STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

(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 501	Continued From page 143 showing that he is certified to do wound debridement. Findings include the following: 1. 4/8/08, at approximately 11:40am, Z1 was interviewed by telephone concerning the facility's wound program. Z1 stated, "I really don't do the wounds. They have a wound care doctor that comes out and does that. So, whatever he purposes, I agree with because he is a doctor." 2. Per record review, the facility did not have consents from the families or POAs to perform wound debridement for R1, R6, R14, R15, R16 R17, R18, R19, R20 and R21. No initial assessments or orders by Z2 were found for the same residents. The only paperwork found for each resident was a consultation sheet signed by Z4 but not co-signed by Z2. The facility was ask to see Z4's credentials. Z4 had to be called because they did not have a copy of his credentials in-house. 3. 4/10/08, Z4 was interviewed, at approximately 12:20pm in the basement conference. Z4 stated that he was a trained family nurse practitioner. "I work under the Nurse Practice act. I am not familiar with State Operation Manual (Long Term Care regulations)." Z4 went on to say that he applied for Wound Certification in March of 2008 after he completed a skin and wound management course, March 21, 2008. Z4 was asked how long had he been debriding wounds in the facility and does Z2 do initial assessments on the wounds before he starts debridement? Z4 said, "I have been treating wounds in this facility	F 501		

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F 501	Continued From page 144 since October of 2007. Z2 does no initial assessments. I meet with Z2 once a month and tell him. Z4 was asked if Z1 or Z2 ever makes "rounds" with him to see the wounds? Z4 stated that Z2 doesn't have to oversee his work or write orders for treatment. And that both Z1 and Z2 have not made "rounds" with him.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS REPEAT TYPE "A" VIOLATION 300.610a) 300.1010a)1) 300.1010h) 300.1210a) 300.1210b)2) 300.1210b)5) 300.1220b)7) 300.3220f) 300.3240a) 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 inthe facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written polices shall be followed in operating the facility. 300.1010 Medical Care Policies a) Advisory Physician or Medical Advisory	F9999		

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F9999	Continued From page 145 Committee 1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin	F9999		

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F9999	Continued From page 146 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. 300.1220 Supervision of Nursing Services 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. 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review, interviews, review of facility policy on pressure sores, and observations, the facility failed to comply with its Plan of Correction from the 01/23/07 survey by failing to implement preventive measures to prevent presure sores, and failing to	F9999		

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F9999	Continued From page 147 appropriately assess and care plan for pressure sores. The facility failed to ensure that residents were free from neglect, that residents who entered the facility without pressure sores did not develop pressure sores and that residents having pressure sores did not develop new sores, for 5 residents inside the sample (R1, R5, R14, R15 and R16) and 4 residents outside the sample (R17, R18, R20 and R21) identified with pressure sores; as evidenced by the failure to: -Accurately assess and document all pressure sores. -Obtain a physician order prior to treatment of pressure sores. -Obtain a written consent before debridement of wounds. -Assure that debridement was provided by a wound care certified nurse or physician. - Ensure that each resident receives pain management related to the debridement procedure. - Ensure that residents are provided with the necessary interventions to aid in the healing of existing pressure sores and/or prevent the development of new ones. -Obtain a physician order for debridement procedure. -Obtain a physician order for the specific treatment of pressure ulcers. -Consistently document the size and condition of	F9999		

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F9999	Continued From page 148 pressure sores. -Follow the "Skin Condition and Pressure Ulcer Assessment Policy." These failures resulted in R1 having acquired pressure sores in the facility that worsened and became infected. It also resulted in R1 recieving sharp debridement of pressure sores by Z4 (contract nurse practitioner) including removal of full thickness skin and subcutaneous tissues and muscles. During one of these procedures R1 had excessive bleeding which could not be controlled at the facility and had to be immediately transferred from the facility to a local hospital to control the bleeding. Upon readmission to the facility Z4 continued to peform sharp debridement on R1. These failures also resulted in R14, who was admitted to the facility with no wounds, acquiring 5 new wounds in the facilty that worsened and became infected. R14 was debrided 8 times in 3 months by Z4, this included 5 sharp debridements including removal of full thickness skin, subcutaneous tissues and muscles. R14 was transferred to a local hospital on 03/11/08 and expired 3 days later (03/14/08) with a cause of death listed as "Sepsis (systemic poisoning) of wounds." R21 was admitted with a small pressure sore to the coccyx. In the time he was in the facility he developed 10 additional pressure sores and the original sore worsened to a very large Stage IV wound. His wounds became infected and after an elevated temperature of 107 degrees rectally on 02/14/08, he was hospitalized with a diagnosis of sepsis.	F9999		

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F9999	Continued From page 149 R15 was admitted to the facility with no wounds. In just over 3 months she acquired 4 pressure ulcers that became worse. She began losing weight and she was hospitalized with diagnoses of dehydration and failure to thrive. R5, R16, R17, R18 and R20 are additional examples of facility failure to provide appropriate treatment and services for pressure sores. Findings include: Upon entering the 2nd floor of the facility identified as "Skilled Unit" during the initial tour on 04/07/08 at approximately 10:15 a.m., surveyor noted very pervasive, foul, pungent wound odors permeating this floor into the hallways. These odors were more pronounced on the North end of the floor at the different locations where residents were located that had pressure sores. It was also noted that the majority of these residents have various types of infections including infections of the wounds/pressure sores. 1. R1 was originally admitted to the facility on 12/11/07. The nursing admission sheet from this date shows that the resident was admitted with a stage 4 pressure sore to the sacral and scrotal areas and sized as follows: Edema to scrotum 1.5cm x 1.2 x 0.8cm. Lower back/ sacrum 7.5cm x 1.2cm x 1.0cm 50% slough serosanguious drainage. Left foot boggy heel. Right posterior heel old scar decubitus healed. There was no other site identified as having pressure sores. During the initial tour with E2 (Director of nurses) R1 was observed on bedrest with bilateral side	F9999		

