STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146064	A. BUILDING _____ B. WING _____	C 09/21/2016

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LINCOLN MANOR	2650 NORTH MONROE STREET DECATUR, IL 62526

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F 000	INITIAL COMMENTS Complaint Investigation #1665156 / IL88356 - F157, F224, F278, F282, F309, F441, F496, and 300.1230 a)1)2)3)b)d)1)2)f)j)5)k)4)5) Complaint Investigation #1665318 / IL88542 - F157, F224, F278, F282, F309, F441, F496, and 300.1230 a)1)2)3)b)d)1)2)f)j)5)k)4)5) A partial extended survey was conducted.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to notify the physician of a surgical wound dehiscence for one of five residents (R1) reviewed for wounds in the sample of five. This failure resulted in more surgical wound dehiscence and an eight day delay in wound treatment for R1. During this time R1's abdominal wound became infected, with R1's internal abdominal pain pump protruding through the wound causing subsequent Sepsis and death of R1. The facility also failed to notify the physician of changes in condition for one of three residents (R2) reviewed for changes in condition on the sample of five residents.

These failures resulted in an Immediate Jeopardy.

While the immediacy was removed on 9/20/16, the facility remains out of compliance at severity level two. The facility is in the process of evaluating the effectiveness of staff re-education for resident skin and wound assessments, physical assessments, change in condition and physician notification.

Findings include:

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1) R1's Physician Order Sheet dated August 2016 documents the following diagnoses: Cerebral Infarction due to Embolism of Unspecified Cerebral Artery, Abnormal Posture, Age-Related Osteoporosis with Current Pathological Fracture, Vertebra, Hemiplegia Unspecified Affecting the unspecified side, Muscle Weakness, Neuromuscular Dysfunction of bladder, and Urinary Tract Infection.

R1's Care Plan dated 6/21/16 documents "(R1) has potential for impairment to skin integrity r/t (related to) fragile skin and picks at self...Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor)." The Care Plan dated initiated 6/29/16 documents R1 "has potential/actual impairment to skin integrity of the abdomen r/t surgical wound (pain pump placement)...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations."

R1's Minimum Data Set (MDS) dated 7/14/16 documents R1 is cognitively intact and requires the extensive assistance of two staff for bed mobility, toileting, and bathing. R1's Skin Assessment dated 7/14/16 documents R1 is at risk for skin breakdown.

The undated facility policy titled "Wound Assessment Policy and Procedure" documents "It is the policy of the facility to do ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities...A description of the wound will be

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noted and the physician will be notified for an appropriate treatment order to be implemented... Upon any change in wound status the assessment will be updated, the physician will be notified promptly to obtain treatment orders that will be implemented..."

The facility's undated "Change in Resident Condition" policy documents "Our facility shall promptly notify the resident, his or her Attending Physician or designee, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..."

R1's Nurses Notes dated 8/20/16 at 8:31 pm documents "MD (Medical Doctor) called to make aware of open skin area around internal pain pump that patient states was placed a few weeks ago; left message on MD cell phone; waiting for MD to reply to phone message." R1's Nurses Notes dated 8/20/16 at 8:37 pm document "the opening is about 1-2 cm (centimeters) in length and 0.5 cm in width."

On 9/8/16 at 11:20 am Z3 (R1's Primary Care Physician) stated Z3 saw R1 on 8/8/16 for a Urinary Tract Infection. Z3 stated Z3 was unaware of R1's open abdominal wound on 8/20/16. Z3 stated Z3 had nothing faxed regarding R1's wound and received no phone messages. Z3 stated "any concerns with the pain pump should have been directed to the pain clinic doctor (Z2, R1's Pain Clinic Physician/Surgeon). No one notified me."

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On 9/12/16 at 11:25 am Z1, Registered Nurse (RN)/Pain Center, stated when R1's open area was found on 8/20/16 the pain center should have been notified. Z1 stated "We would have had R1 seen at the pain center for the doctor (Z2) to evaluate and give orders for treatment. No one notified us that (R1) has an open area over the pump."

On 9/8/16 at 11:05 am E14, Licensed Practical Nurse, LPN, stated E14 stated when an open wound is found on a resident the "Wound doctor is notified. The Primary Care Physician is notified and family and we then implement treatment orders."

On 9/12/16 at 2:20 pm Z4 (Wound Physician) stated no one notified Z4 of R1's wound on 8/20/16. Z4 reviewed E8 nurses note dated 8/20/16 and stated R1's wound should have been cleaned with Normal Saline, or wound cleanser, or betadine and not soap and water.

On 9/8/16 at 9:45 am E1, Administrator stated E1 talked with E14 on 9/7/16. E1 stated E14 said E14 did R1's skin assessment on 8/26/16 and there was a small bandage over the internal pump area. E1 stated E14 should have looked for R1's physician orders for the wound. E1 stated E14 should have looked at the wound, measured the wound, and called Z3 (R1's Primary Care Physician) for orders.

