identified R7's treatment was changed. R7's nurses notes dated 12/28/07, by E3 identified the following: "..Reported to this writer that wound to resident's coccyx noted to be worsening. Upon assessment of area noted wound to (R) side of coccyx measuring 4.0 cm x 2.5 cm. Noted proximal end of wound bed to display dark red/brown area measuring 1.6 cm x 2.4 cm. Area firm to touch. No noted drainage. Remainder of wound bed presents with yellow slouch covering area. Noted periwound erythema measuring 2 cm around wound bed. Erythema hard to touch. Area cleansed. No DuoDerm applied to area per current tx order. Call placed to (Z2) to report such." R7's POMT dated for 12/28/07, identified Z2 gave order for the DuoDerm to be discontinued, and ordered the coccyx wound to be cleansed with wound wash, Panafil to be applied to the wound bed, then covered with a dry dressing and secured with Tegaderm tape. Z2's order identified this treatment was to be done twice a day, and as needed until healed. Facility's "Weekly Pressure Ulcer Report" dated for 01/04/08, identified R7 to have an unstagable pressure ulcer to R7's coccyx that was 4.6 cm x 2.8 cm. This report identified R7's pressure ulcer had been facility acquired on 11/26/07; identified the current treatment of Panafil, dry dressing and Tegaderm; and identified R7's pressure ulcer as a "4" under the section "MDS Stage." Facility's Weekly Pressure Ulcer Report dated for 01/18/08 identified the following for R7: a) an	F9999		

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F9999	Continued From page 76 unstagable, pressure ulcer to right coccyx-7.6 cm x 5.5 cm x 3.9 cm, facility acquired on 11/26/07, MDS Stage 4; b) an unstagable, pressure ulcer to right heel-1.4 cm x 1.2 cm, facility acquired on 12/29/07, MDS Stage 4; c) an unstagable pressure ulcer to left heel-1.0 cm x 1.0 cm, facility acquired on 12/29/07, MDS Stage 4. R7's care plan dated 11/29/07, identified the following; "skin - Res at risk for skin integrity impairment r/t altered nutrition e/b gastric distress and occ urinary incont with use of pads with not always compliant with changing as need requiring assist with personal hygiene and peri care r/t limited use of (Rt) shoulder e/b discomfort and poor posture when up in chair e/b her kyphosis/pain lower back." Facility's goal was for R7's skin integrity to be maintained, and free of any skin problems through next review. Care plan interventions identified R7 was to have bilateral heel protectors on when in bed for pressure protection to R7's heels and feet, and identified R7 to have a special mattress to R7's bed to prevent pressure to bony prominences and pressure areas. On 01/22/08, at 1:21 PM, E8 and E9 (Certified Nurse Aides-CNA's) positioned R7 onto her right side in bed (R7 had been sitting up in her wheelchair). E8 and E9 covered R7 with a top sheet, and made sure R7's bed alarm was on. E8 and E9 did not check R7 for any incontinence, did not place a pillow or any positioning device behind R7's back, and did not apply heel protectors nor float R7's heels (R7 had on light brown, terrycloth, anti-skid anklets). R7's heels rested directly on the air loss mattress. E8 and E9 left R7's room at 1:24 PM. At 1:41 PM, interview of E10, Licensed Practical Nurse (LPN),	F9999		

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F9999	Continued From page 77 related to R7's heels, identified E10's statement of, "We are floating them," and E10 also identified that R7's left heel was still red, and that she had not seen R7's left heel on 01/22/08. On 01/22/08, at 2:40 PM, at 3:30 PM, and at 3:55 PM, R7 remained positioned on her right side in bed without any pillow or positioning device behind R7's back. At each time, R7's knees were flexed (approximately half way), and positioned towards the right side of R7's bed. R7's heels were "dug into" R7's air loss mattress. At 3:55 PM, Surveyor asked R7, "How do your heels feel?", and R7 answered, "Achy." Surveyor asked R7, "How does your bottom feel?", and R7 answered, "Not too good." Surveyor asked R7 related to R7's bottom, "Sore?", and R7 answered, "Sore, yeah." On 01/22/08, at 4:15 PM, Surveyor summoned E2, Registered Nurse(RN)/Director of Nurses(DON) for observation of R7. At 4:17 PM, as Surveyor and E2 entered R7's room, R7 was found positioned on her left side in bed with a pillow positioned behind R7's back; and E2 confirmed, "No, they are not," of R7's heels not being floated. A dressing was seen to R7's right coccyx, and pink to deep pink lines were seen (throughout) across R7's right buttock. Facility's policy/procedure, "Wound Risk Assessment/Prevention/Management", dated 6/05 identified interventions (in part) to be done for those residents identified at moderate to high risk (14 or less per Braden Scale assessment) included the following: a) "Obtain Physical Therapy consult. Physical Therapist to consult with physician for mobility, pressure relieving devices and or activity interventions as	F9999		

