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S9999	Final Observations Statement of Licensure Violations: 300.696a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. 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.	S9999		

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S9999	Continued From page 1 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 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	S9999		

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S9999	Continued From page 2 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 are not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent the development and progression of a pressure ulcer. The facility failed to assess 2 residents (R2 & R3) for pain and provide preemptive measures, prior to dressing changes. These failures contributed to R2 developing a Stage I pressure area which progressed to an infected Stage 4 causing the resident pain and requiring surgical debridement. This applies to 2 of 3 residents (R2 and R3) reviewed for pressure ulcers in the sample of 6. The findings include: 1. R2 is a 74 year old male resident with diagnoses to include Cerebral Aneurysm Right (R) Side, Hypertension (HTN), Diabetes Mellitus (DM), Cerebral Vascular Accident (CVA) with Left (L) hemipelgia, Intercrainal Hemorrhage and Neurogenic Bladder according to the Physician Order Sheet (POS) dated 5/2014. E4 (Licensed Practical Nurse-LPN - Wound	S9999		

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Nurse) identified R2 and R3 as the only residents in the building with pressure ulcers. E4 stated R2 has a facility acquired Stage III-IV area to his sacrum and R3 was admitted with an Unstageable wound to her coccyx. E4 stated R2 developed a Stage I which has progressed to a Stage III. E4 said R2 is scheduled for surgical debridement next week. E4 said R2 is non-compliant with repositioning and has been educated on the importance of pressure relief. E4 stated R3's wound is healing.

R2's Minimum Data Set (MDS) dated 3/8/14 showed R2 has no cognitive or communication deficits. The MDS showed R2 requires extensive and/or total assist of staff for activities of daily living (ADL's) and personal cares. The MDS identified R2 as having occasional pain.

On 5/29/14 at 10:15 AM, wound care was given to R2 by E3 (Registered Nurse - RN). E3 stated she did not pre-medicate R2 for pain prior to the dressing change. E3 stated "he doesn't usually complain." R2's wound exhibited epiboly (rolled edges), full thickness injury with overt necrotic tissue present.

On 5/29/14 at 1:45 PM, R2 stated he prefers not to be positioned on his left side because it makes him "so dizzy I could almost fall off the bed." R2 stated he does not refuse to be repositioned. R2 stated staff do not usually try to turn him. R2 states he does comply with lying on his left side because it is the only way he can see the Television. R2 stated his position of preference is his right side. During the surveyor's two days at the facility, (5/29/14 and 5/30/14), R2 was noted to be repositioned during random room checks. The facility did not provide any documentation of interventions attempted to minimize R2's

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dizziness. On 5/30/14 at 12:00 PM, E1 (Administrator)was asked if R2 was ever evaluated for the cause and/or possible interventions for his dizziness. E1 stated R2 did have a Neurology consult "in the past" but nothing recent. E1 said any documentation of R2 being seen by a Neurologist was so long ago it would be in his closed file. No documentation could be provided to show any efforts to re-arrange R2's room to increase his ability to visualize his TV in an effort to encourage position changes.

On 5/30/14 at 7:10 AM, R2 stated he does have pain during his dressing changes and rated it as a 7-8 on the 1-10 pain scale (1=least pain, 10=most pain). R2 stated he is not offered any pain medication prior to dressing changes. R2 said when he is medicated for complaints of pain, he is only offered Tylenol.

R2's Medication Administration Record (MAR), showed R2 has an order for Tylenol 650 mg every 4-6 hours as needed. The MAR also showed an order for Norco 5/325 every 4 hours as needed for pain. During the month of May, the MAR documents a Norco given on 5/30/14 at 12:05 AM for pain. No other PRN medications were given.

R2's Comprehensive Pain Assessment (reviewed 3/21/14) shows documentation of a "10" on pain intensity "when moved." The medication history and treatment sections shows the use of "Tylenol PRN."

A fax communication from the facility to R2's Primary Care Physician (PCP) on 1/22/14 showed he had two openings to his buttocks at that time. E4 verified R2 has a history of skin break down. The wound sheet dated 4/13/14 showed documentation of R2 with a "history of

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breakdown." According to the care plan for skin breakdown, R2 was on a pressure relieving mattress and had a pressure relieving chair pad due to his history/risk for breakdown. R2 was to be turned every 2 hours and as needed and positioned with pillows.