On 9/7/16 at 4:10 pm E9, RN, stated if an open wound is found on a resident, the nurse does an assessment and provides a treatment to cover the wound and then notify the physician for orders. E9 stated "I would let the physician know what treatment I did and then take down new

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orders."

On 9/8/16 at 2:55 pm E12, Certified Nursing Assistant (CNA) stated E12 "came in early on the third shift (8/28/16) between 2-3:00 am. E12 stated R1 said " I don't feel good." E12 stated R1 "looked sweaty." R1 was wearing a hospital gown that had a brown stain. E12 stated "I looked and it (brown stain) was the dressing on (R1's) right abdomen over the pump. The dressing was full. The whole dressing was saturated and it (drainage) came through on the gown. I didn't smell an odor. I put clean gown on (R1)." E12 stated E12 continued to provide care for R1 before informing E13, Licensed Practical Nurse (LPN) of R1 wound dressing and drainage. E12 stated "I told E13 about the drainage on R1's dressing over pump area." E12 stated E12 then left R1's room. E12 stated when it was time to get residents up for day shift "I was (R1's) aide on days. I asked (E11, Licensed Practical Nurse, LPN) if I can get (R1) up. E11 said 'Yes.'" E12 stated "Me (E12) and E18 got (R1) up into the wheelchair." E12 stated R1 still had the same dressing on that was saturated with brown stain. E12 stated E12 then took R1 to the dining room for breakfast. E12 stated "(R1) was groggy. (R1's) eyes were closed." E12 stated R1's foley was draining a brownish color of urine. E12 stated E12 brought R1 from the dining room and "placed (R1) in the room until all the residents were out of the dining room. Then about 11:00 am I put (R1) back into bed. Another aide (E18) helped me put (R1) back into bed. The brown stain was coming through (R1's) gown. (R1) never complained. I changed (R1's) gown and I told E11 about (R1's) dressing. The next thing I know they (ambulance) were coming to get (R1)."

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On 9/13/16 at 9:20 am E18, CNA, stated E18 worked from 10:00 pm on 8/27/16 to 6:00 am on 8/28/16. E18 stated E18 was one of the CNAs that worked with R1. E18 stated R1 "wasn't looking right. She (R1) was sweating and I got a towel and washed her face then I went and told (E13, LPN) that (R1) wasn't looking her normal self." E18 stated E18 saw E13 go into R1's room and gave R1 a breathing treatment. E18 stated E18 went to help E12, CNA, get R1 up for breakfast. E18 stated there was a brown stain on R1's gown. E18 stated the brown stain came from the leaking dressing on R1's right side. E18 stated E12 got R1 cleaned up then "we pivoted (R1) from the bed to the wheelchair" to have R1 ready for breakfast. E18 stated R1 stood up "but needed more help than usual."

On 9/12/16 at 1:40 pm E13, LPN, stated E13 worked from 6:00 pm on 8/27/16 to 6:00 am on 8/28/16. E13 stated "I was (R1's) nurse. E13 stated E13 did not know if R1 had a dressing or not. E13 stated "No one ever informed me that (R1) had a dressing over the pain pump."

On 9/12/16 at 12:40 pm E17 CNA stated E17 worked on 8/28/16 on the day shift from 6:00 am to 2:00 pm. E17 stated "I saw (R1) during breakfast in the dining room. (R1) looked a little sleepy. I don't know whether she ate or not." E17 stated sometime after breakfast E12 walked past me and mentioned (R1) wasn't feeling good. E17 stated "(R1) was in bed lying on her back and I smelled an odor like a sore or something. There was drainage on (R1's) gown on the right side. It was dark brown like coffee and smelled like an open sore. (R1) was breathing hard and had oxygen on. (R1's) eyes were closed. (R1) could shake her head but wasn't talking. This

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was not (R1's) normal. She always talked a lot. It wasn't like her to be quiet. She was always fussing with clothes and always had something to say. So this wasn't her normal." E17 stated "This was close to 9:00 am. So I stayed with (R1) and E20 (CNA) went to get (E11 Licensed Practical Nurse (LPN)). E11 came and said to me that (R1) was smiling early in the morning. (E11) was concerned about (R1) and looked at the drainage then I left (R1's) room."

On 9/12/16 at 1:08 pm E20, CNA, stated E20 worked on 8/28/16 from 6:00 am to 2:00 pm. E20 stated R1's dressing over the pump site "was wet." E20 stated she smelled an odor that "smelled like infection to me." E20 stated the drainage was "brownish looking" and leaked onto R1's gown. E20 stated "I remember telling (E11, LPN) and (E11) looked at it (R1's dressing)."

