| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **WOODBRIDGE NURSING PAVILION** | **2242 NORTH KEDZIE CHICAGO, IL 60647** |

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| F 441 | Continued From page 26<br>Clean hands, place tied bag into a red bag and dispose of in a biohazard receptacle." | F 441 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210c)<br>300.1210d)2)3)5)<br>300.1220b)2)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | F9999 | | |

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| F9999 | Continued From page 27<br>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)<br>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:<br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br>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:<br>2) All treatments and procedures shall be administered as ordered by the physician.<br>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 | F9999 | | |

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| F9999 | Continued From page 28<br>made by nursing staff and recorded in the resident's medical record.<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>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.<br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as | F9999 | | |

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indicated by the resident's condition. The plan shall be reviewed at least every three months

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on observation, interview and record review the facility failed to accurately assess, document and identify pressure ulcers; the facility also failed to implement preventative and healing interventions to prevent the development of new pressure ulcers and promote the healing of new pressure ulcers for 3 (R1, R3, and R5) of 5 residents reviewed for pressure ulcers in a sample of 30. This deficient practice resulted in R3 developing eschar to the right heel which then became a Stage III pressure ulcer that increased in size and also developed another Stage II pressure ulcer to the left upper buttock. R5 has a facility acquired Stage IV right heel wound, a facility acquired left buttocks abscess and a Stage IV sacral wound.

1) R3 is a 93 year old resident with diagnoses to include Diabetes, Dementia, and a Stage 3 Pressure Ulcer to the right heel per the January 2013 Physician Order Sheets. R3 had a hospital admission for a urinary tract infection 11/30/12, returning to the facility on 12/7/12. A Laboratory Report, 10/26/12, documents a Albumin of 3.1 (Normal 3.4-4.8) and a protein of 5.5 (normal 5.6-8.3). The Laboratory Report, 12/19/12,

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documents R3 as having heavy growth of Mecillinam Resistant Staphylococcal Aureus, moderate growth of Escherichia Coli and heavy growth of Streptococcus Pyogenes and was placed in contact isolation.

The first documentation of R3's pressure ulcer to the right heel was in Nurse's Notes, 10/24/12, which noted eschar tissue to the right heel measuring 3.0 by 3.0 centimeters. R3's Comprehensive Skin Assessment, 10/24/12, documents no risk factors (this section was blank) and the development of a new site to right heel. The original Miscellaneous Weekly Skin Care Documentation Flow Sheet, provided by E5 (Treatment Nurse), documented no measurements or assessment information from 10/24/12 through 11/8/12. On 1/25/13 at 12:25 p.m., E5 stated, "I couldn't find the original form, so I amended this one." E5 then provided an amended copy of the Comprehensive Skin Assessment documenting on 11/2/12 the lesion to the right heel measuring 3.0 by 3.0 centimeters.

The Wound Care Specialist Initial Evaluation, completed by Z1, 11/6/12, documents R3 with a "unstageable (due to necrosis) of the right heel." The Etiology documents the wound acquired from pressure measuring 3.0 by 3.0 centimeters. On 12/18/12, the wound care physician signed off the case and the podiatrist was consulted. The only podiatrist evaluation, 12/13/12, documents a stage 3 pressure ulcer to the right heel.

The Interdisciplinary Care Plan, 9/7/12, documents R3 has an alteration in skin integrity related to Dementia, Incontinence, Decreased

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| F9999 | Continued From page 31<br>Sensory Perception, Diabetes and Comorbidities. Interventions include skin care to be checked during showers and routine care, heel protectors, dietary consult as needed, and nutritional supplements per dietitian recommendations. The Braden Scale, 9/17/12 and 12/7/12, documents R3 is at mild risk for the development of pressure ulcers. The facility was unable to provide documentation of skin care being checked per the care plan interventions.<br><br>On 1/23/13, between 11:30am and 12:50pm, observations were made at 15 minutes intervals of R3 in his bedroom without heel protector boots on. On 1/23/13 at 12:50pm, E19 (nursing assistant) stated, "(R3) is suppose to have on heel protectors. I threw away the dirty ones when I showered R3. I am waiting for the new ones to come up. I will call down." E19 was then observed making a call to obtain the heel protectors. On 1/25/13, at 10:35 a.m., E2 (Director of Nursing) stated heel protectors are available on all units in the storage closets or in the Restorative Office. E2 also stated the staff have access to the heel protectors and they may need some training.<br><br>The Physician Order Sheets, January 21, 2013, document R3 is to "have heel protector boots AT ALL TIMES." There are no orders in the Physician Order Sheets from 1/1/13 through 1/23/13 for dietary supplements. On 1/24/13 supplement orders were obtained from the physician.<br><br>The Miscellaneous Weekly Skin Care Documentation Flow Sheet documents the wound as follows: | F9999 | | |

