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	145937	A. BUILDING ______ B. WING ______	11/04/2010

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FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

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F 425	Continued From page 50 a PRN (as needed)[medication] for agitation, but no return call yet. 8pm entry showed Psych MD was paged again for PRN for agitation. R28's nurse's note of 9/3/10 at 1:40pm documented, "Patient has remained agitated all morning hitting and throwing items. 1:1 continued. Psych MD notified of R28's agitation and ordered Diazepam 5mg every 6 hours for agitation. 2pm entry documented, "Around 2pm he came out of his room yelling at staff." Social Work Services Note of 9/3/10 showed, R28 was moving things around and throwing things at roommate on 9/2, required constant 1:1. During breakfast R28 hit psych social director in the jaw. "R28's agrression came with no warning and stopped immediately after striking staff. R28 lacks communication and coping skills which may be required to maintain safety in the facility." Nurse's note of 9/3/10 at 3:30pm documented, R28 is being involuntarily discharged due to being agitated and combative. On 10/20/10 at 11am E2 (Director of Nursing-DON) stated, "As soon as we know about an admission, the hospital faxes the medication info for us to sent to the pharmacy. The pharmacy will then send the medications out. We will even make a midnight run to the pharmacy if we need to [in order to get the medications for the residents].	F 425		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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300.610c)2)
300.1210a)
300.1210b)3)
300.1210b)5)
300.1220b)1)2)3)
300.3240a)

Section 300.610 Resident Care Policies

c) These written policies shall include, at a minimum the following provisions:
2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing

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Continued From page 52

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:
1) Assigning and directing the activities of nursing service personnel.
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

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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. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observation, record review, and interview, the facility neglected to have a wound management system in place to ensure that nursing staff were knowledgeable in the prevention of pressure ulcers. The facility neglected to identify resident risk factors for skin breakdown. The facility neglected to systematically inspect the skin of a resident at risk for skin breakdown (R14). The facility neglected to re-assess a R14's risk for skin breakdown when R14 had a known decline in condition. The facility neglected to identify the R14's current skin condition and develop an individualized plan to prevent worsening. The facility had no policy for re-assessing resident risk factors when the resident experiences a change in condition. There was no evidence of oversight and supervision to ensure that the facility was implementing its policies and procedures for prevention and treatment of pressure ulcers.

R14 developed a stage III pressure ulcer to his sacrum. R14 developed a pressure ulcer to his

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right ear that was already at stage IV when first identified.

This applies to 1 of 5 residents with facility acquired pressure ulcers.

Findings include:

R14's October, 2010 Physician's Order Sheet shows R14's diagnoses include Neuropathy to the lower legs, Dementia, Parkinson's Disease, Osteoarthritis, and Anemia.

R14's Admission Nursing Assessment (Body Sheet) dated 2/19/10 shows no identified areas of breakdown on R14's skin.

R14's Minimum Data Set (MDS) reference assessment date of 5/28/10 (quarterly) documents that R14 had a short and long term memory problem. R14 had moderately impaired cognitive skills for daily decision making. The same assessment shows that R14 required extensive assistance of two persons for bed mobility and transfer. R14 required supervision and set up help for eating. R14 had range of motion limitations with partial loss of voluntary movement that affected his arm, hand, leg, and foot. R14 was incontinent of bowel and bladder. The assessment showed no weight loss or weight gain, and that R14 had one stage II pressure ulcer.

R14's Braden Scale for Predicting Pressure Sore Risk dated 6/3/10 (no further assessments after this date) showed a score of 19 (Not at risk). The same document shows that scores are 15-18 at risk, 13-14 moderate risk, 10-12 high risk, and 9 or below as very high risk.The same document

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F9999	Continued From page 55 shows; when other major risk factors are present (advanced age, fever, poor dietary intake of protein, etc...advance to the next level of risk.) R14's Nursing Note for 6/3/10 documented that R14 complained of sacral pain and the wound care nurse was notified. R14's Physician's Orders for 6/6/10 shows an order to "Discontinue check of coccyx daily." (No previous order to check the coccyx daily was documented.) On the same day an order for cleansing the coccyx with normal saline and pat dry, apply skin prep to peri wound (area surrounding wound) and cover with a Hydrocolloid dressing, change every 3 days and as needed. R14's same order sheet showed the following orders on 6/23/10 "continue Hydrocolloid to coccyx for 7 more days then discontinue." R14's Nursing Notes for 6/10/10 documents that R14 experienced a decline in condition. On 7/29/10, R14's Physician's Order Sheet shows to discontinue the treatments to R14's Coccyx. R14's Physician's Order for 8/18/10 showed the following orders; continue treatment to left knee, left shin treatment order and coccyx. A Physician's Order dated 9/29/10 documents treatment for R14's Sacrum as: Santyl (enzymatic debriding agent) and foam dressing daily. and TAO (triple antibiotic ointment) dressing to the right ear daily.	F9999		