On 9/8/16 at 4:00 pm E11, LPN stated E11 was R1's nurse on 8/28/16 during the 6 am to 2 pm day shift. E11 stated E11 did not receive any information that R1 had a dressing or drainage over the internal pump site in R1 lower right abdomen when came on duty. E11 stated "No one reported to me until after lunch (on 8/28/16) when E12, CNA or E17, CNA, told me (R1) had drainage, nasty smelling around (R1) pain pump with drainage on (R1's) gown. I went in (into R1's room) and removed the dressing (over the pain pump) and the pain pump was sticking out of the skin." E11 stated R1's open wound was about 2 1/2 inches by 1 1/2 inches. E11 stated E11 did not measure the area. E11 stated "I cleaned the area (R1's wound) with Normal Saline and gauze and left it (wound) open." E11 stated R1 was "having difficulty breathing." E11 stated R1's oxygen saturation level was 96%. E11 stated

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R1's Blood Pressure was 60/40, Temperature was 98.2 degrees Fahrenheit, and Pulse was 76 beats per minute. E11 stated E13, LPN/night shift nurse, said to E11 that "(R1) was having trouble breathing. E13 did not say a word about the drainage at the pump site. Don't know if (E13) knew about it. I did (R1's) vitals myself and called (ambulance) then called family then Z3 (R1's Primary Care Physician)." E11 stated R1 had the pain pump for years for back pain.

R1's Nurses Notes dated 8/28/16 at 12:47 pm documents " (Z3, R1's Primary Care Physician) called, order received to send pt (patient, R1) out for evaluation."

R1's Hospital Emergency Room report dated 8/28/16 documents R1 arrived at the emergency room on 8/28/16 at 1:33 pm. The report documents "EMS (Emergency Medical Services) stated that the patient (R1) is septic with fever and SOB (Shortness of Breath). EMS stated that the patient has a pain pump on the right side of her abdomen." ...Pain pump partially exposed in abdominal wall with erythema...."

R1's Ambulance Incident Log Report dated 8/28/16 documents response to the facility on 8/28/16 at 12:46 pm. The report documents at 12:48 pm "Going Septic-Pain Pump draining ... going downhil (downhill). The report "Narrative" documents "...FOUND PT (Patient, R1) IN NH (Nursing Home) AND RN (Registered Nurse) STAFF STATES SHE IS NOT REAL FAMILIAR WITH THE PT. RN STATES PT HAD A PAIN PUMP A COUPLE DAYS AGO AND IT HANGING OUT OF THE INCISION SITE ... PT HAS APPROX 4 1/2 INCH ROUND SILVER OBJECT HANGING OUT OF INCISION SITE IN LRQ

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(Lower Right Quadrant of Abdomen) ....PT LRQ IS VERY DISTENDED, RED AND HOT TO TOUCH ... "

On 9/12/16 at 8:46 am Z5, Paramedic for Ambulance Service, stated when arrived at the facility on 8/28/16 the nurse stated "I am not the normal nurse and handed me (R1's) DNR sheet." Z5 stated the nurse then said to Z5 "Let me show you this" and pulled (R1's) dressing back. Z5 stated R1's abdominal wound was dry and "looked as if it happened days ago. It (the wound) did not look like a fresh wound. Very red. (R1's) abdomen was distended. (R1) was cool and clammy. (R1) had every indicator that (R1) was in Septic Shock. (R1) was non-verbal and very lethargic. In 26 years I've never seen anything like this. Never seen a pain pump hanging out. Half of the pain pump was hanging out of (R1's) wound. The opening (wound) was about six (6) inches long and 1 1/2 inches wide and three (3) inches of the pump was hanging out."

R1's Emergency Room "Disposition" dated 8/28/16 documents "Patient (R1) brought in from nursing home for evaluation of change in mental status and shortness of breath with fever. She (R1) has intrathecal pain pump extruding from the abdominal wall with erythema and discharge around it (pump) .... septic workup done ... (Z2, R1's Pain Clinic Physician, Surgeon) was contacted and will be coming to remove the pain pump..." The report documents "Sepsis Signs and Symptoms: Hyperthermia ... Altered Mental Status ... Tachycardia ... Sepsis Status: Severe Sepsis: S & Sx (Signs and Symptoms) + Organ dysfunct (dysfunction)..." electronically signed by Z14 Emergency Physician Provider.