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F9999	Continued From page 78 indicated." R7's record identified the Physical Therapist (PT) saw R7 on 12/07/07. The PT did identify R7's "sacral sitting," the strength and range of motion in her extremities, and R7's balance, mobility, transfers, gait analysis. The PT identified R7 needed Active Assistive range of motion to all of her extremities. The PT did not identify any recommendations to R7's Stage 2 pressure ulcer to R7's right coccyx. b) "Reposition at a minimum of every two hours." On 01/22/08, between 1:21 PM-3:55 PM, R7 was not repositioned off her right side while in bed. c) "Utilize pressure relieving devices including air mattress of overlay, elbow and heel protectors." On 01/24/08, interview of E3 identified all mattresses in the facility were pressure relieving; and identified R7 was on a pressure relieving mattress on 11/26/07. R7's record identified R7 was not placed on an Air Mattress until 01/14/08. R7's record identified R7 presented with a Stage 2 pressure ulcer on 11/26/07. Facility's "Weekly Pressure Ulcer Report" dated for 01/04/08, and dated for 01/11/08, identified R7's right coccyx pressure ulcer had increased in size to 4.6 cm x 2.8 cm. on 01/04/08, and had increased in size to 5.0 cm x 4.3 cm on 01/11/08. Z2 changed R7's Panafil order to Santyl and Silveral rope on 01/08/08. Z2's order identified this treatment was to be done daily and as needed. On 01/08/08 Z2 also ordered a consult with Surgeon, Z4. Z4 saw R7 on 01/08/08, and recommended debridement of R7's right coccyx pressure ulcer. On 01/14/08, R7 went to area hospital, and Z4 debrided R7's right coccyx pressure ulcer. Nurses notes dated for 01/14/08, after return from hospital/debridement, identified "...To be turned et (and) positioned side to side q (every) two (hours)..." (Z2 also gave an order for	F9999		

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F9999	Continued From page 79 a "Low-air loss mattress" on 01/14/08 "R/T pressure ulcer to coccyx.") On 01/14/08, Z4 gave order for R7's right coccyx pressure ulcer to be cleaned with wound cleanser, packed with Iodoform, covered with fluffs and Medopore tape to begin on 01/16/08, and change every two days. R7's 01/08 TAR confirmed treatment done as ordered, however as of 01/18/08, this treatment is being done daily. Facility's "Weekly Pressure Ulcer Report" dated for 01/18/08 identified R7's right coccyx pressure ulcer to be 7.6 cm x 5.5 cm x 3.9 cm. R7's nurses notes dated 01/16/08, by E3 identified the following: "..Upon dressing change to residents coccyx noted the following. Noted moderate amount of dark red bloody drainage present on old dressing. Dressing removed. Bloody drainage present on iodoform packing. Packing removed. Wound noted to measure 7.6 cm x 5.5 cm. Depth of wound as follows. 3.9 depth @ 6 o'clock (with) resident's head representing 12 o'clock. Depth of 2.8 cm at 3 o'clock et depth of 1.0 cm @ 12 o'clock. Noted undermining present from 9 o'clock to 12 o'clock measuring 1.6 cm. Also noted undermining present from 10 o'clock to 3 o'clock measuring 1.0 cm. Wound bed presents with yellow stringy slough present to proximal 50% of wound bed. Remaining 50% of wound bed presents with shiny red tissue. Upon cleansing of wound bed noted entire wound bed firm to touch with hardness present to proximal portion of wound bed. Noted firm while structures present consistent with bone present. 1.0 cm from 11 o'clock edge of wound bed. Wound cleansed (with) bloody drainage present during cleansing of area. Wound packed with medicated gauze per order and covered with fluffs. Secured (with) tape. Resident noted to be	F9999		