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F9999	Continued From page 56 A Physician's Consult note dated 9/29/10 showed that R14 had a stage IV pressure ulcer to the right ear. The initial assessment of R14's ear was documented as a stage IV pressure ulcer. A Physician's Consult note dated 10/6/10 showed a stage III pressure ulcer to the upper sacrum. The initial staging and documentation of the wound showed a Stage III pressure ulcer. The next Consultation Note on 10/13/10 documented that R14's sacral ulcer was unstageable, and R14's ear wound was a stage IV. A Skin Check Sheet completed on 10/19/10 documented that R14 had only skin breakdown to the Sacrum. (There was no documentation regarding his ear.) R14 was not identified on the August, 2010 Weekly Pressure Ulcer Surveillance Report. The September, 8, 2010 report documented a resolved left knee ulcer, and a sacral ulcer that is 25% necrotic and 25% slough, with serous drainage. (devitalized tissue) The stage of the wound is not documented. The surveillance sheet dated 9/15/10 documented that R14 acquired the sacral wound in the hospital with an onset date of 9/16/10. (No documentation concerning a prior hospitalization was found in R14's medical records.) R14's Skin Risk Care Plan dated 9/3/09 shows the following: Potential for skin breakdown due to skin desensitized to pain/pressure/discomfort due to severe neuropathy in the lower extremities, compromised health and limited mobility. The goal is that R14 will have no skin breakdown through 9/3/10. The care plan does not address R14's gradual decline in condition beginning in	F9999		

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June, 2010. The care plan does not identify any current pressure areas that R14 has. The interventions include daily multivitamin (discontinued on Physician's Order sheet 9/20/10). The approaches also include to give R14 cues, supervision and set up with meals to assure good nutrition. (R14's MDS of 9/1/10 showed R14 required extensive assistance of 1 to eat). R14's weight record showed a weight of 171 pounds in February, 2010 (no reweigh done). R14 gradually lost weight each month until October, 2010. R14's weight was documented as 133 pounds in May 2010, and 109 pounds in October, 2010)

One, undated, daily skin check sheet was provided for R14 on 10/27/10.

On 10/21/10 at 10:00 AM, E2 (Director of Nursing) said that R14 had recently become hospice because he was weaker. E2 said that R14 was getting help to maintain his weight and nutritional status.

On 10/27/10 at 10:00 AM, R14 was observed with E7 Licensed Practical Nurse, and Z1. R14 was lying on his left side. R14 had an open area on the right, anterior aspect of the upper ear. R14 had a pressure ulcer on the sacrum. R14's appearance was cachetic. No pillow supports were used to position R14.

The facility failed to recognize the need to re-assess R14's risk for pressure ulcer development after R14 experienced a significant decline in condition. The facility failed to perform systematic skin inspections for R14 who was at risk for developing pressure sores. The facility failed to develop a plan of care that identified

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F9999	Continued From page 58 R14's current skin status and individualized approaches to prevent further pressure ulcer development and pressure ulcer worsening. The facility policy for Pressure Ulcer Prevention shows: Residents will be assessed to determine their risk factors for pressure ulcer development. The Guidelines include: All residents will be assessed to determine their risk factors for pressure ulcer development, upon admission and at least quarterly thereafter. The policy does not address re-assessment when the resident experiences a change in condition. Residents who are assessed as being at High Risk will have a plan of care that will include: A) Daily skin checks conducted by either the CNA (Certified Nursing Assistant) or the Licensed Nurse to ensure early identification of potential problem areas. B) Plan of care to address mobility status and ability to reposition self. C) Use of pressure reducing devices, such as pressure reducing mattresses, mattress overlays, wheel chair cushioning devices. E) Any other factor identified on the risk assessment including but not limited to nutritional support, positioning/ support devices, or medication review. 4. The resident's care plan will indicate the resident's the resident's risk factors and include	F9999		

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F9999	Continued From page 59 individualized interventions as needed for a comprehensive pressure ulcer prevention program. 5. All residents will have their skin checked and documented utilizing the CNA skin Attention Form. The facility policy for Pressure Ulcer Treatment and Management showed the following: 5. The clinical record will indicate whether the resident was admitted with a pressure ulcer or the ulcer was acquired in the facility. 6. The plan of care will include the presence of the pressure ulcer and include the individual description of the treatment plan including: pressure relief, turning and repositioning, addition nutritional measures, need for assistance with mobility, and range of motion. 8. Residents with pressure ulcers will be determined to be high risk for pressure ulcer prevention and all components of the High Risk protocol include: pressure relieving devices, nutritional support, assistance with mobility including repositioning and range of motion as outlined in the High Risk Protocol. (A)	F9999		