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	IL6011332	A. BUILDING: _____ B. WING _____	01/17/2014

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VILLAGE AT VICTORY LAKES, THE	1055 EAST GRAND AVENUE LINDENHURST, IL 60046

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 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 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. 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	S9999		

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S9999	Continued From page 1 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 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: 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	S9999		

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S9999	Continued From page 2 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. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to analyze the root cause for the development of facility acquired pressure sore for three residents, R1, R 9 and R10. The facility also failed to develop and consistently implement specific and individualized interventions to promote healing and to prevent the development and worsening of existing pressure ulcers. The facility failed to turn and reposition R1 and R10 for more than two hours. These failures contributed to the development of R1, R 9 and R10 facility acquired pressure ulcer. (a) R1 acquired a Stage II pressure ulcer on the sacrum that progressed to an infected Stage IV. (b) R10 developed (b1) maceration on the sacrum that progressed to infected Stage IV and (b2) an Unstageable pressure ulcer on the right heel and (b3) a Stage II on R10 s right ear lobe that progressed to Stage IV. (c) R9 acquired Stage IV pressure ulcer on the sacrum and on the left hip. This applies to three of three residents (R1, R9 and R10) of five residents reviewed for the development of facility acquired pressure ulcers.	S9999		

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S9999	Continued From page 3 The findings include: I. On 01-16-14 at 10:05 AM, R10 was sleeping flat on the bed. E11/Charge Nurse stated, "She (R10) is in isolation for an infected wound (methicillin resistant staphylococcus aureus), we do not get her up." On 01-16-14 at 3:25 PM, Z3 (family member) during interview said, "They have not been getting her up for a while now. She has multiple pressure ulcers that developed here, maybe because she has not repositioned enough. I was here since 10:00 AM and she (R10) has not repositioned since I came in (five hours and twenty-five minutes)." During the treatment observation on 01-16-14 at 3:30 PM, R10 was flat in bed wearing an adult disposable brief and a cloth pad underneath. R10's heels were resting directly on a pillow. E12 /Treatment Nurse removed R10's dressings and described the wound as follows: "The wound is in (1) the sacrum with a very foul (smelling) odor and with moderate amount of thick brownish yellow drainage. The measurements are 7.8 cm X 5.0 cm X 4.0 cm with undermining of 6.0 cm. at 10 o ' clock. The wound bed is necrotic-black, this was a Stage IV but now it is Unstageable (UST). It has 60% necrotic area and with palpable bone. (2) The right heel measurement is 4.5 cm X 3.0 cm with eschar, this is an unstageable pressure ulcer." E12 did not identify R10's right ear lobe which also has a pressure ulcer. E12 identified R10's sacral wound as infected (methicillin resistant staphylococcus aureus). E 12 was observed to not wash her hands during	S9999		

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the entire procedure, from removing the old dressing to applying a new and clean dressing, from the infected wound to non-infected wound. This observation was discussed with E12, E12 asked, "Could I leave the patient with the Aide to wash my hands? "
On 01-16-14 at 12:00 PM, E12 gave the following explanations regarding R10's three major pressure ulcers:
(1) The sacrum/coccyx that started as maceration on 07-02-13, E12 stated, " This is due to her being incontinent." The wound/skin healing record showed on 08-02-13, this maceration progressed to a Stage IV pressure ulcer and developed a wound infection on 11-12-13. E2/Director of Nursing presented a copy of R10's Physician Order Sheet to isolate R10 on 11-21-13 (nine days after the infection was identified). On 01-17-14 at 2:20 PM, E2 stated, "the patient (R10) is still in isolation for her wound, there was no re-culture that was done yet."
(2) The right heel initially noted on 12-05-13 as a Deep Tissue Injury /Unstageable pressure ulcer measured at 3.0 cm X 5.0 cm. with eschar.
(3) The right ear lobe is a Stage IV; initially noted on 12-10-13 as a Stage II that progressed to Stage IV. The recorded measurement for 01-10-14 on the wound/skin healing record showed a measurement of 1.0 cm X 0.3 cm X 0.2 cm.