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R1's Hospital Discharge Summary report dated 9/2/16 documents "Reason for Admission-brought in to ED (Emergency Department) for further evaluation of fever, shortness of breath, altered mental status. Patient (R1) was noted to have Infected pump pocket with dehiscence of wound and expression of pump through wound in RLQ (Right Lower Quadrant)...Intrathecal pain pump explanted on 8/28/16...Subsequently during hospital course, patient's (R1's) symptoms and clinical condition deteriorated...Patient expired and pronounced dead on 9/2/16 at 1259 hours (12:59 pm)... "(Final Diagnoses: 1. Septic Shock: likely due to pain pump site infection and/or HCAP (Healthcare associated pneumonia) and/or Complicated UTI (Urinary Tract Infection ...2. Acute Respiratory Failure, Hypoxic: 3. Atrial fibrillation with RVR: 4. Acute Kidney Injury, nonoliguric: due to septic shock 5. History of CVA (Cerebral Vascular Accident, Stroke) with right residual weakness 6. Dementia 7. FBSS; requiring intrathecal programmable pain pump implantation 6/2016 (June 2016) electronically signed by Z7(Hospitalist/Physician) .

R1's "State of Illinois Certificate of Death Worksheet" dated 9/6/16 documents R1's date of death occurred on 9/2/16 as a hospital inpatient and documents "Septic Shock" as the R1's cause of death, certified by Z7.

On 9/12/16 at 9:15 am Z7 (R1's Hospitalist/Physician in Charge on Death Certificate) stated R1 came into the hospital with Septic Shock. Z7 stated the primary site of R1's Septic Shock was the pain pump. Z7 stated the pain pump site was infected.

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On 9/7/16 at 3:46 pm Z2 (R1's Pain Clinic Physician/Surgeon) stated R1 was fine when seen at the clinic on 8/1/16. Z2 stated R1 was brought into the emergency room on 8/28/16 with the "pump breaking through the wound and the metal portion of the pump exposed. Never seen anything like this to break open like this. It appeared to be days and days in the making. The edges (of the wound) were retracted and didn't look fresh. I cannot for the life of me know how (R1) was changed and bathed and no one noticed."

On 9/14/16 at 10:05 am E2 stated there is no documentation in R1's record that a physician was reached for treatment orders for R1's wound. E2 stated "If a wound is not treated it (wound) can become infected, septic, necrotic." E2 stated when E12 (CNA) found R1 with leaking dressing on 8/28/16 (on the night shift) E12 should have reported to the nurse immediately and should not have moved R1 until the nurse found R1 safe to be moved and the physician should have been notified for R1's change in condition, skin assessment and wound drainage. E2 stated there was no documentation, assessments, treatments or care found in R1's medical record that addressed R1's wound since the initial assessment and treatment on 8/20/16 in the progress notes.

On 9/19/16 an Immediate Jeopardy was identified. The immediate jeopardy situation began on 8/20/16 when the facility identified R1's open abdominal wound at the internal pain pump site and failed to notify the physician for orders. R1's wound was untreated for eight days resulting in wound drainage, infection, and expulsion of an

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internal abdominal pump. E1 was notified of the Immediate Jeopardy on 9/19/16 at 3:30 pm.

The surveyor was able to confirm through record review and interview that the facility took the following actions to remove the immediacy:

Nurses will or have been inserviced by E2, Director of Nursing (DON) on Skin Assessments, Wound policy and the evaluation and treatment of wounds, resident change in condition and Physician notification. The DON provided education for licensed nurses on 9/15/16 and 9/19/16 on physician notification with any resident change of wound condition or implantable pump site condition change including timely follow up with treatment orders. Two nurses have not yet received the education and have been removed from the schedule until education is complete. The licensed nurses completed a general physical assessment and vitals for all residents on 9/19/16 and skin audits were conducted on 9/16/16, 9/17/16, 9/18/16, and 9/19/16 for all residents. The Administrator and DON are reviewing all progress notes to ensure proper notification of wound changes and implantable pump sites. The facility does not have a resident with an implantable pump at the time of this survey. The Administrator and DON are meeting with all day shift and evening shift nurses and Certified Nursing Assistants (CNAs) regarding resident conditions daily, five (5) times a week at 9:30 am and 2:30 pm.

2) R2's Physician's Progress Note dated 9/1/16 at 12:49pm documents R2's diagnoses including Left Hip Surgery, Alzheimer's Disease, Hypertension, Cerebrovascular Accident,

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Coronary Artery Disease and Atrial Fibrillation.

R2's Progress Notes dated 9/1/16 at 7:28pm document "The order you have entered Coumadin (Anticoagulant) Tablet 4mg... has triggered the following drug protocol alerts/warnings: Drug to Drug Interaction... Daily Multiple Vitamins Tablet (Supplement)... Trazodone HCL (Hydrochloride) Tablet (Antidepressant)... Hydrocodone-Acetaminophen Tablet (Pain)... and Ranitidine HCL Tablet (Antacid)..." There is no documentation that Z3 (R2's Physician) or Z15 (R2's Orthopedic Physician) were notified of these alerts/warnings.

R2's Progress Notes dated 9/4/16 at 11:41pm document "... {R2} currently has pain. left hip... Noted facial grimacing/facial expressions of pain. Noted guarding, rubbing or holding a body part during movement." There is no documentation that Z3 or Z15 were notified.

