STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005771	A. BUILDING: _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE COR MARIAE CENTER	3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)5) 300.1220b)3) 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005771	A. BUILDING: _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE COR MARIAE CENTER	3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114

(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) COMPLETE DATE
S9999	Continued From page 1	S9999		

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.

These Requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to identify a pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005771	A. BUILDING: _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE COR MARIAE CENTER	3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114

(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) COMPLETE DATE
S9999	Continued From page 2	S9999		

ulcer prior to progressing to Unstageable. The facility failed to identify the resident ' s risk and predisposing factors, and put interventions in place to reduce the resident's potential to develop pressure ulcers. These failures resulted in R55 developing an unstageable pressure ulcer.
This applies to 1 of 3 residents (R55) reviewed for pressure ulcers in the sample of 15.
The findings include:
The Physician Order Sheet shows R55 was admitted to the facility on 10/29/13 with diagnoses to include: GI Bleed, Hyponatremia, Anemia.
The skin assessment for R55 dated 10/30/13 states, " Bottom is intact, without redness or breakdown " .
The Nursing note on 11/9/13 at 9:20 PM for R55 states, " Patient noted to have a pressure ulcer on coccyx; open skin with yellow drainage, surrounding skin red and non-bleachable, skin crease between buttocks is also red with open skin. 5 x 5 aqua cell dressing applied " . No wound measurements or staging was documented.
On 11/10/13 the nursing notes for R55 states " New order - utilize aqua cell dressing and barrier cream to coccyx, keep off coccyx as much as possible, utilize foam or air cushion when in chair." No wound assessment was documented.
The Wound Summary document for R55 shows a wound assessment was initiated on 11/12/13. (3 days after the wound was found). The wound on 11/12/13 measured 7.00 cm x 3.5 cm x 0.10cm. The tissue is identified as Granulation tissue - bright red 40% with moderate serous exudate. The PUSH score was 16 and it was listed as Unstageable and facility acquired.
The Wound Care specialist Initial Evaluation completed by Z3 (Wound Physician) on 11/12/13 documents the wound size is 7.0 cm x 3.5 cm with 30% thick adherent devitalized necrotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005771	A. BUILDING: _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE COR MARIAE CENTER	3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

tissue. Z3 documents, "The wound is acquired in house, likely started off as moisture associated breakdown due to increased loose stools last week per staff." Z3 performed surgical excisional debridement of the tissure to remove necrotic tissue and establish the margins of viable tissue.
The November 2013 treatment record shows by nurse initials that skin checks for R55 were performed daily. No exception charting regarding R55's coccyx was found in the medical record prior to 11/9/13.
On 1/15/14 at 1:15 PM, E2 (Director of Nurses) states the nursing staff chart by exception, meaning if there is something unusual or abnormal it should be recorded.
R55 ' s care plan dated 11/13/13 states R55 acquired an unstageable pressure ulcer to the coccyx identified on 11/12/13. The risk factors and predisposing factors for R55 are not identified. Pressure relief interventions were not identified or intiated prior to 11/8/13.
The Minimum Data Set of 11/5/13 shows R55 requires staff assistance for bed mobility and transfer, hygiene and toileting. R55 was identified as occasionally incontinent of bowel and uses a urinary catheter. R55 was assessed as being at risk to develop pressure ulcers, and did not have any unhealed pressure ulcers on admission.
The Skin and Ulcer treatments included a turning and repositioning program.

(B)