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F 518	Continued From page 42 evacuation of residents to a safe area within the facility. E13, Licensed Practical Nurse on 12-12-13 at 10:30 A. M. stated that she had not been to any training of the use of fire extinguishers in a few years. According to the facility's Centers for Medicare and Medicaid Services, CMS 672, "Resident Census and Conditions of Residents" dated 12-10-13, 74 residents resides at the facility.	F 518		
F9999	FINAL OBSERVATIONS STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating	F9999		

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F9999	Continued From page 43 the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies 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. 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.	F9999		

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F9999	Continued From page 44 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. 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. 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.	F9999		

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F9999	Continued From page 45 These requirements are not met as evidenced by: Based on observation, record review and interview, the facility failed to follow operational policies and procedures for pressure ulcer care and failed to utilize the required pressure ulcer prevention interventions identified in the Plan of Care, for two of eight residents (R6, R8) reviewed for pressure ulcers, in a sample of 15. This failure resulted in R8's right heel ulcer to increase in size and R8 developing three new Stage II pressure ulcers on the coccyx and gluteus. This failure also resulted in R6 developing multiple (6) new Stage II pressure ulcers to her right posterior thigh. Findings include: 1. A Physician's Order Sheet, dated 12/01/13, documents R8 has the diagnoses of Peripheral Vascular Disease, Diabetes Mellitus, and Venous Insufficiency. The only skin treatment documented on the 12/01/13 Physician's Order Sheet, is for Hydrogel AG and Collagen treatment to the back of the right heel. The most current Braden Assessment (used to identify resident risk of pressure ulcer development) was dated 7/02/13 and identified R8 as being at Moderate Risk for skin breakdown. A Quarterly Dietary Note, dated 10/24/13, indicates R8's meal intake as typically being below 75% and as experiencing a steady weight loss of 9 pounds over the previous three months (leaving R8 at 237.2 pounds and above the Ideal Body Weight). The 10/24/13 Quarterly Dietary Note advises staff to monitor R8's oral intake and skin. R8's most current Plan of Care was last updated on 3/01/13	F9999		

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and identifies R8 as having "Actual Skin Breakdown." The Pressure Ulcer Prevention Interventions identified on the 3/01/13 Plan of Care, instruct staff to: Turn and reposition at least every two hours, position with pads and pillows to alleviate pressure, inspect skin integrity every day and report concerns, and use a low airloss mattress overlay on bed. A Minimum Data Set, dated 10/18/13, indicates R8 is cognitively intact, without memory impairment, and totally dependent on staff for Activities of Daily Living and transfers.

Skin Integrity Reports dated back to 12/14/12, indicate R8 has a chronic 1.0 cm (centimeters) by 2.0 cm, right heel wound, identified as a "Stasis Ulcer", which developed 11/27/12. Skin Integrity Reports document weekly monitoring of R8's right heel wound, documenting the size of the wound, presence of wound drainage, and current treatment. R8's wound measurements obtained on 5/17/13, failed to indicate the size of R8's right heel wound, and simply documented the wound as "better." R8's wound was not assessed again until 7/19/13, in which the right heel wound is again documented as "better" and without measurement. The Skin Integrity Report does not identify a measurement of R8's right heel wound, until 8/09/13, when it increased in size to 6.1 cm by 2.6 cm by 0.3 cm. The facility failed to document any further wound assessments for R8, until 10/25/13, in which R8's right heel wound measured 1.9 cm by 1.5 cm by 0.1 cm. The Skin Integrity Reports, dated 11/08/13, 11/15/13 and 11/25/13 have R8's right heel wound is listed as "improved" at 2.0 cm by 2.0 cm by 0.1 cm (on each date). The facility had no further wound assessments documented in the Skin Integrity Report or Nursing Notes, for R8, after 11/25/13.