R2's Progress Notes dated 9/5/16 at 4:42pm document R2 was sent to the hospital for an evaluation of the left hip. R2's left hip site of previous fracture was noted to be swollen, bruised and warm to touch. At 8:36pm, R2 returned to the facility with diagnoses of Postoperative Hematoma of subcutaneous tissue and Supratherapeutic International Normalized Ratio (INR).

R2's Emergency Care Center Discharge Instructions dated 9/5/16 document, "... Hold Coumadin today and get repeat INR tomorrow. Call {Z15} with results and further instructions on further Coumadin use..."

R2's Progress notes dated 9/6/16 at 11:08am

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F 157	Continued From page 14 document "{R2} has a surgical area on {R2's} left hip... {R2} has bruising and redness in this area and down {R2's} left side." There is no documentation that Z3 was notified of the left side bruising. R2's Progress Notes dated 9/6/16 at 5:45pm document, "...received an order from {Z15's} office r/t (related to) resident's {R2's} PT (Prothrombin Time)/INR results from this morning PT 31.0 INR 2.9, Coumadin was held last night... was given new orders of Coumadin 2mg (milligrams) PO (by mouth) daily..." R2's Progress Notes dated 9/6/16 at 5:59pm document, "Coumadin 4mg was given prior to receiving new Coumadin order." There is no documentation that Z15 was notified that R2 was given the Coumadin 4mg instead of Coumadin 2mg as ordered. On 9/20/16 at 2:10pm, E2, Director of Nursing stated she was unable to find documentation that Z3 or Z15 were notified regarding changes in R2's condition on 9/4/16 and 9/6/16. E2 also stated she could not find where Z15 was notified of R2 receiving Coumadin 4mg instead of Coumadin 2mg on 9/6/16.	F 157		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility neglected to follow facility policy on Skin Assessment Policy and Procedure, Wound Assessment Policy and Procedure, and notification of a resident's Change in Condition policy for one of five residents (R1) reviewed for wounds on the sample of five residents. These failures resulted in R1's abdominal wound left untreated for eight (8) days. The wound become infected, R1's internal abdominal pain pump protruding through the wound, with subsequent Septic Shock and R 's death.

These failures resulted in an Immediate Jeopardy.

While the immediacy was removed on 9/20/16, the facility remains out of compliance at severity level two. The facility is in the process of evaluating the effectiveness of staff re-education for resident skin and wound assessments, physical assessments, change in condition and physician notification.

Findings include:

The untitled facility policy titled "Skin Assessment Policy and Procedure" documents "Intact, healthy skin is the body's first line of defense. It is the policy of this facility to monitor the skin integrity for signs of injury and irritation...Purpose to continually inspect the resident's skin for early signs of pressure ulcer development and other abnormalities...Residents who are determined "AT RISK" for the development of pressure ulcer

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will have a head-to-toe skin assessment done by a licensed nurse weekly and documented on the Treatment Administration Record (TAR)..."

The undated facility policy titled "Wound Assessment Policy and Procedure" documents "It is the policy of the facility to do ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities...To document an accurate, ongoing assessment of wounds in the medical record...Procedure 1. The presence of wounds, ulcers, and/or other skin abnormalities will be indicated on the admission nursing assessment, weekly skin assessment or identified at any other time. 2. A completed wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairments in the skin integrity. 3. A description of the wound will be noted and the physician will be notified for an appropriated treatment order to be implemented. 4. A weekly comprehensive assessment of each wound will be done until healed including site, classification/type, stage, measurements, drainage, odor, healing process, and condition of surrounding skin. 5. Upon any change in wound status the assessment will be updated, the physician will be notified promptly to obtain treatment orders that will be implemented. 6. Care Plan will be updated with changes."

The facility's undated "Change in Resident Condition" policy documents "Our facility shall promptly notify the resident, his or her Attending Physician or designee, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...The nurse supervisor/charge nurse will record in the resident's medical record information relative to

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changes in the resident's medical/mental condition or status.

R1's Physician Order Sheet dated August 2016 documents the following diagnoses: Cerebral Infarction due to Embolism of Unspecified Cerebral Artery, Abnormal Posture, Age-Related Osteoporosis with Current Pathological Fracture, Vertebra, Hemiplegia Unspecified Affecting the unspecified side, Muscle Weakness, Neuromuscular Dysfunction of bladder, and Urinary Tract Infection.

R1's Minimum Data Set (MDS) dated 7/14/16 documents R1 is cognitively intact and requires the extensive assistance of two staff for bed mobility, toileting, and bathing. The MDS documents R1 has an indwelling urinary catheter and is at risk for pressure ulcers. R1's Skin Assessment dated 7/14/16 documents R1 is at risk for skin breakdown.

