STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146130	A. BUILDING _____ B. WING _____	11/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RETIREMENT VILLAGE	1740 NORTH CIRCUIT DRIVE ROUND LAKE BEACH, IL 60073

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F9999	FINAL OBSERVATIONS Statement of Licensure Violations: 300.1210a) 300.1210d)5) 300.1220b)3 300.3240a) 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) 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: 5) A regular program to prevent and treat	F9999		

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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:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

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Based on observation, interview and record review, the facility failed to analyze and identify the causal factors placing R4 at risk for the development of a pressure ulcer, failed to develop a plan of care addressing pressure sore prevention; implement relevant and individualized interventions in order to promote healing and failed to identify R4 ' s pressure ulcer Stage correctly.
This applies to two of four residents (R4 and R7) in the sample of 24 residents reviewed for pressure sores.
These failures contributed to the development of R4's avoidable, unstageable pressure ulcer on the right lateral ankle (malleolus).
The findings include:
1. On 11-06-13 at 11:50 AM, R4 was in the dining room sitting in a wheelchair with off-loading device (bunny boot) on the left foot. None was noted on the right foot.
On 11-06-13 at 11:50 AM, E15 (Certified Nursing Assistant) said R4 needs extensive assistance from staff in all of her activities of daily living. She needs (R4) a sit to stand transfer. She does not walk anymore. She usually gets up at 7:15AM and goes back to bed after lunch around 1:30 PM. She cannot reposition herself.
On 11-07-13 at 11:25 AM, the Treatment Nurse/E3 stated R4 used to walk, then she had a fall on 09-07-13. Her legs become swollen and unable to walk after that. It was on 10-07-13 when they initially found the pressure ulcer on her right lateral ankle. It was a 95% blackened area when found. It was already necrotic. It was due to pressure and immobility. R4 is confused and needs total assistance with her activities of daily living and in turning and repositioning. "

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R4's wound care specialist initial evaluation dated 10-11-13, under additional information (page 2 of 2) reads: per nursing staff, patient(R4) fell and had ankle pain but no fracture on x-ray since then patient has been in bed more ...
R4 ' s (initial) wound-weekly observation tool dated 10-08-13 showed: Instructions: Use the following definitions for staging of pressure ulcers:
Suspected Deep Tissue Injury- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
Unstageable - A full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
(B) Observation/Data: (1) Location Right lateral ankle (2 b) Date acquired- 10-08-13 (3 a) Type- Pressure (4) Pressure ulcer stage: (4 a) Original -Suspected Deep Tissue Injury (SDTI) (4 b) Current- Suspected Deep Tissue Injury.
(5) Visible Tissue: (5 e) Necrotic tissue present (brown, black, leathery, scab-like) (5 i) 100% necrotic tissue.
(8) Wound Measurements 0.6 cm X 0.8 cm.
The facility identified R4's pressure ulcer as "SDTI" (wound weekly observation tool page 2 of;section 4 (4a) (4b). Based on this assessment tool R4 pressure ulcer should be staged as unstageable not Suspected Deep Tissue Injury.

The wound assessment flow sheet showed on 10-18-13, R4's pressure ulcer was measured at 1.0 cm X 1.0 cm and described with 75%- black necrotic and with 25% slough - identified as

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Stage IV. This documentation also showed a treatment order for Collagenase with foam dressing since 10-14-15 up to the present.

On 11-07-13 at 2:25 PM, during treatment observation E3 identified and described R4's wound as located on the right lateral ankle (malleolus), acquired in the facility, covered with yellow slough of around 90%, Stage IV and the measurements are 0.6 cm X 0.8 cm. "
According to National Pressure Ulcer Advisory Panel (NPUAP) and the Wound, Ostomy and Continence Nursing Society R4's pressure ulcer is "unstageable."
The NPUAP Pressure Ulcer Stages/categories define unstageable pressure ulcers as full thickness tissue loss in which actual depth of the ulcer is completely obscure by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
The Wound, Ostomy and Continence Nursing Society define Unstageable as Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
On 11-07-13 at 12:00 PM, E3 presented R4's most current Braden Scale for Predicting Pressure Sore Risk Assessment dated 08-13-13. This assessment showed a score of 18 (mild risk per Braden score scale). E3 stated there was no preventative skin plan of care. E3 claimed, R4 is not high risk for pressure ulcers and that ' s why there's no care plan developed.
R4's care plan interventions dated 10-08-13 was not individualized based on the identified problem and needs of R4 and there was no revision done.
The following are the interventions listed:
The resident requires the bed as flat as possible

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to reduce shear ...Assess/record/monitor wound healing ...Avoid positioning the resident on right ankle, right side. Cleanse ...wound with NSS and apply foam dressing ...educate resident ...as to cause of skin breakdown ... and Follow facility policies/protocols for the prevention/treatment ... On 11-07-13 at 1:00 PM, E3 was unable to provide documentation the facility analyzed R4 ' s risk factors for the development of pressure ulcers. E3 said they use the Braden Scale for Predicting Pressure Sore Risk Assessment. The weekly wound assessment flow sheet- where measurements are written, the weekly observation tool, the treatment administration record and the care plan and the doctor's notes are the only documentation.

2. On 11/05/2013 at 12:12 pm E14 (Certified Nurse Aide) provided incontinence care for R7. There was a dressing on R7's sacral area. E14 stated it was applied that morning. E14 also stated R7 had diarrhea last week and that is why she needed a dressing on her sacrum.

On 11/07/2013 at 10:00 am E3(Treatment Nurse) stated R7 has redness on her bottom with a dressing covering it.

On 11/07/2013 at 1:48 pm E3 did dressing change on R7's sacrum. E3 stated R7 developed excoriation on 11/05/2013, and also had flu last week. There was no dressing on R7's sacrum when the adult incontinence briefs were removed. E3 measured R7's sore on her sacrum and described area as 2.2 cm x 1.1 cm, stage 3 as granulation tissue is yellow and 40% non-viable tissue and it is a pressure sore.

On 11/07/2013 at 2:10 pm E3 stated wound

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F9999	Continued From page 29 doctor was phoned and received an order for change of treatment, Santyl and foam dressing. R7's Braden Scale for predicting Pressure Sore Risk dated 08/30/2013 shows score of '11.' R7's Progress Note dated 11/05/2013 16:00 hours showed "Resident noted with redness to sacrum with excoriation to area present, resident is up for meals only and to be repositioned every 2 hours by staff. Will continue daily skin assessment to area and treat every shift. To apply Moisture Barrier Cream after each incontinent episode at this time." The facility did not conduct an evaluation of R7's tissue tolerance to determine an individualized repositioning schedule. The facility also did not conduct a comprehensive evaluation of R7's pressure sore risk factors to show if R7's pressure sore was unavoidable. There was no nursing plan of care for R7's pressure ulcer. (B)	F9999		