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On 12/11/13, at 8:52 a.m., R8 was lying supine in bed with the head of the bed elevated. R8 was lying on a basic mattress and a low airloss mattress overlay was lying on the floor rolled up at the foot of R8's bed. R8's heels were directly on the bed and a pair of padded boots were sitting on the nightstand. At that time, R8 stated (R8) had been sitting in the bed in that position since breakfast, which was served around 8:00 a.m. At 10:08 a.m., R8 was in the same position when E6 (Certified Nursing Assistant) and E7 (Certified Nursing Assistant) entered the room to get R8 dressed for the day and provide incontinence care. E6 removed R8's incontinence brief, which was saturated with urine. R8 was then positioned, by E6 and E7, onto the right side. R8's coccyx was purplish/red with a open wound at the location of the tailbone, which was actively bleeding. R8's right and left buttocks, near the gluteal folds, had large purplish/red areas with evidence of skin being broken open, which were actively seeping clear fluid. At 10:13 a.m., E6 stated R8's bottom "looked similar" on the previous day and noted that R8's gluteal folds were red, but E6 stated (E6) did not fully assess the skin, because (E6) "didn't want to remove all of the barrier cream" from R8's buttocks. E6 stated (E6) did not report to the nurse, on the prior day, the condition of R8's buttocks. E6 summoned E8 (Licensed Practical Nurse) to evaluate R8's buttocks. At 10:38 a.m., E8 looked at R8's buttocks and stated, "(R8's) bottom has been like this for a while." E8 instructed E6 to finish incontinence care so E8 could do R8's wound treatments. E8 stated R8 has been receiving Zinc Oxide to the buttocks "for some time" and Hydrogel dressing to the coccyx for a "couple of weeks."

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On 12/11/13, at 11:10 a.m., E8 applied a Hydrogel dressing to R8's coccyx wound and covered the wound with a foam dressing. E8 then applied Zinc Oxide to the entire right and left buttock. E8 removed R8's right heel dressing. R8's right heel had a large, red open area located at the point where the heel would rest on the bed. At that time, E8 indicated R8's right heel wound "looked better." E8 applied Optifoam AG to R8's right heel and covered the wound with a dressing. At 11:32 a.m., R8 was transferred by E8 and E6, via mechanical lift, to a high back wheelchair and R8 was wheeled by E6 to the dining room. A protective boot was left laying on R8's dresser and not utilized.

On 12/11/13, at 1:45 p.m., E3 confirmed that the air mattress, which was rolled up on the floor at the foot of R8's bed, was to be utilized as a pressure ulcer prevention measure. E3 also stated, the protective boot which was lying on R8's dresser, was initiated by the Wound Clinic (date unknown) and R8 was to wear the boot on the right heel to help alleviate pressure when up in the wheelchair.

Observation of R8 was made from 11:32 a.m. to 3:30 p.m., at every 15 minute intervals, and R8 remained sitting upright in the wheelchair, directly on the buttock, without evidence of pressure relief and repositioning. At 2:00 p.m., E3 placed the protective boot on R8's right foot. At 3:28 p.m., R8 indicated (R8) had been in the same position in the wheelchair since going to the dining room for lunch and no one had offered to reposition (R8) or offer to lay (R8) down.

Further review of the 12/01/13 Physician's Order

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Sheet and recent Telephone Orders, revealed there are no current physician ordered treatments for R8's coccyx pressure ulcer or the pressure ulcers on the gluteal folds. The Treatment Record indicates R8 has been sporadically receiving Zinc Oxide on the scrotal area and buttock, for "redness" since 11/01/13 and a treatment of Hydrogel Ointment covered with non-stick gauze and non-bordered foam to the coccyx wound since 11/27/13. However, documentation indicates the Hydrogel Ointment treatment to the coccyx was only completed on 11/27/13, 11/28/13, 11/29/13, 12/02/13, 12/03/13, 12/04/13, and 12/06/13 through 12/10/13 (indicating that the treatment was missed on a total of three days in that time frame).