R1's Care Plan, initiated on 12/18/15 with a revision on 6/21/16, documents "(R1) has potential for impairment to skin integrity r/t (related to) fragile skin and picks at self...Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor)." Care Plan Focus initiated 6/29/16 documents R1 "has potential/actual impairment to skin integrity of the abdomen r/t (related to) surgical wound (pain pump placement)...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage) and any other notable changes or observations."

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On 9/13/16 at 1:15 pm E12 CNA (Certified Nursing Assistant) stated E12 worked on 8/20/16 from 2:00 pm to 10:00 pm. E12 stated E12 noticed a small "open wound where the incision was for (R1's) pump (right abdomen) and saw a little piece of silver." E12 stated E12 didn't know what it was and "it scared me. I went and told the nurse (E8)."

On 9/12/16 at 4:59 pm E8, Registered Nurse (RN), stated the CNA (E12) that put R1 to bed on 8/20/16 reported to E8 that R1 had an open area over the pain pump. E8 stated "I went in and looked and saw an opening in (R1's) skin and I could see the metal part of the pain pump." E8 stated E8 left a message on Z3's (R1's Primary Care Physician) cell phone. E8 stated E8 informed the oncoming, night shift nurse of R1's open area over the pain pump site "since I had not heard from (R1's) doctor. " E8 stated E8 could not remember the name of the night shift nurse. E8 stated "When I said (to oncoming nurse) that (R1) had pain pump surgery she (oncoming nurse) didn't know."

R1's Nurses Notes dated 8/20/16 at 8:31 pm documents "MD (Medical Doctor) called to make aware of open skin area around internal pain pump that patient states was placed a few weeks ago. left message on MD cell phone. Skin does not appear irritated. Cleanse with iodine, warm soapy water, and antibiotic ointment and dressing applied to protect from infection. Waiting for MD to reply to phone message." R1's Nurses Notes dated 8/20/16 at 8:37 pm document "the opening is about 1-2 cm (centimeters) in length and 0.5 cm in width."

On 9/6/16 at 3:30 pm and 9/8/16 at 11:25 am Z1,

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Registered Nurse at Hospital Pain Clinic, stated R1 had internal pain pump replaced on 6/27/16. Z1 stated R1 and was last seen at pain clinic on 8/1/16 and "at that time the pump wound in the abdomen was healed." Z1 stated R1 was to return to the clinic for follow up on 9/1/16 and there were no other instructions. Z1 stated R1's incision site was healed and did not require a dressing.

On 9/8/16 at 11:20 am Z3 (R1's Primary Care Physician) stated Z3 saw R1 on 8/8/16 for a Urinary Tract Infection. Z3 stated Z3 was unaware of R1's open abdominal wound on 8/20/16. Z3 stated Z3 had nothing faxed regarding R1's wound and received no phone messages. Z3 stated "any concerns with the pain pump should have been directed to the pain clinic doctor (Z2, R1's Pain Clinic Physician/Surgeon). No one notified me."

On 9/12/16 at 2:20 pm Z4 (Wound Physician) stated no one notified Z4 of R1's wound on 8/20/16. Z4 reviewed E8 nurses note dated 8/2016 and stated R1's wound should have been cleaned with Normal Saline, or wound cleanser, or betadine and not soap and water.

On 9/12/16 at 11:25 am Z1, RN/Pain Clinic, stated when R1's open area was found on 8/20/16 the pain center should have been notified. Z1 stated "We would have had (R1) seen at the pain center for the doctor (Z2) to evaluate and give orders for treatment. No one notified us that (R1) has an open area over the pump."

On 9/12/16 at 2:40 pm E2, DON (Director of Nursing), stated E8 should have notified E2 of

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R1's open wound when E8 did not receive a treatment order from Z3. E2 stated "I would give the order to send (R1) out (to emergency room). E2 stated there should have been communication with E8 (off going nurse) and the oncoming nurse (E21, RN).

On 9/12/16 at 1:20 pm E21, RN, stated E21 started working at the facility on 8/11/16. E21 stated "I didn't know (R1) had a pain pump till 8/28/16. No nurse ever told me (R1) had a dressing or a wound or a pain pump." E21 stated "(E8, RN) never told me on 8/20/16 about (R1's) open wound and the call to the doctor (when came on duty)."

On 9/8/16 at 3:35 pm E15, Licensed Practical Nurse (LPN) stated E15 worked the day shift on 8/20/16. E15 stated "I knew (R1) had a pain pump on right side of abdomen. I did not check the site during my shift. I don't know if (R1) had an open area. No one reported to me from the previous shift that there was a skin issue (for R1)."

On 9/8/16 at 9:30 am E12 CNA stated E12 gave R1 a shower on 8/22/16. E12 stated R1 had a white dressing on the right side and pointed to E12's right lower abdominal area. E12 stated the dressing "must have had a water proof cover because I gave her a shower."