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F9999	Continued From page 150 rails in up position and recieving oxygen therapy via trach (tracheostomy) collar to a tracheostomy in R1's neck. R1 recieves all his nutrition via G-tube and requires total assist of staff in all areas of care. R1 was also noted to be under contact isolation precautions due to infection of wound/pressure sores. These precautions require anyone who enters R1's room to wear protective clothing. There was also a very foul pungent wound odor noted that permeated outside R1's room into the hallway. On 04/07/08 at approximately 10:35a.m. E4 (wound nurse) was interviewed regarding the status of R1's pressure sores. E4 stated, "(R1) has a stage 3 wound on the sacrum and a stage 2 to the left heel." Upon further interview E4 added, "(R1) has a wound to the left lower leg that heals and opens back up. It is now open and I applied duoderm to it." At approximately 3:45p.m. on this day E2 and E4, with the assist of E7 (nurse assistant), were observed providing treatment to R1's wounds. E4 was observed to gown, glove, position R1 to the left side and remove the soiled dressing from R1's sacral area. E4 then cleaned this area with normal saline solution, applied Accuzyme ointment to several 4 x 4 gauze pads to apply to R1's sacral wound before finally covering with Omnifix tape. There was a Duoderm intact to R1's left lower leg. E4 stated this is changed every 3 days. There was a small healed linear scar noted to the underside of R1's scrotum. E2 and E4 stated, "(R1) had surgery there." E4 was observed to require prompting from E2 during this entire procedure regarding setting up supplies, when to change gloves, when and how to dispose of soiled supplies etc.	F9999		

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F9999	Continued From page 151 Pressure Ulcer Report dated 12/14/07 documents Lower back stage 4 size 10 x 6 x 3.5 cm. treated with 0.5% Betadine. There was no documentation of the size or condition of the scrotal area or left heel that was identified on 12/13/07. This documentation indicates an increase in the size of R1's pressure sore to the lower back. Pressure ulcer report documentation dated 12/21/07 was as follows: Lower back stage 4 and sized as 10 x 6 x 3.5cm and was treated with 0.5% Betadine. There was no change in R1's pressure sores. The documentation for R1's pressure sores for the following dates was as follows: 01/18/08 - Lower back 9.0 x 6.0 x 2.5cm scrotum 2.0x 0.5 x 4.0cm 01/25/08 - Lower back 9.4 x 7.5 x 2.3 cm scrotum 2.0 x 1.5 x 1.5cm The documentation for this week indicates an increase in the length and width of R1's pressure sores. 02/05/08 - No assessment documented for this week related to R1's pressure sores. 02/12/08 - No sizing for R1's presure sores for this week, however, per documentation R1 developed a pressure sore to the right thigh staged as a 3 and treated with Duoderm. 02/19/08 - Lower back stage 4 and sized as 7.0 x 5.0 x 3.0 cm.. There was no other site identified or assessed, even though R1 was identifed with a scrotal wound and right thigh wound.	F9999		

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F9999	Continued From page 152 02/26/08 - Lower back stage 4 sized as 8.0 x 6.5 x 2.5cm. This indicated an increase in the size of R1's pressure sore since last week (week of 02/19/08). There were no other sites identified on this week. 03/04/08 - Lower back stage 4 and sized as 8.5 x 6.0 x 2.0 cm. This was the only site sized or assessed again this week even though other sites were identified before. 03/11/08 - Lower back stage 4 and sized as 8.5 x 7.0 x 2.5cm. This indicates an increase in the width and depth of this pressure sore in a week. There was no other site identified, assessed or sized. 03/18/08 - Lower back stage 4 and sized as 8.0 x 7.5 x 2.2cm. This indicated an increase in the width of R1's back wound. Right lower leg stage 2 and sized as 1.0 x 1.5 x 0.3cm. This is a newly developed wound for R1. 03/25/08 - Lower back stage 4 and sized as 7.5 x 7.2 x 2.0 cm. Right lower leg stage 2 and sized as 1.0 x 1.0 x 0.2cm. 04/01/08 - Lower back stage 4 and sized 7.0 x 6.9 x 1.8cm. Right lower leg stage 2 and sized 0.8cm x 0.7 x 0.8cm. 04/08/08 - Lower back 2.3 x 1.4cm x 1.5 cm. Right lower leg 0.7 x 0.8 x 0.0cm. Review of the TAR (treatment administration record) indicated that R1 received treatments that were not ordered by a physician. The documentation was not comprehensive and did not consistently address all of the wounds. The	F9999		

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F9999	Continued From page 153 resident's careplan did not identify and address the specific needs related to pressure sores for R1. During review of physician's progress notes from 12/11/07 through 04/07/08 surveyor was unable to locate physician's assessment or progress notes related to R1's pressure sores. Finding no physician's notes, surveyor interviewed E4 regarding treatments for R1's sores. E4 stated, "I follow the treatment orders of (Z4, Contract nurse practitioner)." E4 then provided surveyor with forms titled Wound Consultation Reports. According to the Wound Consultation Reports regarding procedures performed and signed by Z4 the following is documented: "wound on the lower back debrided down to subcutaneous tissue/full thickness skin (through the muscle) using a (sharp) debridement kit on 01/11/08 and 01/18/08 (which required compression to control bleeding on both days)." On 02/01/08 Z4 again performed debridement on R1 with sharp debridement tray including removal of full thickness skin and subcutaneous tissues and muscles. During this procedure R1 had excessive bleeding which could not be controlled at the facility with compression and electric cauterization and resulted in R1 being transferred out to a local hospital to control the bleeding. This review indicated that R1 continued to have debridement using a sharp debridement kit with resulting bleeding 4 times between 01/11/08 and 02/15/08 and debridement using sterile gauze abrasion 5 times between 2/8/08 and 3/4/08.	F9999		

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F9999	Continued From page 154 This was a total of 9 debridements in less than 3 months. The only wound that received debridement was the lower back. There were no consents for any of the procedures, and there was no assessment of pain prior to or after any of the procedures. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. Z4 also stated that he has been performing debridement of pressure ulcers in the facility since 12/07 and he did not take the class for certification until 3/08. At the time of the survey (04/07/08), Z4 still had not been certified to perform wound care debridement. There was no counter signature of a physician on any of these procedures. 2. R21 was a 33 year old resident admitted to the facility on 11/6/07 with diagnoses that included Head Injury, Respiratory Failure, Renal Failure, Diabetes Melllitus and MRSA Nares and Wound. The resident was on a ventilator. Review of the physician's orders indicated that there were no orders for wound care treatments from the time of admission until the time of discharge on 2/14/08. The resident was hospitalized with a diagnosis of sepsis. Review of the R21's clinical record indicated that from the time of admission until the time of discharge (just over 3 months), R21 acquired 10 wounds. As of 2/14/08, there were at least 11 wounds with a number of them being unstageable. The documentation was not comprehensive and did not consistently address all of the wounds; the facility's weekly Pressure Ulcer Report failed to address 7 of the wounds at all. The resident's care plan did not identify and	F9999		