On 12/11/13, at 12:30 p.m., E3 (Wound Nurse/Licensed Practical Nurse) stated (E3) took over wound monitoring in October 2013. E3 confirmed that there were multiple weeks between 5/2013 and 10/2013, in which R8's right heel ulcer was not assessed at all or inappropriately assessed, due to a lack of wound measurement. E3 stated that the most current wound assessments for R8 are those that were completed on 11/25/13 of the right heel ulcer, indicating that (E3) "has either been ill or working the floor" and has not had the time to do the weekly wound monitoring. E3 was unaware of the development of any new pressure ulcers on R8's bottom and was unaware of any treatments that were being provided by staff. E3 stated nursing staff are responsible to call the physician as soon as possible with the onset of new pressure ulcers and obtain treatment orders. E3 was unable to locate any documentation in R8's medical record to support that the physician was notified of the development of the coccyx wound

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or wounds on the gluteal folds.

A "Stop and Watch" note was located in R8's medical record, dated 11/19/13. The "Stop and Watch" note documents E8 was notified R8's buttocks was "red with open areas" and E8 implemented the use of Zinc Oxide on the buttocks as a nursing measure. On 12/11/13, at 3:10 p.m., E8 stated (E8) did observed R8's buttocks to be red with open areas on 11/19/13 and "thought" the physician was notified of R8's newly identified wounds, but did not document the physician notification in the chart. E8 stated the Zinc Oxide was initiated as a nursing measure, for which they have a standing order from the physician. E8 stated the wounds on R8's buttocks were not measured at that time and no notification was made to E3 (Wound Nurse).

E3 did obtain measurements of R8's pressure ulcers and right heel wound on 12/11/13. E3 stated (E3) identified a total of three Stage II wounds on R8, one on the coccyx (3.5 cm by 1.5 cm by 0.1 cm), one on the left buttock (1.0 cm by 1.0 cm), and one on the right buttock (0.5 cm by 0.5 cm). E3 measured R8's right heel wound as 4.5 cm by 4.0 cm by 0.1 cm, on 12/11/13, indicating the wound has increased in size since the last measurement of 2.0 cm by 2.0 cm by 0.1 cm on 11/25/13. Nursing notes, dated 12/12/13 at 7:00 a.m., indicate the physician was still unaware of the development of R8's new pressure ulcers and the changes observed in the size of R8's right heel, as the facility was "awaiting a return call."

2. R6's Physician Order Sheet (POS) dated December 2013 documents the following diagnoses: Jacksonian Disorder, Diabetes,

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Diabetic Neuropathy, Obesity, Non-Compliance with Medication and History of Abcess of Buttocks. The same POS documents a wound treatment of: Clean wound with wound cleanser, apply Hydrogel Alginate, then apply collagen gauze and cover with foam border dressing once a day. The Minimum Data Set dated 11/22/13 documents R6 as cognitively intact. R6's Treatment Administration Record (TAR) dated November 2013 documents a treatment to R6's posterior right thigh to be done on the facility's 10:00 pm to 6:00 am night shift. The following days have no documented treatment to R6's posterior thigh wounds: 11/1, 11/5 through 11/9, 11/11-refused, 11/12 , 11/13, 11/16, 11/19 through 11/22 and 11/30, totaling 15 days of treatments not documented for the month of November 2013. The TAR for December 2013 shows 6 days of undocumented treatments as follows: 12/1, 12/2, 12/3, 12/4, 12/6 and 12/10 with R6 refusing. The POS dated 12/13 documents that R6 is to have skin checks every week. R6's TAR dated 12/13 has no documented skin checks. The Plan of Care for R6, last updated on 10/30/13 identifies no wounds to the posterior thigh of R6. The section titled Skin Breakdown identifies abrasions to right shin and left arm only. The facility report titled "Skin Integrity Report-Other Skin Conditions and dated 11/25/13 documents two wounds to R6's right posterior thigh measuring wound #1 as 0.5 cm wide by 0.5 cm long by 0 cm in depth. Wound #2 is measured as 3 cm wide by 1 cm long by 0 cm in depth. The report documents the wounds as improving. There were no other assessments or wound measurements available for review until 12/12/13. These measurements were done by E3 (Licensed Practical Nurse and Wound Care Coordinator). E3 provided a Nursing Note dated