On 9/8/16 at 11:05 am E14 LPN, stated E14 last saw R1 on 8/26/16 on the second shift. E14 stated "I did (R1's) skin assessment on 8/26/16. (R1) had a dressing (over pain pump area) that was clean, dry, intact, no drainage." E14 stated E14 did not remove the dressing. E14 stated E14 did not recall if there was a date recorded on the

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dressing to identify when the dressing was placed. E14 stated "I was under the impression that the dressing was not to be removed" according to orders from Z2 (R1's Physician/Surgeon at Pain Clinic). E14 stated "As far as I know we were not allowed to touch that dressing (over R1's pain pump incision site). I don't' recall (R1's) current physician orders.

R1's Physician Orders Dated August 2016 does not document orders for R1's pain pump site.

On 9/8/16 at 2:55 pm E12 CNA stated E12 "came in early on the third shift (8/28/16) between 2-3:00 am. E12 stated E12 was providing care to R1's roommate sometime before 4:00 am when E12 heard R1 called "(E12)." E12 stated "I went to (R1) and asked 'What you need (R1)?' E12 stated R1 said "(E12 I don't feel good." E12 stated R1 "looked sweaty and let me wash (R1) up. (R1) was wearing a hospital gown that there was brown stain (on the gown) and thought for a minute that (R1) had a BM (bowel movement). I looked and it was the dressing on (R1's) right abdomen over the pump. The dressing was full. The whole dressing was saturated and it (drainage) came through on the gown. I didn't smell an odor. I put clean gown on (R1)." E12 stated E12 rolled R1 onto R1's right side to finish R1's bed bath and provide perineal care. E12 stated R1 did not have a bowel movement. E12 stated E12 then called for E18, CNA, to "help me pull (R1) up in bed." E12 stated (E18) then went to get E13, Licensed Practical Nurse. E12 stated E12 remained with R1 until E13 came in R1's room. E12 stated "I told E13 about the drainage on R1's dressing over pump area." E12 stated E12 then left R1's room. E12 stated when it was time to get residents up for day shift "I was (R1's)

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aide on days. I asked (E11, Licensed Practical Nurse, LPN) if I can get (R1) up. E11 said 'Yes.'" E12 stated "Me (E12) and (E18) got (R1) up into the wheelchair." E12 stated R1 still had the same dressing on that was saturated with brown stain. E12 stated E12 then took R1 to the dining room for breakfast. E12 stated "(R1) was groggy. (R1's) eyes were closed." E12 stated R1's Foley (catheter) was draining a brownish color of urine. E12 stated E12 brought R1 from the dining room and "placed (R1) in the room until all the residents were out of the dining room. Then about 11:00 am, I put (R1) back into bed. Another aide (E18) helped me put (R1) back into bed. The brown stain was coming through (R1's) gown. (R1) never complained. I changed (R1's) gown and I told (E11) about (R1's) dressing. The next think I know they (ambulance) were coming to get (R1)."

On 9/13/16 at 9:20 am E18, CNA, stated E18 worked from 10:00 pm on 8/27/16 to 6:00 am on 8/28/16. E18 stated R1 "wasn't looking right. She (R1) was sweating and I got a towel and washed her fact then I went and told (E13, LPN) that (R1) wasn't looking her normal self." E18 stated E18 saw E13 go into R1's room and gave R1 a breathing treatment. E18 stated E18 went to help E12, CNA, get R1 up for breakfast. E18 stated there was a brown stain on R1's gown. E18 stated the brown stain came from the leaking dressing on R1's right side. E18 stated E12 got R1 cleaned up then ready for breakfast. E18 stated R1 stood up "but needed more help than usual."

On 9/12/16 at 1:40 pm E13, LPN, stated E13 worked from 6:00 pm on 8/27/16 to 6:00 am on 8/28/16. E13 stated "I was (R1's) nurse. E13

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stated E13 did not know if R1 had a dressing or not. E13 stated E13 gave R1 a breathing treatment that morning and put oxygen on per nasal cannula at two (2) liters per minute. E13 stated R1's oxygen saturation level was 90% before the breathing treatment and 96% after the breathing treatment. E13 stated "No one ever informed me that (R1) had a dressing over the pain pump."