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F9999	Continued From page 155 address the specific needs related to pressure sores for R21. On interview, on 4/16/08, Z10 stated that when the resident was first admitted to the facility he had a pressure sore on his buttocks that was the size of a quarter. She further stated that when she would visit the resident she would find him soaked with urine and feces and she would bathe him herself and change the linens. She stated that she was not able to visit for several weeks due to her own illness, and when she returned, the pressure sore was the size of a softball and he had 4 others. Z10 stated that the second time he was hospitalized for sepsis after admission, she would not allow him to go back. She stated that since the time of discharge on 2/14/08, he has struggled with sepsis related issues and has had a decline in his limited mental status. He has had numerous hospitalizations and they are preparing to remove him from life support. She confirmed that the family was never contacted for consent of debridement procedures. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. The evidence was as follows. Review of the nurses' notes: The resident had pressure sores and was previously hospitalized for sepsis. Upon return, on 1/3/08, there was little monitoring documented. - 1/3/08 the resident was readmitted to the facility after being hospitalized for sepsis. It was noted that when he returned he had a decubitus	F9999		

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F9999	Continued From page 156 ulcer on the coccyx, the right outer foot, the left outer foot and redness of the buttocks. - 1/16/08 the resident had an elevated temperature of 103.1 at 11:00pm. Acetaminophen 650mg was administered and at 11:30pm the temperature was 102.1. (The note failed to identify the method of taking the temperature, i.e. axillary or rectal.) - 1/17/08 at 12:30am (1 hour after the previous temperature) the temperature was up to 103.4. There were no further temperatures recorded in the nurses' notes. - 1/28/08 at 6:50am the resident was noted to have a temperature of 100.8 (Method of measurement unknown). - 1/29/08 documents the resident's temperature within normal limits on 2 shifts. - There was no further documentation of temperature until 2/14/08 when at 7:30am the nurse documented that the resident's rectal temperature was 107.1 and the axillary temperature was 104.2. The resident was sent to the hospital for evaluation. - 2/15/08 the resident was admitted to the hospital with a diagnosis of sepsis. Review of the Wound Consultation Reports completed by Z4 (Nurse Practitioner): - The report dated 1/18/08 indicated the presence of 4 wounds (Right Lateral Foot, Left Lateral Foot, Lower Back and Right Hip). The treatment was stated as, "Necrotic tissues removed, healthy tissues exposed from wound with abrasion using 0.9 normal saline with Betadine (5cc Betadine to every 100cc saline)." The recommendations for treatment were, "Clean open wounds thoroughly with .05% betadine solution, loosely pack/cover wounds with sterile gauze soaked in .05% betadine solution and	F9999		

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F9999	Continued From page 157 cover with a sterile dressing every 2 days and prn if dressing becomes soiled or 50% saturated." - The report dated 1/22/08 included the same information and recommendations. The measurements of the wounds demonstrated a small decrease in size. - The report dated 1/25/08 only addresses 2 wounds (Lower Back and Right Hip). The measurements indicated a slight increase in size for the Lower Back Wound and a slight decrease in size for the Right Hip wound. The treatment and recommendations remained the same. - The report dated 2/1/08 was conducted by Z2 (the physician from the consultation group). This report identified 11 wounds, however it did not address the Right Hip from previous reports. The following 7 wounds had not been documented on either the Wound Consultation Report or the facility Weekly Pressure Report; Right Buttock - Unstageable - 5.4 X 5.0 Right Tip of the 2nd Toe - Unstageable - 1.5 X 0.4 Right Heel - Unstageable - 3.7 X 4.3 Head of the Right 1st MTJ - Unstageable - 1.1 X 0.8 Left Lateral Malleolus - Unstageable - 1.5 X 1.5 Midback - Unstageable - 0.5 X 1.7 Left ear - Stage 2 - 2.8 X 1.5 The treatment was stated as, "All necrotic and devitalized tissues removed which include full thickness skin and subcutaneous tisssues, healthy tissues exposed using sharp debridement tray. Bleeding controlled with compression, patient tolerated procedure well." There was no assessment of pain prior to or after the procedure. There was no consent for the procedure. - The report dated 2/8/08 addressed only 3 of the 11 wounds (Lower Back, Right Hip and Mid	F9999		

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F9999	Continued From page 158 Back). In comparing the measurements from the previous report, what is now being called the Right Hip was previously the Right Buttock. The resident was seen and treated by Z4 (Nurse Practioner Consultant). The treatment included incision and drainage of the right hip wound. There was no consent and no assessment of pain prior to or after the procedure. Review of the weekly Pressure Ulcer Report (Reports with measurements): Left Lateral Foot - Stage IV 1/18/08 4.0 X 1.5 X 0.2 1/25/08 3.0 X 2.8 X 0.1 2/21/08 4.8 X 3.2 X 0.5 - "bone exposed" 2/5/08 No Measurements 2/12/08 No Measurements 2/19/09 No Measurements Lower Back - Stage IV 1/18/08 8.5 X 7.5 X 1.5 1/25/08 8.0 X 6.0 X 1 2/21/08 9.5 X 8.0 X 2.2 - "bone exposed" 2/5/08 No Measurements Heavy serosanguineous exudate; 30% necrotic tissue with exposed bone 2/12/08 No Measurements Heavy serosanguineous exudate; 25% necrotic tissue with exposed bone 2/19/08 No Measurements Heavy serosanguineous exudate; 20% necrotic tissue with exposed bone Right Hip - Stage III 1/18/08 1.8 X 1.5 1/25/08 1.5 X 2.8 2/5/08 No Measurements Mild serosanguineous exudate; partially stable eschar	F9999		

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F9999	Continued From page 159 2/12/08 No Measurements Mild serosanguineous exudate; partially stable eschar 2/19/08 No Measurements Mild serosanguineous exudate; partially stable eschar Right Lateral Foot - Stage III 1/18/08 2.0 X 1.0 1/25/08 2.3 X 1.7 2/21/08 2.5 X 1.5 X 0.6 2/05/08 No Measurements 2/12/08 No Measurements 2/19/08 No Measurements Right Trochanter - Stage II 2/19/08 No Measurements 2/21/08 Unstageable 2.5 X 3.0 Identified by Z2 on 2/1/08 Right Buttocks - Unstageable 2/21/08 5.4 X 5.0 (1st mention of this wound) Identified by Z2 on 2/1/08 Right Tip of 2nd Toe - Unstageable 2/21/08 1.5 X 0.4 (1st mention of this wound) Identified by Z2 on 2/1/08 Right Heel - Unstageable 2/21/08 3.7 X 4.3 (1st mention of this wound) Identified by Z2 on 2/1/08 3. R15 was a 73 year old resident with diagnoses including Cellulitis of Leg, Mental Disorder and Right Below the Knee Amputation. She was admitted to the facility on 11/23/07 and according to the initial Minimum Data Set (MDS) the resident did not have any pressure ulcers at the time of admission. Review of the physician's orders indicated that there were no orders for wound care treatments from the time of	F9999		

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F9999	Continued From page 160	F9999		

admission until the time of discharge on 3/18/08. The resident was hospitalized with diagnoses of dehydration and failure to thrive.