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F9999	Continued From page 80 very tearful during procedure et c/o pain to area. MD updated. Awaiting return call." R7's POMT dated for 01/16/08, identified Z2 gave an order for R7 to have Roxanol 30 minutes prior to dressing change daily related to R7's increase in pain. On 01/23/08, observation confirmed nursing staff to have given R7 her Roxanol 30 minutes before E3 began her treatment of R7's right coccyx pressure ulcer. R7's nurses notes dated 01/21/08 by E3 identified the following: "...Noted wound to be showing signs of improvement..." On 01/23/08, during observation of treatment to R7's right coccyx pressure ulcer, E3 identified R7's right coccyx pressure ulcer is "filling in." R7's nurses notes dated for 12/29/07 identified an intact blister was noted to R7's right heel, and identified a reddened area with a blister was noted to R7's left heel. The blister on R7's left heel was identified to be 1.0 cm x 2.4 cm with a linear 4.3 cm x 1.0 cm purple area to the center. An area of erythema 4.0 cm x 1.0 cm was identified to surround R7's blister. This note also identified "Heels floated." R7's TAR dated for 12/07 and 01/08, identified R7's heels were monitored per Z2's orders through 01/03/08, when Z2 changed order to cleanse with wound wash and apply Allkare wipes three times a day and as needed until resolved. R7's 01/08 TAR identified, and observation of treatment to R7's heels on 01/23/08 confirmed this treatment continues. R7's 01/08 TAR identified float heels when in bed." Facility's "Weekly Pressure Ulcer Report" dated for 01/18/08, interview of E3 on 01/23/08, and	F9999		

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F9999	Continued From page 81 observation of R7's heels on 01/23/08, identified R7's unstagable pressure ulcers to each heel are improving/healing. (Left heel was 2.6 cm x 1.8 cm on 01/04/08, as of 01/18/08, 1.0 cm x 1.0 cm; Right heel was 3.0 cm x 7.0 cm on 01/04/08, as of 01/18/08, 1.4 cm x 1.2 cm.) On 01/24/08, 12:05 PM, interview of Z2 identified Z2's statement "...her (R7) immobility and debilitation are contributing factors to the deterioration in her ulcer." 3. R20 was originally admitted to the facility on 10/25/07, with diagnoses, in part, of dementia, bipolar disorder and sacral decubitus ulcers. R20's most recent MDS dated 11/30/07 reflects that she has moderately impaired cognitive skills, requires the extensive assistance of one person for transfers, does not ambulate and is incontinent of bowel and bladder. R20's Facility plan of care, dated 11/5/07, shows a "Problem" of "Skin-is at risk of infection and poor healing due to admitted with Stage 4 and Stage 2 pressure areas." The "Goal" for this "Problem" is "Stage 4 pressure area will decrease in size or be resolved by the next review." The "Interventions" for this "Problem" is: "Turn and reposition per positioning schedule above the bed. Assist with repositioning in chair if needed." Facility "Weekly Pressure Ulcer Report" shows that the Stage II pressure ulcer on R20's left buttock was healed on 11/15/07. From 10/25/07 until 1/13/08, facility documentation indicates R20's pressure sore increased in size from a Stage 2 to a Stage 4, to the bone, pressure sore. Facility "Photographic Wound Documentation," dated 10/25/07, shows that R20 was admitted to the Facility with a Stage	F9999		