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| F9999 | Continued From page 32<br>11/2/12- 3.0 by 3.0 centimeters of necrotic tissue to the right heel pressure ulcer.<br>11/9/12- 3.0 by 3.0 centimeters of necrotic eschar tissue to the right heel pressure ulcer.<br>11/16/12- 2.7 by 3.0 of 30% necrotic tissue, 10% slough to the right heel pressure ulcer.<br>11/30/12- R3 was in the hospital.<br>12/7/12- Upon return from he hospital R3's pressure ulcer to the left heal measured 2.8 by 4.5 centimeters with 20% necrotic tissue, 20% slough.<br>12/14/12- 3.0 by 5.0 centimeters with 10% necrotic tissue to the right heel pressure ulcer.<br>12/21/12- 3.1 by 5.0 centimeters, with 10% necrotic tissue to the right heel pressure ulcer.<br>12/28/12- 3.2 by 5.0 centimeters with 10% necrotic tissue to the right heel pressure ulcer.<br>1/4/13 3.4 by 5.0 centimeters the right heel pressure ulcer.<br>1/11/13- 3.6 by 5.0 centimeters to the right heel pressure ulcer.<br>1/18/13- 3.2 by 4.3 centimeters to the right heel pressure ulcer.<br><br>The Quarterly Nutrition Progress Note, 10/1/12, documents R3's skin condition as intact The Nutritional Progress Notes, 12/10/12, documents R3 has no skin breakdown The Nutritional Progress Note, 1/22/13, documents a stage 2 area to the left upper buttock with recommendations to add supplements. There is no documentation by the dietitian of the stage 3 pressure ulcer to the right heel, only the left buttock. On 1/24/13, E16 (Dietitian), stated she documents on every pressure ulcer monthly and receives a weekly skin care report. E16 stated the first note on any pressure ulcers was the 1/22/13 note. E16 further stated, "I would have | F9999 | | |

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started (R3) on a protein supplement had I seen there was a stage 3 pressure ulcer, even without a low protein and albumin level, to promote wound heeling. The recommendations made 1/22/13 provides an additional 30 grams of protein." On 1/24/12 at 11:35 a.m., E2 (Director of Nursing) stated, the dietician is notified weekly of pressure ulcers.

On 1/23/12 at 11:20 a.m., E5 stated R3's only pressure ulcer was to the right heel. R3's Comprehensive Skin Assessment, 1/19/13, documents the development of a new pressure ulcer, stage 2, to the left upper buttock area measuring 1.2 by 0.9 centimeters.

On 1/25/13 at 11:30 a.m., Z1(wound physician) was interviewed by phone and indicated he was out of town and without access to documentation he was unable to provide responses to questions regarding the care of R3.

The facility policy, 8/11, Pressure Ulcer Prevention/Skin Care, documents 3. Protocol for prevention of pressure ulcers guidelines will be followed for all at-risk residents (moderate, high or severe). Moderate Risk, 1. Quarterly review of nutritional status and more frequently if indicated and 3. Nutritional supplement as indicated per recommendation of dietician and physician's orders.

2. On 1/22/12 at 10:00 a.m. the facility provided a copy of the facility ' s current pressure ulcer report. R1 was not listed on the report. On 1/23/13 at 10:15 a.m., E5 (Wound Care Nurse/Licensed Practical Nurse, LPN) was asked if R1 has any pressure ulcers? E5 stated that R1

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does not have any pressure ulcers. R1 was lying in bed. Visualization of R1 ' s buttocks revealed two pressures ulcers to the right buttock. The wounds with opened, and the wound bed was reddened. R1 ' s peri-wound (surrounding tissue) was macerated. Located over the bottom most ulcer was a hydrocolloid dressing that was rolled up and peeling at the edges. E5 stated " Oh this is new, it wasn't ' t there before. " E5 stated she had worked the previous day (1/21/13) and R1 did not have a pressure ulcer. R1 ' s Physician ' s Order Sheet for January 2013 documents that R1 had a wound on the upper coccyx (tail bone), which was healed on 1/14/13. There was no documentation in R1 ' s medical record related to the two wounds on R1 ' s right buttock. There were no treatment orders located in R1 ' s medical records for the pressure ulcers. E5 stated that the facility ' s policy is for nurses to notify the physician immediately and obtain wound care orders. E5 stated " I will call the doctor and get an order. " E5 then stated she will measure the wounds. With assistance from E7 (Certified Nursing Assistant, C.N.A), E5 measured the wounds and stated the measurements are as follows: Upper most wound 0.2 X 0.1cm; lower most wound 2.2 X 1.3cm. E5 stated " the night nurse is still here, maybe she put it (hydrocolloid dressing) there. "

At 10:25 a.m., E6 (Registered Nurse, RN) was sitting at the desk. E6 stated that she worked with R1 on the night shift (1/22/13). E6 stated that R1 does not have any pressure ulcers.