Review of the R15's clinical record indicated that from the time of admission until the time of discharge, the resident acquired 4 wounds. As of 3/18/08, two of the wounds had worsened and were noted to be Stage III. The documentation was not comprehensive and did not consistently address all of the wounds; the weekly wound care log failed to address the ankle wound at all. The resident's care plan did not identify and address the specific needs related to pressure sores for R15.

According to the Wound Consultation Reports, R15 had mechanical debridement of the wound on the left ischium 1/25/08 (which required compression to control bleeding) and debridement with sterile gauze abrasion 6 times between 2/8/08 and 3/4/08. The only wound that received debridement was the left ischium (except on 3/4/08 when there was the mention of the left hip as a new wound). There were no consents for any of the procedures, and there was no assessment of pain prior to or after any of the procedures. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. At the time of the survey, Z4 had not been certified to perform wound care debridement. On interview on 4/15/08, Z9 (POA) confirmed that she had not been contacted regarding the debridement procedures. She further stated that she was not aware that the resident had pressure sores until she was discharged to the hospital. The evidence is as

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F9999	Continued From page 161 follows: Review of the nurses' notes: - 11/23/07 indicated that on admission the resident had, "redness on the buttocks." - 11/25/07 stated, "Stage I bilateral buttocks and inguinal area," and "Left heel reddened with boggy texture." - 12/28/07 stated, "Wound to right inner groin area. 3.5cm X 2.1cm X 0.1cm Eschar 25% noted with reddened periwound." - 1/13/08 stated, "Dressing changed to left buttocks." - 1/14/08 stated, "Dressing to left buttocks clean and intact." - 1/18/08 stated, "Wound to left buttocks cleaned and dressed." - 1/22/08 stated, "Dressing to left buttock cleaned and changed." - 2/13/08 stated, "Dressing to buttocks wound intact." - 2/19/08 stated, "Wound team assessed and changed dressing on left buttocks." - 2/21/08 stated, "Skin is intact. During assessment Stage III breakdown on buttocks left side." - 2/25/08 stated, "Wound to left buttocks clean and dressed." - 2/26/08 stated, "Left buttocks dressing dry and intact." - 2/27/08 stated, "Wound to left buttocks cleaned and dressed and intact." - 3/5/08 stated, "Wound to left ankle cleaned and covered with dry 4 X 4's. Wound nurse made aware." - 3/12/08 stated, "Wounds to left buttocks cleaned and dressed and covered with 4 X 4 dressings." - After the initial mention of the right inner groin,	F9999		

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F9999	Continued From page 162 left heel and the left ankle, there was no further mention of these wounds. There was also no specific documentation on the status of these wounds in the nurses's notes. Review of the treatment administration records (TAR) for 2/08 and 3/08: - There was documentation of treatments being administered that were not on the physician orders; - All wounds were documented as being treated with a DuoDerm dressing every 3 days after cleansing with normal saline solution; - In 2/08 there was also a wound treatment to the right buttocks which was discontinued on 2/12/08. - The wounds listed as being treated were to the Right Buttocks, Left Buttocks, Left Inner Thigh and Left Ankle. Review of the Wound Consultation Reports completed by Z4 (Nurse Practitioner): - 1/25/08 indicated that the resident's wound was debrided and the report stated, "Wound debrided down to subcutaneous / full thickness skin using a debridement kit, healthy tissue exposed bleeding controlled with compression." The wound listed was the Left Ischium which was identified as a Stage II. - The reports dated 2/8/08, 2/15/08, 2/19/08, 2/22/08 and 2/26/08 all had exactly the same statement, "Wound cleansed with .05% Betadine Solution. Periwound area prepped with Betadine. Wound debrided with sterile gauze abrasion." - The report dated 3/4/08 added a 2nd wound, a Stage II to the Left Hip. The statement of wound care was exactly the same as the reports from 2/8/08, 2/15/08, 2/19/08, 2/22/08 and 2/26/08. - The reports do not mention any wounds to the	F9999		

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F9999	Continued From page 163 buttocks, left thigh or left ankle. - There is nothing in the reports to differentiate between the condition and treatment of the various wounds. There were no physician's orders and the orders written on the consultation report were the same for all residents. Review of the weekly pressure ulcer reports: - The weekly pressure ulcer report dated 1/27/08 indicated that R15 had a Stage II pressure sore on the left ischium and this was the first identification of this wound. The measurement was listed as 3.0 X 4.0. The wound was acquired in the facility on 1/17/08. - The weekly pressure ulcer report dated 2/5/08 indicated that the measurements for the Stage II pressure sore on the ischium were 3.0 X 2.5. - The weekly pressure ulcer report dated 2/12/08 and 2/19/08, indicated that the measurements for the Stage II pressure sore on the ischium were 2.5 X 3.5. - The weekly pressure ulcer report dated 2/26/08 indicated that R15 had acquired another Stage II pressure sore on the left inner thigh. The pressure sore on the left ischium measured 2.3 X 5.0. The newly identified pressure sore was recorded as measuring 2.0 X 3.5. - The weekly pressure ulcer report dated 3/4/08 indicated that the pressure sore on the left ischium measured 2.0 X 4.5; the pressure sore on the left inner thigh measured 1.5 X 3.0. - The weekly pressure ulcer report dated 3/11/08 indicated that R15 had acquired an unstageable pressure ulcer on her left ankle which measured 0.8 X 0.5. The pressure sore on the left ischium was measured at 1.5 X 2.0 X 0.1; the pressure sore on the left inner thigh measured 3.5 X 3.0. - The weekly pressure ulcer report dated 3/18/08 indicated that 2 of the wounds were now at the	F9999		

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level of stage III, which indicates a decline. The measurements for the pressure sore on the left ischium were recorded as 2.0 X 2.5 X 0.2. The measurements for the pressure sore on the left inner thigh were recorded as 4.5 X 2.5 X 0.5 which indicates an increase in the size of the wound.

4. R16 was admitted to the facility on 12/12/07 with diagnoses that included Type II Diabetes Melliltus, Cardiomyopathy, Respiratory Failure, Chronic Obstructive Pulmonary Disease and Decubitus Ulcer. At the time of admission, she was noted to have 2 Stage II pressure ulcers (Left Buttocks - 1 X 1.8 X 0.1 and Right Buttocks - 1.7 X 2 X 0.1). Review of the physician's orders indicated that there were no orders for wound care treatments from the time of admission until the time of discharge on 1/23/08. The resident was discharged from the facility on 1/23/08 and expired on 1/24/08. In the month and a half that she resided in the facility, the resident acquired 2 additonal pressure sores on the left buttocks and a pressure ulcer on the lower back.