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F9999	Continued From page 82 III decubitus on her right buttock, which measured 2.0 x 1.4 x 2.5 centimeters with 0.3 cm of tunneling. Facility nurses note, dated 1/13/08, states "Upon assessment of wound to coccyx noted wound to have deteriorated. Wound bed measures 4.2 x 3.6 cm with depth measuring 5.0 cm. Upon cleansing of wound noted firm object at base of wound depth. Upon visual assessment, noted white structure present consistent with appearance of bone. Wound bed noted to be beefy red in color with yellow white scattered tissue. Periwound tissue reddened in color." Facility "Weekly Pressure Ulcer Report," dated 11/1/07, shows the same wound was now a Stage 4, and measured 4.2 x 4.0 x 0.8 cm. A review of "Facility Weekly Pressure Ulcer Reports," dated from 11/9/07 to present, shows that on 11/9/07 this pressure ulcer measured 1.8 x 2.5 x 1.0 cm. This report further shows the wound decreasing in size, measuring 1.2 x 1.0 x 0.3 cm on 12/13/07. On 12/20/07, the decubitus on R20's right buttock measured 2.6 x 1.6 x 0.4 cm. On 12/28/07, the decubitus measured 4.0 x 2.9 x 2.5 cm. On 1/4/08, the right buttock decubitus measured 4.2 x 3.3 x 2.6 cm. On 1/11/08 the decubitus measured 4.2 x 4.4 x 4.1 cm. On 1/18/08, Facility documentation shows that on 1/18/08 the wound measured 4.2 x 4.4 x 4.1 cm. R20 was sent to the hospital on 1/18/07, and remains at the hospital as of 1/24/08 for the right buttock wound. A review of R20's Facility physician's orders show that "Xenaderm every shift" was ordered for the right buttock wound on 10/25/07. On 11/15/07, the treatment was changed to "Hydrogel impregnated gauze and acrylic	F9999		

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Tegaderm." On 11/28/07, the treatment was changed to "Xenaderm, pack with Aquacel, cover with Tegaderm." This treatment was not changed until 1/6/08. On 1/6/08, the treatment was changed to "Aquacel with Tegaderm three times a day."

During an interview with E3 (Treatment Nurse) it was stated that the facility policy for turning and positioning is every two hours. E3 said that R20 had a turning schedule over her bed which would indicate that R20 should be turned every two hours. There is no evidence in R20's clinical record that she was assessed for turning and repositioning more frequently.
R20's pressure ulcers worsened from admission on 10/25/07, to requiring hospitalization on 1/18/08 for Stage IV pressure ulcer with bone exposed.

4. R5's POS dated January 2008, indicated he had a partial diagnose of Stroke with Left-Sided Weakness. R5's MDS dated 9/26/07 and 12/20/07, noted he required extensive assistance from staff with bed mobility and transfers. R5 is incontinent of bowel and bladder. R5's most recent Braden Scale Assessment dated 12/20/07, noted he was at moderate risk for skin breakdown.

R5's nurse's note, dated 10/29/07, noted he developed a new "Stage II" measuring 0.9 cm x 0.3 cm with a 0.1 cm depth on his coccyx. The care plan identified the area as a skin tear. The physician ordered Xenaderm to be applied to the area every shift.

R5's nurse's note, dated 12/31/07, noted R5 acquired a 1.0 cm by 1.6 cm open area to the

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F9999	Continued From page 84 scrotum. The facility identified the new open area as a pressure ulcer. The physician ordered Xenaderm every shift to the pressure ulcer on his scrotum. The facility's Weekly Wound Report from 11/1/07 through 1/11/08 were reviewed. On 11/01/07, the facility identified the wound to R5's coccyx measured 1.6 cm. From 11/01/07 through 1/11/08, R5's wound remained opened. The current Weekly Wound Report of 1/11/08 documented R5's wound size as 1.5 cm by .8 cm. The wound remained open and had not improved significantly with the ordered treatment for 10 weeks. On 1/23/08, at 10:02 AM, E3 applied AlloDerm treatment to the pressure ulcers on R5's scrotum and coccyx. As of 1/23/08, the treatment had not been changed since initially prescribed on 10/29/07. On 1/23/08, at 10:20 PM, E11 and E12 placed R5 into his high-back wheelchair. He remained in his wheelchair at 10:50 AM, 11:20 AM, 11:55 AM, 12:25 PM and 12:45 PM. At 12:58 PM, two hours and 38 minutes after he was transferred into his wheelchair, E12 and E13 transferred R5 from his wheelchair into his bed. On 1/25/08, at 9:30 AM, E2 noted that R5's wound on his coccyx was probably a pressure ulcer. She said the facility should have changed the treatment to the pressure ulcer if the ulcer was not healing or showing improvement. The facility's policy regarding pressure ulcers, dated 6/05, noted residents with moderate to high risk for pressure ulcers should be repositioned at a minimum of every two hours. 5. R16's POS dated January 2008, noted he	F9999		