The wound sheet of 4/3/14 shows a 1.2 cm X 1.5 cm reddened area to sacrum. The intervention listed on the care plan for 4/3/14 was to educate R2 on repositioning. The wound care sheet dated 4/10/14 described the area as a "red, blanchable area measuring 1.5 cm X 1.4 cm." No new interventions were added at this time. On 4/17/14 the wound documentation showed no improvement. Again, no new interventions were implemented in an attempt to prevent further decline. On 4/24/14, the wound documentation now showed R2 with a Stage I pressure area measuring 1.5 cm X 1.6 cm to sacrum. The facility still did not implement any new interventions despite the worsening of the area. A PUSH (Pressure Ulcer Healing Chart) was started with R2 having a score of 5 (0=healed. The higher the score the worsening of the wound.) On 5/1/14, R2's wound was identified as a Stage II wound, bed is red in color and measures 1.6 cm X 1.5 cm with a PUSH score of 7 (worsened). At this time a treatment of cleansing sacrum with wound cleanser and apply adhesive foam dressing was implemented. A physician's note dated 5/1/14 documents, "Patient has a stage 2 pressure ulcer on his sacrum."

On 5/5/14, the wound care sheets documents the wound as a pale pink color wound bed measuring 1.6 cm X 1.5 cm X 0.3 cm with a PUSH score of 7 (no improvement). No new interventions were implemented according to the care plan. On 5/8/14 the wound sheet documents slough to

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wound with peri edges unattached. Peri wound bed red with 25% slough and 75% pink. The PUSH score at this time is 9 showing worsening of the wound. The wound care sheet reads: "(R2) Complains of pain when sitting. Resident allowing staff to position on lateral side only 'a little.' States that it makes him dizzy." The wound measurements are documented as 2.0 cm X 1.6 cm X 0.3 cm but there is no staging documentation. The care plan showed no new interventions attempted.

On 5/12/14 at 3:30 PM, R2's PCP was sent a fax which reads; "coccyx wound has been worsening - has foul odor - serosang (serosanguanous drainage) - purulent yellow drainage." A debrideing agent was requested at this time and an order was received to cleanse the scrum with wound cleanser and apply Santyl (debrideing agent) and cover with a foam dressing. R2's PUSH score on this date is documented as a 10. The Physician Progress Note dated 5/15/14 showed the following; "approximately around 4/13/14, (R2) started having a red area. It has progressively gotten worse. He also had some drainage this week. I was notified and put him on an antibiotic. The patient reports....he (R2) does not like laying in a certain position but he is willing to try...." R2's PCP ordered Zithromax for "an infected wound" to the sacrum. Dietary was notified and Protein Powder was ordered.

The 5/15/14 wound documentation showed R2's wound measured 2.0 cm X 1.6 cm X 0.5 cm with 75% slough and 25% full thickness Stage III wound. This wound care note reads, "exudate, foul odor, slough firmly adherent to wound bed. Wound edges unattached. Surrounding tissue red. Pain stated when on sore." At this time, the PCP referred R2 to a Surgeon for a Consult.

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S9999	Continued From page 7 On 5/20/14, R2 was seen by a surgeon. The surgical progress note documented, "The patient (R2) does have some soreness on his tailbone...There is a 4 cm by 3 cm by 2 cm stage three to four sacral decubitus with some superficial necrotic exudate and some foul smelling odor as well....(R2) with stage three to four infected sacral decubitus ulcer. A surgical debridement in the operating room would be recommended here....The patient understands the plan, he agrees and he is appreciative." The 5/20/14 wound documentation showed R2's wound measures 3.6 cm X 2.1 cm X 1.8 cm. with new orders, (from the surgeon), for R2 to be turned/repositioned every 30 minutes. "The resident is on alternating air mattress...wound is 90% slough 10% pink, foul odor present. Wound edges unattached peri wound red. Complains of mild pain when wound cleansed." R2's PUSH score is now at 11. The 5/26/14 wound documentation now measures 3.7 cm X 2.1 cm X 1.8 cm. Area with "90% slough 10% pink, foul odor. Red to peri wound...Surgeon appt June 4 for debridement." R2's PUSH score remains at 11, (no improvement). R2's care plan for "pain" contains the following intervention; "Nurse will administer pain medication 20-30 minutes prior to PT/OT (physical therapy/occupational therapy) exercises." It does not address pain related to the pressure ulcer. R2's care plan related to skin break down has no interventions to address his pain. The Stage III-IV pressure ulcer problem is identified. R2's care plan for repositioning showed he was to be turned every 2 hours until	S9999		

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the new order on 5/20/14, at which time he was to be turned every 30 minutes. The care plan does not address interventions for R2 if he refused to turn. The care plan does not document any alternative measures nor interventions to encourage repositioning and/or to alleviate his complaints of dizziness and pain.