Review of the weekly Pressure Ulcer Reports:
12/14/07 Left Buttocks Stage II 1 X 1.8 X 0.1
12/14/07 Right Buttocks Stage II 1.7 X 2 X 0.1
12/21/07 Left Buttocks Stage II 1 X 1.8 X 0.1
12/21/07 Right Buttocks Stage II 1.7 X 2 X 0.1

The development of additional pressure ulcers acquired in the facility were not addressed on any subsequent Pressure Ulcer Reports. R16 was not listed on the weekly Pressure Ulcer Report for any other weeks in December or January.

Review of the Wound Consultation Reports completed by Z4 (Nurse Practitioner):

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F9999	Continued From page 165 - The report dated 12/14/07 documented the size of the wounds on the left and right buttocks at the same measurement that were recorded on the Presssure Ulcer Report. The wounds were to be cleansed thoroughly with 0.5% betadine and covered with duoderm or equivalent every 3 days. - The report dated 12/28/07 added 3 additional Stage II Pressure Ulcers (2 additional wounds on the Left Buttocks and a wound on the Lower Back) The wounds were to be cleansed thoroughly with 0.5% betadine and covered with duoderm or equivalent every 3 days. - The report dated 1/18/08 indicated that the wounds on the Left Buttocks had healed, but the wounds on the Right Buttocks and lower back were still present. The dressing recommendations were changed to, "cleanse with 0.5% betadine solution, apply gauze soaked in 0.5% betadine solution and cover with a sterile dressing every 2 days and PRN. - There were no physician's orders for the recommended treatments. 5. R17 is a 66 year old resident with diagnoses that included Seizure Disorder and Acute Respiratory Failure. R17 is totally dependent on staff in all areas of care. R17 was admitted to the facility on 11/29/07 and according to the initial Minimum Data Set (MDS) the resident was admitted with a stage 2 sacral wound. Review of the R17's clinical record indicated that from the time of admission until the date of survey, R17 acquired 3 wounds. As of 3/18/08, the wounds had worsened and were noted to be Stage II and Stage IV. The documentation was not comprehensive and did not consistently	F9999		

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F9999	Continued From page 166 address all of the wounds. The resident's care plan did not identify and address the specific needs related to pressure sores for R17. According to the Wound Consultation Reports regarding procedure performed and signed by Z4 (contract nurse practitioner), R17 had debridement of lower back using a debridement kit down to the subcutaneous tissue/full thickness (through muscle) on 12/14/07, 12/21/07, 01/18/08, 01/22/08, 01/25/08 and 02/08/08 (which required compression to control bleeding). This was a total of 7 times in less than 3 months and debridement with sterile gauze abrasion 6 times between 2/15/08 and 3/7/08. The only wound that received debridement was the lower back. There were no consents for any of the procedures; there was no assessment of pain prior to or after any of the procedures. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. At the time of the survey, Z4 had not been certified to perform wound care debridement. These procedures were not counter signed by a physician, nor was there evidence that R17's wounds were assessed by a physician. On 04/08/08, surveyor observed the debridement of R17's heel by Z3 (contract podiatrist). R17 who is receiving isolation precautions was on bedrest with eyes closed, bilateral side rails in up position and receiving oxygen therapy via trach (tracheostomy) collar to a trach in R17's neck. Z6 (family/guardian) and another family member were present during this procedure and were sitting near R17's head. Z3 was not noted to discuss the procedure with	F9999		

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F9999	Continued From page 167 family prior to doing it, nor was Z3 noted to anesthetize the area before cutting dark tissue on R17's heel using scissors. After the procedure surveyor interviewed Z6 regarding a discussion of this procedure with her. Z6 confirmed that she had not been contacted regarding the debridement procedures. She further stated that she was not aware that R17 was having pressure sores debrided until she happened to be in the facility today (04/08/08). Review of the nurses' notes documents the following: - 11/30/07 indicated that on admission the resident had, "stage (II) to sacral area. No other site was identified." - 03/27/08 indicated "(R17's) right ear with purulent drainage and pressure ulcer to right posterior thigh." Review of the treatment administration records (TAR) for 12/07 - 04/08: - There was documentation of treatments being administered that were not on the physician orders; Review of the weekly Pressure Ulcer Reports document on the following dates: 12/14/07 - Left medial heel stage IV and sized as 5.0 x 4.0. This indicated a newly developed wound since admitted on 11/29/07. There was no documentation related to the sacral wound. 12/21/07 - Left medial heel stage IV and sized as 5.0 x 4.0. There was no documentation related to the sacral wound.	F9999		

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F9999	Continued From page 168 01/18/08 - Lower back 7.0 x 4.5 x 4.0cm. This indicated a significant increase in the size since admission on 11/29/07. There was no documentation related to the left heel even though it was a stage IV and 5 x 4cm in size last month. 01/25/08 - Lower back 8.5 x 6.5 x 4.0cm. This is another significant increase in size in 1 week. There was no documentation related to the left heel. 02/05/08 - Lower back stage IV and sized as 8.0 x 6.5 x 3.5cm. 90% necrotic. There was no documentation related to the left heel. 02/12/08 - Lower back stage IV and sized as 6.0 x 6.0 x 4.0 cm. No documentation of left heel. 02/19/08 - Lower back stage IV and sized as 6.5 x 6.0 x 5.0cm. No documentation of left heel. This is an increase in length and depth of this wound in 1 week. 02/26/08 - Lower back stage IV and sized as 5.5 x 4.5 x 2.3cm. No documentation of left heel. 03/04/08 - Lower back stage IV and sized as 3.5 x 4.0 x 2.0cm. No documentation of left heel. 03/11/08 - Lower back stage IV and sized as 6.0 x 5.0 x 4.0cm. This indicates a significant increase in R17's presure sore in 1 week. 03/18/08 - Right foot - stage II and sized as 1.5 x 1.5 cm. Lower back - stage IV and sized as 5.8 x 5.0 x 4.5cm.	F9999		

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	145942	A. BUILDING _____ B. WING _____	04/17/2008

