STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALDEN LONG GROVE REHAB &HC CTR	BOX 2308 RFD HICKS ROAD LONG GROVE, IL 60047

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F 441	Continued From page 28 plastic bag under R1's left foot and proceeded to cleanse wound and apply treatment and dressing. During daily status on 12/20/11, E2 (DON) verified a plastic bag is not an appropriate barrier. Facility's wound dressing change policy documents: Purpose: Non sterile dressings protect open wounds from contamination and absorb drainage. Policy: Designated staff member will use non sterile dressing technique for all dressing changes unless otherwise indicated by physician or manufacturer guidelines. Clean aseptic technique should be used. Procedure includes: -Prepare a clean, dry work area. - Place trash bag at the end of bed or within easy reach of working area. - Wash hands and apply gloves. - Prepare/open dressing items on work area. - Place the linen saver or towel under the resident. - Remove soiled dressing, place it in trash bag. - Remove gloves, wash hands and apply new gloves. - Pat the tissue surrounding the wound dry with a 4x4. - Discard gloves and all supplies in trash bag and remove equipment E11 did not follow the above wound dressing policy and procedure.	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations:	F9999		

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F9999	Continued From page 29	F9999		

300.1210a)
300.1210b)
300.1210c)
300.1210d)4)A)5)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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Continued From page 30

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on observation, interview and record review the facility failed to assess and to provide care to prevent the development of acquired

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pressure sores. This is for 3 of 5 residents (R4, R1, R6) reviewed for pressure sores in a sample of 30. This failure resulted in R1 and R4 developing pressure sores.

Findings Include:

1. Review Of R4's medical record, R4 was initially admitted to the facility in March 2011. At this time R4 was ambulatory and has no documentation of any pressure sores.

Interview with E10 (Registered Nurse) stated R4 fractured her hip while on leave at her sons home. 911 was called at that time and R4 sent to the hospital for a hip repair.

R4 was readmitted to the facility on 7/14/11. R4's initial nursing assessment dated 7/14/11 indicates R4 has redness of a callous on her right heel at this time. There are no preventative measures taken to prevent any further break down to R4's right heel until 9/26/11. On 9/26/11 there is a physicians order for bilateral heel protectors. On 9/29/11 R4 has an un-stageable pressure sore on her right heel. Since 9/29/11 R4 has had her right heel debrided at least once in December 2011.

On 12/19/11 R4's right heel was observed to have a stage 4 pressure sore.

2. R1 was readmitted to facility on 7/23/11 with diagnosis includes Dementia, Neuropathy and Anemia. At time of readmission R1's initial nursing assessment denotes R1 had no pressure ulcers at that time. R1's Braden Scale dated 8/12/11 assessed R1 as at moderate risk for pressure sores. R1 is assessed as incontinent

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F9999	Continued From page 32 of urine and requiring extensive assist by staff. Nurses notes dated 10/29/11 denotes R1 was found with "pressure ulcer to left heel #1 about 1.8 centimeters x 1.8 centimeters with dark brown discoloration, skin intact. #2 0.6 cm x 0.8 centimeters whitish discoloration. R1's physician was notified and order obtained R1 was assessed by wound doctor on 11/3/11. Documentation includes R1's wound to left heel measured 2 x 2, color black, eschar 100%. Dressing instructions include to clean with normal saline, apply Betadine and cover with foam. E3 stated on 12/21/11 R1 did not have two wounds found on 10/29/11, that when the wound doctor measured the left heel wound it was measured as only one to the left heel. 3. Review of "Comprehensive Pressure Ulcer Assessment" dated 8/25/2011 showed R6 is a 69 year old with diagnoses including restless leg syndrome, DJD(degenerative joint disease), depression, osteoporosis, and CHF (congestive heart failure). This assessment also showed that R6 has a stage 2 pressure ulcer on the right ischium. As indicated in this assessment, R6 is chair-fast and need physical assist for ADL (activities of daily living). Review of the pressure ulcer report dated 8/25/2011 showed that R6 has a stage 2 pressure ulcer on the right ischium. The pressure ulcer measured 1.5 cm in width, 0.5 cm in length and 0.1 cm in depth. There was also a minimum serosanguinous drainage of the wound.	F9999		

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E3 (Assistant Director of Nursing) stated on 12/21/201 at 1:15 P.M. stated that R6's stage 2 pressure ulcer on the right ischium was acquired at the facility. E3 also stated that this pressure ulcer had healed on 9/8/2011 however, it had reopened on 10/13/2011. E3 further stated that "(R6's) right ischium pressure ulcer had reopened because (R6) is always sitting on her wheelchair and scoots down a lot which causes too much friction."

Review of current POS (physician order sheet) showed that R6 has an order dated 12/6/2011 for " Right ischium cleanse with normal saline and apply DuoDerm patch every 3 days and if needed."

Review of pressure ulcer report dated 12/12/2011 showed that R6's reopened stage 2 pressure ulcer wound measures 0.5 cm in length, 0.5 cm in width and 0.1 cm in depth . The pressure ulcer has minimal serosanguinous drainage.