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had partial diagnoses of Degenerative Osteoarthritis and Quadriplegia. R16's nurse's note, dated 1/6/08, indicated he developed a new Stage II pressure ulcer to his right buttock measuring 1.0 cm by 0.8 cm and a new Stage II pressure ulcer to his left buttock measuring 0.5 cm by 0.5 cm. The physician ordered Xenaderm to the pressure ulcers every shift. R16's care plan, dated 10/23/07, indicated R16 was at risk for skin breakdown. However, the care plan did not address the new Stage II pressure ulcers on his right or left buttock or interventions to address the pressure ulcers.

6. R11 has diagnoses, in part, of Alzheimer's, Anemia and Depression. Throughout all days of the survey, R11 was noted either lying in her bed or sitting in a wheelchair with a lap top cushion in place. R11's most recent MDS dated 11/7/07, shows that R11 requires the assistance of 1 staff with transfers, bed mobility and ambulation. R11's facility plan of care, dated 11/15/07, includes interventions which state: "Resident has use of lap top cushion in wheelchair. Resident to transfer to high back chair for meals with removal of lap top cushion with staff supervision and reapplied after meal. Resident maintains independent mobility via wheelchair with lap top cushion. Staff to observe resident for proper body alignment and safety when in wheelchair with lap top cushion. Resident to have a lap top cushion when in wheelchair. Checked every 30 minutes and released every two hours times ten minutes."

On 1/22/008 at 10:40AM, observation indicated that R11 was pushed in her wheel chair down the 100 hall, and sat at the west hall nurses station. R11 had a lap top cushion applied to the chair that kept her from rising up out of the chair. R11

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had no cushioning in the seat of the chair. A piece of toast with jelly lay inside the wheel chair on the seat next to R11's right outer thigh.

Continuous observation of R11 indicated that she stayed seated in the wheel chair at the nurse's station from 10:40 AM until 11:50 AM, when R11 was wheeled by staff to the dining room to eat lunch. At 11:55 AM, R11's lunch tray was brought to her and she was assisted by staff to eat her lunch. R11's lap top cushion remained on her lap throughout the meal, as well as the piece of toast and jelly that was on the seat of her wheel chair by her right leg.

R11 finished eating and at 1:20 PM was taken back to the nurses station and left sitting in the hall. At 1:45 PM E4 and E5 took R11 to her room to toilet her in the bathroom. Observation of R11's skin indicated that her lower buttocks and upper back thighs were dark red and creased from her clothing.

E4 and E5 stated that R11 had been gotten up at six thirty by the night staff, dressed and put in the wheel chair. E4 and E5 stated that R11 had sat up till she went to breakfast at 8:30 AM. E4 and E5 stated R11 then went to activities at 9:30 AM, and after that church at 10:00 AM to 10:30 AM, after which she was moved to the 100 hall nurses station. E4 and E5 indicated that R11's lap top cushion was for safety to keep R11 from getting up and falling. E4 and E5 stated that they were not assigned to care for R11, and therefore were not responsible for repositioning her throughout the morning. E4 and E5 indicated that E6 (CNA) was responsible for R11's care.

On 1/22/08 at 2:20 PM an interview with E6, she

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stated that she had not seen R11 since breakfast, and had not cared for her because she had been called to help in another area of the building. E6 stated that all staff working on the 100 west halls are considered responsible for R11's care if the CNA assigned is off the floor, away from their residents. A review of R11's care plan dated 11/15/07, indicated "Res to have lap top cushion when in wheel chair. Checked every 30 minutes, and released every two hours. Also to be removed for meals."