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F9999	Continued From page 169 Left foot - stage II and sized as 1.6 x 1.2 cm. Right lower leg - stage II and sized as 0.5 x 1.0cm. This indicated 3 newly acquired pressure sores for R17 in 1 week. 03/25/08 - Right foot- stage II and sized as 1.5 x 1.0cm. Left foot - stage II and sized as 1.3 x 1.2cm. Right lower leg - stage II and sized as 0.4 x 0.8cm. Lower back - stage IV and sized as 6.0 x 5.0 x 3.8cm. 04/01/08 - Right foot - stage II and sized as 1.3 x 1.0cm. Lower back - stage IV and sized as 5.5 x 4.5 3.5cm. Left foot - stage II and sized as 1.0 x 1.0cm. Right lower leg stage II and sized as 0.2 x 0.6cm. Review of this Pressure Ulcer Report indicated that R17 acquired 4 new wounds in the facility since admission on 11/29/07, as well. Not all wounds previously identified were consistently assessed and some of these wounds were increasing in size and in staging which indicates a decline. There was no assessement at all for R17's right ear wound with purulent drainage and right posterior thigh wound that was found by facility staff on 03/27/08. Review of the dietary notes show that the dietician evaluated R17 on 01/23/08 and mentions a "left medial heel 100% eschar and lower back 9.0 x 6.0 with tunneling and stage 2 on left hip 4.0 x 5.0cm." This documentation of sites and sizing is clearly in conflict with the facility's "Pressure Ulcer report" at that time. The Dietician's evaluation on 03/25/08 does not	F9999		

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F9999	Continued From page 170	F9999		

mention pressure sores and there were no dietary recommendations for healing of the sores. R17 has not been on any type of multi-vitamin or zinc or protein supplement to promote healing since admission.

6. Closed record review indicated that R14 was an 87 year old resident with diagnoses that included Arthritis, Diabetes Melllitus and VRE of urine (vancomycin resistant enterococcus). R14 was admitted to the facility on 12/30/05. In interview with Z5 (family of R14), Z5 stated that R14 did not have pressure sores when admitted to the facility, since R14 lived with Z5 prior to being admitted to the facility.

According to the most recent Minimum Data Set (MDS) R14 had full loss of both legs and required total assist of staff in all areas of care. R14 also has one stage I and two stage IV pressure sores at this time. Review of the physician's orders included an order for wound treatment as follows: "Santyl to all decubitus daily." This order does not address the different sites or condition of each wound. This wound treatment order by the physician was not followed for the last 6 months of R14's stay at the facility.

Review of the resident's clinical record indicated in the last 5 months until the time of discharge, R14 acquired 5 wounds. As of 03/11/08, 2 of the wounds had worsened and 1 was not mentioned at all. R14's wound documentation was not comprehensive and did not consistently address all of the wounds. The resident's care plan did not identify and address the specific needs related to pressure sores for R14.

Review of the nurses' notes document the

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F9999	Continued From page 171 following: - 12/21/07 R14 was readmitted to the facility. -12/22/07 at 10:00 p.m. wound assessment coccyx 1.8cm x 1.2cm 85% eschar perioribital; redden bilateral anus. Left knee 2.6 x 2.1cm, left knee scabs. Left 3rd toe 1cm x 0.6cm eschar 100% right hip. Review of the treatment administration records (TAR) for 12/07 until discharge on 3/11/08: - There was documentation of treatments being administered that were not on the physician orders. Review of the weekly pressure ulcer reports: - 12/07 - No assessment performed for any of R14's wounds during this month. - 01/20/08 - Left knee unstageable and sized as 2.5 x 2.8cm. 100% necrotic. -Left shoulder 0.6 x 0.5cm. -Lower back unstageable 3.0 x 3.2 x 0.3cm 75% necrotic. - 01/25/08 - Lower back 3.5 x 3.5 x 0.5cm. -Left hip 5.0 x 5.0cm. -Right knee 3.0 x 3.0cm. -Right hip 7.0 x 5.0 x 0.1cm. -Left knee 3.0 x 3.0cm. -Left shoulder 1.0 x 0.8cm. -Left upper arm 5.0 x 5.5cm. This review indicated newly developed pressure sores, as well as an increase in the size of the pressures sores for the left knee, left shoulder and lower back.	F9999		

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F9999	Continued From page 172 - 02/05/08 - Right knee unstageable 3.0 x 2.8 x 0.2cm. 80% necrotic. -Right hip unstageable 6.5 x 4.5 x 0.1cm. -Left knee unstageable 2.8 x 3.0 x 0.2cm. -Left shoulder stage II and sized as 1.5 x 0.8cm 100% necrotic. The lower back, left hip and left upper arm not assessed. - 02/12/08 - Right knee unstageable 2.8 x 2.5 x 0.2cm 70% necrotic. -Right hip unstageable 6.7 x 4.5 x 0.2cm. -Left knee unstageable 2.5 x 2.5 x 0.2 cm 100% necrotic. -Left shoulder stage 2 and sized as 1.0 x 0.5cm. The lower back, left hip and left upper arm not assessed. - 02/19/08 - Right knee unstageable 3.2 x 2.0 x 0.2cm. -Right hip unstageable 6.5 x 4.0 x 0.2cm -Left knee unstageable 2.0 x 2.5 x 0.2cm. -Left shoulder stage 2 and sized as 1.2 x 0.4cm. The lower back, left hip and left upper arm not assessed. - 02/26/08 - Left knee unstageable 1.5 x 2.0 x 0.1cm, 100% necrotic. -Left lower back unstageable 1.0 x 3.0cm, 100% necrotic. -Left hip unstageable 8 x 7.5cm. -Right hip unstageable 10 x 7.5 x 1.7cm. The right knee, left shoulder, left upper arm not assessed. This review indicated that R14's left hip has not been assessed since 01/25/08, has declined significantly and remains unstageable. - 03/04/08 - Left knee unstageable 1.0 x 2.0 x 0.1cm.	F9999		

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F9999	Continued From page 173 -Left lower back unstageable 1.0 x 2.5cm. -Right knee unstageable 2.5 x 1.5 x 0.1cm. -Right hip unstageable 5.0 x 3.5 x 0.2cm. There was no assessment for R14's left hip, left upper arm and left shoulder. - 03/11/08 - Right hip unstageable 10.5 x 9.0 x 1.0, 40% necrotic. -Left lower back unstageable 2.0 x 2.0, 100% necrotic. -Right iliac crest stage 2 and staged as 2.0 x 3.0, 80% necrotic. -Left knee unstageable 1.5 x 2.0, 100% necrotic. -Right knee unstageable 1.2 x 1.5cm., 100% necrotic. This review indicated that R14 developed a new pressure sore this week and there was no assessment for R14's left upper arm left hip or left shoulder. Review indicated that R14 developed 5 new pressure sores (coccyx, right iliac crest, right hip, right knee and left upper arm) between December 2007 and March 2008 when R14 was discharged from the facility. R14 also had pressure sores that worsened. The coccyx was never assessed or treated at all. According to the Wound Consultation Reports, (Procedure performed and signed by Z4) indicated the following : R14 had sharp debridement using debridement kit of the wounds down to subcutaneous tissue/full thickness (which required compression to control bleeding) 5 times and debridement with sterile gauze abrasion 3 times between 01/11/08 and 03/07/08. This was a total of 8 debridement procedures for R14 in 3 months. There were no consents for any of the procedures; there was no assessment of pain prior to or after any of the	F9999		