There was no pressure ulcer care plan found in R10's clinical record. On 01-16-14 at 3:15 PM. The Assistant Director of Nursing reviewed the 24 pages of R10's care plan and stated, "I cannot find any pressure ulcer care plan only the skin tears were addressed and the shear wound to the sacrum on page 24 but none for the pressure ulcers. "

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S9999	Continued From page 5 II. On 01-16-14 at 11:20 AM, R9 was in bed sitting at a 90-degree angle, with an adult disposable brief and with cloth pad on top of the mattress. R9 was verbally responsive but with periods of confusion. At 11:40 AM E13/Certified Nursing Assistant (CNA) stated, "She's (R9) totally dependent on staff for activities of daily living, including turning and repositioning. She usually gets up (from bed to wheelchair) at around 11:00 AM because her husband comes and visits. I do not put her back to bed; I leave at 2:30 PM. I don't know what time the afternoon shift put her back to bed. " On 01-16-14 at 10:55 AM, E12 reviewed the wound/skin healing record and stated, " She (R9) acquired the pressure ulcer on the sacrum on 06-01-13, it was initially noted with slough and with black eschar and the left hip was noted on 07-14-13 as redness/Unstageable/Deep Tissue Injury, with no open areas noted." During treatment observation on 01-16-14 at 11:55 AM, E12 identified and explained the status of R 9 ' s two areas of pressure ulcers as follows: (1) "The left hip is a Stage IV it has 80% yellow slough and 20 % black eschar, the measurement are 1.8 cm X 1.8 cm X 0.8 cm with no granulation noted. (R9's wound/skin healing record dated 1-2-14 showed a smaller measurement of 1.8 cm X 1.7 cm X 0.3 cm, comments reads: improved- decreased in necrosis, increased in granulation.) (2) "This is the sacrum, it's a Stage IV. The measurements are 6.0 cm X 6.2 cm X 1.0 cm with 2.5 cm undermining at 11 o'clock, the bone is visible at 3 o'clock. " During the entire treatment observation, E12 did not wash	S9999		

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her hands. R9 pressure ulcer plan of care was not individualized and specific based on R9's identified problems and needs. There were no revision noted, the interventions for the sacral wound and R9's left hips are identical.

III. On 01/14/2014 at 12:25 PM, R1 was in bed with a strong BM odor. At 12:30 pm an incontinence care was provided by E8 and E 9/Certified Nursing Assistants. R1 adult disposable brief was soiled with moderate amount of black semi liquid stool that penetrated inside R1's wound.

On 01/16/2014 at 1:15 pm, R1 was in a wheelchair in the dining room. E6/Nurse stated she had not yet changed R1's dressing because she has been up since she started today. E6 stated R1 was brought to the dining room around 7 am and will be brought back to bed after lunch. E6 stated she has a cushion on her wheelchair and they try to have all residents out in the dining room to be visualized during the day.
On 01/16/2014 at 1:45 pm, E 7 (treatment nurse) during interview stated R1 has a stage 2 pressure sore noted on 11/15/13. E7 stated it was likely from moisture and pressure and resident non-compliance. The facility policy dated October 1, 2012 stated. " ...If the resident is non-compliant with care, an evaluation of the basis of refusal, and the identification and evaluation of potential alternatives is indicated." The facility failed to identify and document any indicated alternatives. E7 stated 7 days after treatment began wound worsened from Stage II to an Unstageable on 11/22/13. E7 performed wound care and described the wound as Unstageable with 100 % necrosis measuring at 4.0 x 3.6 x 2.8 cm with foul odor, slight exudates,

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S9999	Continued From page 7 and with surrounding skin grey/pallor. E7 stated R1 just completed oral antibiotic for this wound being infected. E7 stated Z2 (wound doctor) did not perform a wound culture but diagnosed the infection by the deterioration of the wound and the progressing foul odor of the wound. The medication administration record (MAR) showed Keflex 500 mg three times a day for 10 days (wound infection) written on 01/10/2014. Z2 assessed R 1's wound on 01/10/2014 as 4.0 x 3.5 x 2.5 cm with moderate drainage, 80% necrotic and 20% slough. Z2 stated in wound notes: stage 4-pressure wound of the sacrum deteriorated due to infection. The facility did not develop a comprehensive care plan for R1 s pressure ulcer and did not revise the interventions when the pressure ulcer advanced. The intervention for R1's stage 2 ulcer are the same as the interventions for her unstageable ulcer and were not individualized to meet the progressing wound. (B)	S9999		