At 11:00 a.m., E5 returned with a typed document stating these are the physician ' s notes. E5 now states, " I forgot, we noticed it yesterday " . E5

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refused to give the surveyor the documentation and stated " this is mine, I will get you one " . E5 was asked to provide the nursing (wound care) documentation, the original physician ' s documentation and physician ' s orders for the pressure ulcers. E5 stated there was no nursing documentation or physicians ' orders. E5 stated she doesn't ' t have access to the computer, and would not provide the information.

On 1/24/13 at 9:15 a.m., there was still no documentation in R1 ' s medical records related to the 2 pressure ulcers. There were no documented physician ' s orders as well. The latest wound care plan located in R1 ' s medical record was for Nov/2012. E5 stated " I ' m going to write the order. " E5 then stated she didn't ' t have time to complete the wound care documentation. E5 then documented a physician ' s order (on 1/24/13), dated the order 1/23/13 and wrote that it was ordered on 1/22/13.

On 1/29/13 at 11:52 a.m., R1 ' s care plan still had not reflected the wound that was healed on 1/14/13 or the new wound currently being treated. E5 stated she had not had a chance to document on either incident.
On 1/30/13 at 9:50 a.m., R1 ' s care plan was still not updated. E5 again stated she has not had time to update the care plan. Z1 was informed at 9:53 a.m. and stated " she has not done it, and she is going to do it. "

3. Minimum Data Set (MDS) for R5 dated 11/6/12 shows an 83 year old resident at high risk for pressure sore requiring total staff assist for transfer and extensive assist for bed mobility. Weekly Wound report dated 1/11/13 reveals R5

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has a facility acquired Stage IV right heel wound, a facility acquired left buttocks abscess and a Stage IV sacral wound. The Physician's Order Sheet (POS) dated 1/1/13 through 1/31/13 states R5's heels are to be uploaded off the mattress. Review of R5's clinical record reveals no Care Plan for alteration in skin integrity.

During the initial tour of the facility on 1/22/13 at approximately 10:00 a.m., R5 was observed in her room, lying supine in a low bed under the covers, awake, alert and oriented, complaining of not wanting to be in the facility. R5's bilateral heel were in direct contact with the mattress. R5 stated she does not want to get out of bed today. There was a urinary catheter in place. At 2:30 p.m., R5 was observed in the dining room, sitting in a wheelchair with a sad look on her face.

On 1/23/13 at approximately 11:30 a.m., R5 was in her wheelchair in her room. E5 (Treatment Nurse) was present and was asked by surveyor to assess R5's right heel wound. R5's sock was removed and there was no dressing on the right heel. E5 proceeded to conduct wound assessment of the right heel and stated the wound is open and healing. E5 stated she will apply a collagen dressing and contact the physician for a change in treatment order. E5 applied collagen and optifoam dressing and covered right heel wound with border gauze. E5 was asked to provide the current treatment administration record (TAR) for R5 but was unable to locate it. R5 was transferred to the dining room for lunch. On 1/24/13 at approximately 10:00 a.m., E2 (Director of Nursing-DON) provided survey team with a current treatment order for treatment to the right

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| F9999 | Continued From page 37<br>heel every three days. Neither E1 (Administrator) nor E2 (DON) were able to explain why treatment order was not available nor accessible on the previous day.<br><br>On 1/23/13 at 1:25 p.m., R5 was observed being transferred from wheelchair to bed with 2 person physical assist. R5 was being assisted by E13 (Certified Nurses Aid-CNA) and E14 (CNA). R5 was moaning and complaining of "my butt hurts terribly". Once in bed, E13 and E14 proceeded to provide incontinent care for R5. There was an undated dressing on R5's sacral area. The dressing was soiled and of poor integrity. E13 and E14 completed the incontinent care, failing to apply protective barrier cream to R5's perineum. R5 was placed on multiple layers of linen, a draw sheet folded in four under the incontinent pad. E13 stated R5 usually has draw sheet and incontinent pad on her bed. R5 was made comfortable in bed, E13 and E14 left the room. R5's heel were not off loaded.<br><br>Facility Pressure Ulcer policy dated 8/11 states all residents at risk for pressure sore should have moisture barrier cream applied as needed. On 1/25/13 at approximately 10:30 a.m., E2 presented survey team with hand written care plans for pressure sore for R5. E2 had no explanation as to why the care plan was not available in the clinical record on 1/22/13 through 1/24/13. (B) | F9999 | | |