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F9999	Continued From page 174 procedures. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. On 04/09/08 at approximately 9:00am Z5 (family of R14) was interviewed regarding R14's pressure sores. Z5 stated she was not aware of the severity of R14's pressure sores and not aware of the one on R14's back stating "It was terrible"! Upon further interview Z5 denied ever giving consent for debridement and was not aware of it being done. R14 was discharged from the facility to local hospital on 03/11/08. R14 expired 3 days later (03/14/08) at local hospital with a diagnosis of "Sepsis multiple wounds." 7. R18 is a 54 year old resident with diagnoses including History of seizures, Status post CVA (cerebral vascular accident), Vent dependent and recieves all nutrition and hydration through a G-tube (gastrostomy). R18 requires total assist from staff in all areas of care. Review of R18's clinical record indicated R18's wound documentation was not comprehensive and did not consistently address all of the wounds. The resident's care plan did not identify and address the specific needs related to pressure sores for R18. Review of the treatment administration records (TAR) for 12/07 until current 04/07/08: - There was documentation of treatments being administered that were not on the physician orders;	F9999		

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F9999	Continued From page 175 According to the Wound Consultation Reports, Procedure (performed and signed by Z4) indicated the following : R18 had sharp debridement using debridement kit of the wounds down to subcutaneous tissue/full thickness (which required compression to control bleeding) 2 times and debridement with sterile gauze abrasion 3 times between 01/11/08 and 02/26/08. This was a total of 5 debridement procedures for R18 in 3 months. There were no consents for any of the procedures, and there was no assessment of pain prior to or after any of the procedures. In an interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. None of Z4's debridement procedures were countersigned or overseen by a physician. 8. R20 is a 40 year old resident with diagnoses including respiratory failure and Ventilator dependent. R20 receives all nutrition through a G-tube and requires total assist of staff in all areas of care. R20 was admitted to the facility on 02/23/08. Review of the resident's clinical record indicated R20's wound documentation was not comprehensive and did not consistently address all of the wounds. The resident's care plan did not identify and address the specific needs related to pressure sores for R20. Review of the treatment administration records (TAR) for 12/07 until discharge on 3/11/08:	F9999		

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F9999	Continued From page 176 - There was documentation of treatments being administered that were not on the physician orders; According to the Wound Consultation Reports, (Procedure performed and signed by Z4) indicated the following : R20 had debridement with mechanical abrasion 2 times between 02/08 and 03/08. There were no consents for any of the procedures; there was no assessment of pain prior to or after any of the procedures. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not assessed for pain. 9. R5 is a 76 year old resident with diagnoses that included Epilepsy, Polio, Left Side Paralysis, Dementia with Delusions and Vascular Dementia with Psychosis. The resident acquired 2 wounds in the facility (Left Ischium and Lower Back). Review of the resident's physician's orders indicated that there were no orders for treatment of pressure sores. Review of the Treatment Administration Record indicated that he was receiving treatment. There was no indication that there were any consents obtained for the procedures. There was no indication that any pain assessments were conducted prior to or after the debridement procedure. The resident's care plan did not identify and address the specific needs related to pressure sores for R5. Review of the Wound Consultation Reports indicated that R5 received debridement procedures on a regular basis. On interview, on 4/10/08, Z4 (Nurse Practitioner who did the debridement procedures) confirmed that he did not obtain consents and that the resident was not	F9999		

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F9999	Continued From page 177 assessed for pain. At the time of the survey, Z4 had not been certified to perform wound care debridement. Review of the Wound Consultation Reports completed by Z4 (Nurse Practitioner): - The Reports dated 1/11/08, 1/25/08, 2/8/08, 2/15/08, 2/19/08 and 2/22/08 all state, "All necrotic tissues removed, healthy tissues exposed from wounds with abrasion using 0.9 normal saline with Betadine (5cc Betadine to every 100cc saline)." - The treatment recommendations were all, "Cleanse wound well 0.5% Betadine Solution." "Cover wound with Duoderm or equivalent every 3 days and PRN (whenever necessary)." The report dated 1/11/08 was the exception - this report recommended cleansing with normal saline. - There were no consents for the procedure to remove tissue by debridement. - There were no pain assessments before or after the procedures. - The report dated 1/25/08 indicated that the lower back wound was at a Stage III and measured 1.0 X 2.0 X 0.1. The report also indicated that there were necrotic tissues that were removed. The next report was dated 2/8/08 and indicated that the wound was closed. Sevem days later on 2/15/08, the report indicated that there was again a Stage III, which measured 1.0 X 1.8 X 0.1 cm., that required debridement of necrotic tissues. When compared to the facility Pressure Ulcer Report, there was no documentation to indicate the presence of a lower back wound after 2/5/08. Review of the "Skin Condition and Pressure Ulcer Assessment Policy" provided by the facility	F9999		

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F9999	Continued From page 178 contains the following standards/guidelines: 1. A complete head to toe skin assesment will be completed at time of admission/readmission. Observation of any skin condition will be recorded on the Admission/Readmission Assessment. 2. Assess for history of prior ulcer and presence of current ulcer, previous treatments, or surgical interventions that increase risk. 3. A pressure risk assessment (braden) will be completed at the time of admission/readmission and weekly x 4 weeks. The braden will be updated quarterly and as neccessary. 4. The MDS Coordinator will be responsible for monitoring the 24 hour report and determine if criteria for a significant change (is met). Use pillows, blanket or sheets when positioning to prevent skin to skin and maintain body alignment. 5. Residents identified by the braden scale of being at risk for pressure ulcers will have interventions implemented based on the assessment of the resident's individual clinical condition and current status of skin condition. 6. Each resident will be observed for skin breakdown daily with special attention bony prominences during care and on the assigned bath day by the nurse assistant. 7. At least weekly all residents will have a head to toe skin assessment. findings will be documented on the facility approved form. if resident recieve shower, it will be necessary to have the resident stand or be returned to bed to	F9999		

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F9999	Continued From page 179 visualize the buttock area and groin. 8. Caregivers are responsible for promptly notifying the charge nurse of any new skin observations. 9. Nurse to have a sufficient supply of clean disposable gloves to perform assessmments on multiple areas prior to performing skin assessments. 10. Notify resident, and/or legal representative and attending at the earliest sign of a pressure ulcer or other skin problem. 11. Physician's ordered treatments shall be initialed by the staff on the Treatment administration record after each administration. 12. Dressings shall include the date and initials of the licensed nurse who performed the procedure.If dressings changes are ordered more than daily, the shift will also be noted on the dressing. Dressings will be checked daily for placement and cleanliness. 13. An individual wound asessment record will be initiated when a pressure and/or other ulcers are identified by licensed nurse. 14. Pressure and other ulcers will be measured at least weekly and recorded in centimeters on wound assessment record. 15. A separate wound assessment record for each identified ulcer will be completed. 16. Weekly measurements are not required for areas such as bruises rashes, skin tears,	F9999		