Peri care was given to R2 by E8 and E9 (Certified Nursing Assistant, CNA) at 10:50 AM on 5/29/14. During the provision of cares, a previously unidentified, partial thickness open area was identified on R2's scrotum.

2. R3 is a 72 year old resident with diagnoses to include Unstageable Pressure Ulcer, Respiratory Failure, Laryngeal Cancer, HTN and Hypothyroidism according to the POS of 5/14.

According to R3's 4/3/14 MDS, she has no cognitive deficits and requires physical assist with cares/ADL's.

On 5/29/14 at 10:50 AM, wound care/dressing change was being completed by E7 (Registered Nurse, RN). E7 removed the current dressing, placed the dressing in a clear garbage bag, removed her gloves and donned a new pair without washing or sanitizing her hands. E7 had the blinds closed and the curtains drawn but no lights on in the room. This surveyor obtained a flashlight to visualize the wound and a CMS Surveyor turned the overhead lights on in an effort to see the wound. E7 continued with the dressing change. E7 did not cleanse nor sanitize her hands between any glove changes. After completing the dressing change, E7 removed her gloves. With bare hands, E7 obtained a marking pen from her smock and marked the date of the dressing change on the dressing after it had

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already been applied to the coccyx. E7 then returned the marking pen to the pocket of her smock. E7 proceeded to tie up the clear trash bag with the soiled dressing, touch the resident's linens and other items in the room. At 11:05 AM, E7 was asked about her hand washing and glove use. E7 verbalized that she should at least have used hand sanitizer between glove changes. E7 stated she always marks the dressings after they have been applied to the wound and did not give a thought to cross contamination. When asked what E7 was going to do with the clear bag containing the soiled dressing, she replied she was going to walk it to the dumpster outside. E7 was asked if she was going to place it in a red bag (hazardous waste bag) and she stated no because she was walking it directly to the dumpster.

On 5/29/14 at 11:35 AM, E4 stated hands are to be sanitized or washed between each glove change. E4 stated all soiled dressings are to be discarded in a red (hazardous waste bag) and placed in the hazardous waste container in the soiled utility for disposal.

On 5/29/14 at 1:30 PM, E4 stated lighting is necessary for dressing changes. E4 stated light is needed to see and assess the wound. E4 stated it is inappropriate not to turn on the room light prior to doing a dressing change. On 5/29/14 at 2:00 PM, E1 stated hand washing and/or sanitizer is to be used before and after contact with potentially contaminated materials and between each glove change while providing cares.

The facility policy dated 11/1/11 titled Handwashing and Glove Use documents Hands should be washed ten to fifteen seconds under

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the following circumstances: Before handling clean or soiled dressings, gauze pads, etc.; After handling used dressings, contaminated equipment, etc.; After handling items potentially contaminated with blood, body fluids, excretions, or secretions. The policy also documents gloves "Must be worn at all times during patient care if contact with infective material is likely....HANDS MUST BE WASHED and GLOVES MUST BE CHANGED between each procedure."

The facility presented an undated document entitled Skin Conditions Policy. The policy reads: The facility will provide A & D ointment for all residents and this may be applied by direct care staff during daily AM & HS care as well as after incontinence as a matter of routine except when the resident is currently receiving treatment for a skin condition.....Repositioning of residents will be done according to their individual plan of care."

The facility's undated Basic Skin Protocol shows that when a Stage I area is identified Calmoseptine is applied BID (twice daily) and PRN (as needed). Residents are to have scheduled repositioning implemented. When a Stage II is identified, the area is to be cleansed with Normal Saline and skin-prep to peri-wound and covered with duoderm. This is to be done every 5 days and as needed. If the wound is in a location a dressing can not be applied, the facility is to implement a thin layer of Silvadene BID and PRN
The Protocol states when a wound area is a Stage III or IV, if there is drainage the wound is to be cleansed with normal saline and covered with a foam dressing. If the wound is dry, it is to be cleansed with Normal Saline and covered with Duoderm.

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