7. On 1/22/08 at 12:35 PM, R10 was sitting up in his bed and stated that his buttocks hurt. R10 stated "I think I sat up too long today." When asked how long he had been up he stated "about 3 or 4 hours." E4 and E5 were both in the room at this time and stated R10 had been up since 6:30 AM, and they put him back to bed at 10:45 AM, after church. Both E4 and E5 stated that they had not repositioned R10 during this time, and R10 verified that he had not been out of the chair during this time or repositioned off his buttocks.

Observation of R10's buttocks indicated a pressure ulcer approximately .5cm x .5cm, bright red with the edges of the ulcer very reddened and pronounced. Additionally on R10's right upper inner thigh were two nickle sized excoriated/reddened areas. R10's right groin was also reddened and tender tothe touch. R10 stated "that's sore" as staff attempted to clean his groin and scrotum. No treatment or protective cream was on the pressure ulcer or thigh area or groin.

At 2:30 PM, in an interview with the 400 hall charge nurse, E7 (Registered Nurse) stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145309	A. BUILDING _____ B. WING _____	01/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED BUD NURSING HOME	350 WEST SOUTH 1ST STREET RED BUD, IL 62278

(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 88	F9999		

she had not done any treatment to R10's buttocks or thighs as she thought his wound was healed, and neither E4 or E5 had told her the buttock ulcer needed care, nor that R10's right thigh was excoriated.

On 1/22/08 at 2:35 PM, a review of R10's TAR indicated an order dated 1/8/08 for Sensicare to be applied to buttocks three times a day and as needed. E7 stated that she had not done the treatment but would do so now. A review of the care plan dated 12/30/07, indicated R10's Stage 2 was 1.0 x 1.0 on his buttock. On 1/22/08 the measurement of R10's Stage 2 was .4 cm X .5 cm.

In an interview with E3 she stated that R10's Stage 2 on his buttocks started in house as a blistered area that opened. E3 stated the ulcer was healing and was now smaller in size. E3 stated that staff should have repositioned R10, at least every two hours or sooner as directed in the care plan, and that CNA staff should have informed E7, after peri care, that R10 needed treatment to his buttock and thighs.

Additionally, R10's care plan dated 12/27/07 indicated that R10 was to have heel protectors on when in bed. Observation of R10 on 1/22/07 from 11:45 AM thru 2:45 PM indicated no heel protectors were applied while he was in bed. On 1/23/07, from 8:45 AM thru 9:45 AM, R10 was observed in bed resting with no heel protectors on his feet. In an interview with E2 and E3 both stated that they had no information to explain staff's not following the care plan to provide additional pressure relief to R10's feet.

8. On 1/23/08 a review of R12's POS indicated a

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	145309	A. BUILDING _____ B. WING _____	01/31/2008

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RED BUD NURSING HOME	350 WEST SOUTH 1ST STREET RED BUD, IL 62278

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diagnoses in part of Angina, Atrial Fibulation and Urinary Frequency. The most recent MDS indicated she is alert with slight cognitive impairment, is independent with activities of daily living, needs assistance with bathing, and is occasionally incontinent.

The most recent care plan is dated 10/17/07. Additional updated information was added on 1/1/08 that indicated R12 had developed a Stage 2 pressure ulcer on her coccyx while in the facility. The care plan stated, "resident may have special mattress to bed/chair cushion to prevent pressure to bony prominences and pressure areas."

Observation of R12 on 1/22/08 and 1/23/08 indicated that R12 could get up on her own and move about the facility. Throughout the day on both days it was observed that R12 preferred to sit in her own personal recliner, rather than lay in bed. The recliner is leather with a very firm/hard seat. No pressure relief cushion was in the recliner when R12 was observed sitting in it.

On 1/24/07 at 10:00 AM, R12 was observed lying in her bed. R12 stated "I can't sit in my chair it hurts my bottom, where the sore is. Observation of R12's buttocks indicated a small scabbed area approximately .3 cm on the right upper inner buttocks. There was no drainage or odor, and the wound appeared to be healing. Observation again indicated no pressure relief to R12's chair. In an interview with the charge nurse, E10, she stated that she did not know why no pressure relief had been provided for R10 when she sat in her chair. In an interview with E3, she stated that she did not know why staff did not follow the care plan and provide R12 with pressure relief in here