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F 000	INITIAL COMMENTS Complaint Investigation 0891838/ IL34671 - Licensure Findings. 0892499/IL35426 - No deficiency cited. An extended survey was conducted. The Regal Health and Rehabilitation Center is in compliance with 42 CFR Part 483, Requirements for Long Term Care facilities for this survey.	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS REPEAT TYPE "A" VIOLATION 300.1210a) 300.1210b)3) 300.1210b)5) 300.1220b)2) 300.3240a) 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 psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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	F9999		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(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 1 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by:	F9999		

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	145942	A. BUILDING _____ B. WING _____	C 06/03/2008

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F9999	Continued From page 2 Based on observation, staff interview, review of facility's documents and hospital record the facility failed to comply with its Plan of Correction from the 01/23/08 survey by failing to implement preventive measures to prevent presure sores, and failing to appropriately assess and care plan for pressure sores. The facility failed to provide the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for a resident (R5). The facility did not: 1) correctly assess the potential for further skin breakdown. 2) follow their Intensive Skin Care procedure/policy for a resident (R5) at risk for further skin breakdown. 3) monitor and document the status and progression of R5's wounds. 4). identify and address the rapid deterioration of R5 wounds. R5 developed gangrene of the right leg, and R5's leg was amputated above the right knee. R5 was observed on 05/29/08 at 9:50 am in another facility. Surveyor observed R5 was totally dependent on staff for activities of daily living. R5's diagnoses include dehydration, sepsis, uncontrolled hypertension, altered mental status, and multiple pressure sores. R5 was observed with a dressing on the sacral ulcer. The sacral ulcer dressing was removed. R5 was observed with a sacral pressure ulcer approximately 6 cm X 6 cm X 1/2 cm in depth. The sacral ulcer was observed to be beefy red tissue with a small amount sanguinous drainage. There was no odor. R5 was observed with a stage 4 sacral pressure sore. Surveyor also observed R5 had a	F9999		

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F9999	Continued From page 3 right above knee amputation. R5's wound line was observed to be clean and dry. Surveyor did not observe any pressure sores on the left leg. According to the most recent comprehensive resident assessment (Minimum Data Set) R5 has severely impaired cognitive skills for decision making. During interview with E1 (Director of Nursing) on 05/29/08 at 3:10 pm in the lower level conference room, E1 stated, "The treatment nurse does not work here anymore. The treatment was not documented. If it is not documented, it was not done. There is no identified assessment of the pressure sores on the right heel. The documentation is very poor. I don't have a assessment or care plan. She (R5) should not had a right above knee amputation. She did not have gangrene or infection of the ulcer." Surveyor asked where the documentation of the condition of the right and left legs and foot was. E1 stated, "I don't have the documentation." Review of the facility's weekly pressure ulcer report dated 11/02/07 through 02/05/08 identified, "(R5) had pressure sore to the right buttock stage 2." Further review of the weekly pressure ulcer report confirmed that there was no documentation of pressure sores on the right or left heel or leg. According to interview with E2 (Assistant Administrator) on 06/03/08 at 10:30 am per telephone, E2 stated, "that there was no continual nursing assessment of the wound care due to the resident's fragile condition. There was no documentation in the record indicating that the	F9999		

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F9999	Continued From page 4 physician was notified of (R5's) right leg pressure sore nor was a treatment plan initiated." Review of the treatment sheet dated 02/01/08 through 02/29/08 stated, "Apply 100% Betadine Solution to right leg after cleanse with normal saline solution and leave open to air dry daily. (R5's) wound care was discontinued on 02/15/08." Further review of the treatment sheets confirmed that there was no other documented treatment done for R5. Surveyor requested nursing assessments, nurses notes, treatment sheets and physician order sheets multiple times for the pressure ulcers (05/29/08, 06/02/08 and 06/03/08). Review of R5's physician order sheets dated 02/01/08 confirmed there was no pressure ulcer treatments. Review of the Nurses' Notes, Treatment Sheet and Facility Weekly Pressure Sore reports on 2/01/08, identified that there was no documentation of changes in R5's wound condition in the clinical record. The hospital Emergency Treatment Record documented that R5 was found with a Stage 2 Decubitus present on arrival to the hospital on the Buttock/Sacrum, also Eschar/Necrosis to both feet. The Interdisciplinary Plan of Care Notes from the hospital dated 02/24/08 stated,"(Z2) recommends right above knee amputation and	F9999		

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F9999	Continued From page 5 Debridement of Sacral decubitus." Review of the hospital record dated 03/05/08 stated, "There is a 6 X 5 cm black and brown necrotic ulcer on the heel with mummified skin. Another ulcer is on the lateral aspect of the foot and measures 8 X 2.5 cm. Just another ulcer is on the medial aspect of the dorsum and measure 8.5 X 4 cm., demonstrates yellowish-green base with oozing amorphous material and exposed portion of the tendon of the extensor of the big toe. In the distal third of the shin, right above the medial ankles, there is another 7.5 X 3.2 flat yellowish-gray ulcer. The skin of the plantar is sloughing and demonstrates yellowish, green and gray scales. Ulcer on the heel and Ulcer on the dorsum of the foot." Review of the Intensive Skin Care Procedure/Policy stated, "Our system of documentation is intended to demonstrate all actions take by the facility including notifications and reaction to treatments. Our system of documentation to track incidence of skin breakdown is as follows: 1. Direct caregiver will observe for any reddened, open areas and record these occurrences in the notebook at the station. Any new areas will be reported to the nurse immediately. 2. The on duty nurse will check this notebook daily and check skin condition of reported resident. Attending physician will be contacted for any orders. 3. Documentation of physician's orders and detailed description of area will be made on a treatment sheet and placed in treatment book. A brief entry will be entered in nurse's notes regarding contact of physician. 4. Documentation of initial treatment including but not limited to site,	F9999		

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F9999	Continued From page 6 stage, appearance, drainage odor, if applicable, surrounding tissue condition, response of resident to treatment will be by nurse. 5. Documentation of treatments given will e recorded and progress notes will be done weekly. These notes will indicate progress or lack of healing at least twice a month. 6. After four weeks of treatment, the attending physician will be contacted if no improvement is noted. 7. Nurse will do all treatment and documentation. Facility presented documents on 06-12-08 that were not part of the original closed medical record reviewed by surveyor. The documents contradict the original documentation reviewed in the record. (A)	F9999		