On 12/20/2011 at 1:40 P.M., E16 (Registered Nurse) was observed performing pressure sore treatment on R6's in R6's room. E17 (CNA-certified nurse assistant)) was in the room for standby assist. Observation showed that there was no dressing that was in place prior to E16 applying DuoDerm dressing. E17 confirmed that there was no dressing on R6's pressure ulcer when E17 gave R6 shower at 7:00 A.M. on 12/20/2011. E17 also stated that she did not inform E16 that there was no dressing because E16 was not aware that R6 was supposed to have a dressing on the pressure ulcer. E16

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stated that R6 was supposed to have the "DuoDerm dressing" , however, she was not aware that the dressing was off.

R6 stated on 12/20/2011 at 1:50 P.M. that her pressure ulcer hurts when she sits because the dressing was off and that the dressing serves as a pad and protection from her scooting down. R6 also stated that her DuoDerm has not been applied for 3- 5 days.

E17 stated on 12/20/2011 at around 3:30 P.M. that she replaced the R6's DuoDerm on 12/19/2011.

Review of TAR (Treatment administration record) showed that DuoDerm dressing was not signed by E17 to indicate that the DuoDerm was applied.
E17 stated on 12/21/2011 at 1:15 P.M. that R6 removes the DuoDerm herself. E17 also validated that she did not revise R6's plan of care for the pressure ulcer in order to address why R6 removes the DuoDerm.
(B)

Licensure Violations:

300.1210a)
300.1210b)5)
300.1210c)
300.1210d)3)6)
300.3240a)

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Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest

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practicable level of functioning.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 are not met as evidence by:

A. Based on observation, interview and record review the facility failed to ensure that R3 was transferred safely, and failed to adequately assess and care plan for transfers. These failures resulted in (R3) sustaining a severe comminuted humeral neck fracture. This is for 1 resident (R3) out of 7 reviewed for falls in

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F9999	Continued From page 37 the total sample of 30. The findings include: R3 is a severely cognitively impaired resident with multiple diagnoses including traumatic brain injury, right below the knee amputation (BKA) and dementia according to the Minimum Data Sets (MDS) dated 10/31/11. R3 is totally dependent on staff for all transfers and requires 2+ persons physical assist according to the MDS's dated 10/31/11, 8/1/11 and 5/2/11. R3 has a right BKA and a left foot drop, and is unable to flex and extend her left foot, according to the Functional Limitation in Range of Motion (ROM) Assessment completed by E5 (Restorative Nurse) and dated 10/31/11. Additionally, R3 has limitations in both shoulders, both elbows, both wrists, both hands, both knees and in her left hip according to the 10/31/11 ROM Assessment. R3 sustained a shoulder fracture according to an x-ray report dated 12/5/11. According to the facility's investigation, E7 (CNA) transferred R3 on 12/3/11 (7-3 shift) without assistance from another staff member and without a gait belt. On 12/3/11 E7 noted that R3's shoulder/upper arm was swollen but did not tell anyone according to documentation on the Injury of Unknown Origin Staff Interviews form and Occurrence report. R3's physician was not notified about R3's swollen shoulder/upper arm until 12/4/11 at 11:55 AM according to nursing note documentation. During an interview on 12/21/11 at 3:45 PM E7 (CNA) stated that on 12/3/11 (7-3 shift) she transferred R3 from the bed to the wheelchair without assistance from another staff member	F9999		

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F9999	Continued From page 38 and without using a gait belt. E7 stated that R3 could not bear weight at all. E7 said that she placed R3 on the side of the bed and placed the wheelchair next to the bed. E7 said that she transferred R3 by placing her arms under R3's arms and around R3's mid-back. E7 said that she then "scooped" R3 up from the bed and transferred her to the wheelchair. E7 said that she had transferred R3 this way before without any problems. There was no assessment and no care plan regarding how R3 was to be safely transferred according to review of the record. On 12/14/11 at 12:10 PM E5 (Restorative Nurse) confirmed that there was no assessment or care plan developed for R3's transfers. E5 said that prior to the fracture R3 needed a mechanical lift for transfers because she couldn't bear weight. At 12:30 PM E5 retracted her statement and said that R3 did not need a mechanical lift prior to the fracture, but needed to be transferred using a gait belt and 2 - 3 assist. On 12/14/11 at 2:35 PM E2 (Director of Nursing) also confirmed that there was no care plan that addressed how R3 was to be transferred, prior to R3's fracture. R3 was in bed on 12/14/11 at 9:20 AM. R3 had extensive bruising on her left shoulder, left upper arm and left chest/breast area, adjacent to her underarm. R3's upper arm appeared swollen and tight. R3 smiled and rattled the right bed rail with her right hand when her name was called, but was otherwise unable to communicate. R3 was in bed on 12/20/11 at 10:30 AM. R3's left foot was noted in a fixed extended position. (B)	F9999		