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F9999	Continued From page 52 12/12/13 with the following information: Reddened area on back of right leg is 9 cm wide by 15 cm long. Open areas within reddened area are documented as wound #1. 4 cm wide by 1 cm long, wound #2. 2.5 cm wide by 1 cm long, wound #3. 3 cm wide by 1 cm long, wound #4. 1 cm wide by 1 cm long, wound #5. 1 cm wide by 1 cm long, wound # 6. 1 cm wide by 1 cm long, wound #7. 0.5 cm wide by 0.5 cm long, #8. 0.5 cm wide by 0.5 cm long. A Nursing Note dated 12/12/13 at 7:45 am documents E3 notifying R6's Physician (Z1) of the new multiple stage II pressure ulcers on the posterior thigh. A new treatment order was received, increasing treatment to twice a day due to area worsening. The facility Policy and Procedure, titled "Pressure Ulcer Care", documents "When a pressure area is identified, an aggressive treatment program will be instituted and closely monitored to promote healing. The "Pressure Ulcer Care Policy" further indicates, under "Procedure": 1.) When the charge nurse is aware of skin breakdown, whether inhouse or upon a resident's admission, area is to be assessed and initial treatment started per physician orders. 2.) Make entry in nurses's notes that pressure ulcer was identified and refer to Pressure Ulcer Report.....6.) Documentation of decubitus must occur at least once each week. 7.) The physician is to be notified when a pressure sore develops, if no improvement is noted after a reasonable amount of time, and/or upon signs of deterioration. 8.) The DON (Director of Nursing) or designee and nurses are to make pressure sore rounds every week and discuss each resident's progress and make necessary changes." There is no documentation in R6's Medical Record indicating that R6's Physician (Z1) has been notified of the new or worsening Stage II areas.	F9999		

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On 12/10/13 at 1:45 pm E16 (Licensed Practical Nurse) performed a dressing change to R6's right posterior thigh. R6 was rolled to her left side. R6's right posterior thigh wounds were visualized and were actively bleeding, the dressing was saturated with serosanguineous fluids and dated 12/8/13, indicating that the dressing had not been changed for two days. R6's drawsheet was also soiled. E16 cleansed the wound with wound cleanser and applied the collagen gauze, omitting the Hydrogel Alginate cream. E16 stated while performing the dressing change that R6's wounds appeared much worse than when last seen by him a month previous. R6 was lying on a non-therapeutic mattress and stated she rarely gets out of bed. R6's head of the bed was at an approximate 70 degree angle causing her to slide down in the bed putting her at risk for friction and shearing. On both days of 12/10/13 and 12/11/13, R6 ate lunch in her bed at 12:45 pm. Her intake was good, consuming all of her food and snacking on sweets that R6 keeps in her room along with sodas. Facility weight records for R6 document a weight of 241.9 as of 11/21/13.

On 12/10/13 at 2:45 pm Z1 (Primary Care Physician) stated that he was not aware of the additional open areas to R6's posterior thigh. Z1 stated R6 was last seen by him about 2 to 3 weeks earlier and he was aware that there were two open areas at that time being treated. Z1 stated "I have not been notified by the facility of any additional areas to (R6's) thigh." On 12/10/13 at 4:00 pm E3 (Licensed Practical Nurse and Wound Care Coordinator) acknowledged that R6's wounds had not been measured and assessed since 11/25/13. "I was off one week and sick on the following week." E3 stated she

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF CHAMPAIGN	1915 SOUTH MATTIS STREET CHAMPAIGN, IL 61821

(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 54 was not aware that R6's wounds had worsened and acknowledged that Z1 had not been notified of the wound changes to R6's thigh since R6's last measurements on 11/25/13. On 12/11/13 at 1:30 pm E1 (Administrator) acknowledged that R6's wounds should have been measured and reassessed every week and Z1 notified of the changes. E3 acknowledged on 12/11/13 at 1:20 pm that the treatments should have been identified as a problem on nights and treatment time should have been discussed with the interdisciplinary team and treatments changed to better care for R6. (B)	F9999		