On 9/12/16 at 12:40 pm E17, CNA stated E17 worked on 8/28/16 on the day shift from 6:00 am to 2:00 pm. E17 stated "I saw (R1) during breakfast in the dining room. (R1) looked a little sleepy. I don't know whether she ate or not." E17 stated sometime after breakfast E12 walked past me and mentioned (R1) wasn't feeling good. E17 stated "(R1) was in bed lying on her back and I smelled an odor like a sore or something. There was drainage on (R1's) gown on the right side. It was dark brown like coffee and smelled like an open sore. (R1) was breathing hard and had oxygen on. (R1's) eyes were closed. (R1) could shake her head but wasn't talking. This was not (R1's) normal. She always talked a lot. It wasn't like her to be quiet. She was always fussing with clothes and always had something to say. So this wasn't her normal." E17 stated "This was close to 9:00 am. So I stayed with (R1) and E20 (CNA) went to get (E11). E11 came and said to me that (R1) was smiling early in the morning. (E11) was concerned about (R1) and looked at the drainage then I left (R1's) room."

On 9/12/16 at 1:08 pm E20, CNA, stated E20 worked on 8/28/16 from 6:00 am to 2:00 pm. E20 stated R1's dressing over the pump site "was wet." E20 stated E20 smelled an odor that "smelled like infection to me." E20 stated the

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drainage was "brownish looking" and leaked onto R1's gown. E20 stated "I remember telling (E11, LPN) and (E11) looked at it (R1's dressing)."

On 9/8/16 at 4:00 pm E11, Licensed Practical Nurse (LPN) stated E11 was R1's nurse on 8/28/16 during the 6 am to 2 pm day shift. E11 stated E11 did not receive any information that R1 had a dressing or drainage over the internal pump site in R1 lower right abdomen when came on duty. E11 stated "No one reported to me until after lunch (on 8/28/16) when E12, CNA or E17, CNA, told me (R1) had drainage, nasty smelling around (R1) pain pump with drainage on (R1's) gown. I went in (into R1's room) and removed the dressing (over the pain pump) and the pain pump was sticking out of the skin." E11 stated R1's open wound was about 2 1/2 inches by 1 1/2 inches. E11 stated E11 did not measure the area. E11 stated "I cleaned the area (R1's wound) with Normal Saline and gauze and left it (wound) open." E11 stated R1 was "having difficulty breathing." E11 stated R1's oxygen saturation level was 96%. E11 stated R1's Blood Pressure was 60/40, Temperature was 98.2 degrees Fahrenheit, and Pulse was 76 beats per minute. E11 stated E13, LPN/night shift nurse, said to E11 that "(R1) was having trouble breathing. E13 did not say a word about the drainage at the pump site. Don't know if (E13) knew about it. I did (R1's) vitals myself and called (ambulance) then called family, then (Z3) (R1's Primary Care Physician)." E11 stated R1 had the pain pump for years for back pain.

R1's Nurses Notes dated 8/28/16 document the following: at 12:44 pm "...vs (Vital Signs) t (Temperature) 98.1 (degrees Fahrenheit) p (Pulse) 76 r (Respirations) 28 bp (Blood

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Pressure) 60/40." ... at 12:47 pm " (Z3, R1's Primary Care Physician) called, order received to send pt (patient, R1) out for evaluation." ...at 12:49 pm "das (Decatur Ambulance Service) called to transport pt. to er (emergency room) at (local hospital) for evaluation." ...at 1:00 pm documents "das here resident transported to (local hospital) per stretcher for evaluation."

R1's Hospital Emergency Room report dated 8/28/16 documents R1 arrived at the emergency room on 8/28/16 at 1:33 pm. The report documents "EMS (Emergency Medical Services) stated that the patient (R1) is septic with fever and SOB (Shortness of Breath). EMS stated that the patient has a pain pump on the right side of her abdomen." R1's abdominal assessment documents "Distended: Non-Tender: Normal Bowel Sounds: Other (Pain pump partially exposed in abdominal wall with erythema...)."

R1's Ambulance Incident Log Report dated 8/28/16 documents response to the facility on 8/28/16 at 12:46 pm. The report documents at 12:48 pm "Going Septic-Pain Pump draining and B/P (Blood Pressure) 60/40 R (Respirations) 28 P (Pulse) 76- 96% on 2 LPM (Liters of oxygen per minute) and going downhil (downhill). The report "Narrative" documents "...FOUND PT (Patient, R1) IN NH (Nursing Home) AND RN (Registered Nurse) STAFF STATES SHE IS NOT REAL FAMILIAR WITH THE PT. RN STATES PT HAD A PAIN PUMP A COUPLE DAYS AGO AND IT HANGING OUT OF THE INCISION SITE. PT HAS HX (History) OF CA (Cancer) AND IS A DNR (Do Not Resuscitate). ALS (Advanced Life Support) ASSESSMENT PERFORMED AND VITALS OBTAINED AS NOTED. PT HAS APPROX 4 1/2 INCH ROUND SILVER OBJECT

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HANGING OUT OF INCISION SITE IN LRQ (Lower Right Quadrant of Abdomen) PT O2 (Oxygen) SAT (Saturation) 80% ON O2 2 L'S (Liters)/NC (Nasal Cannula)...PT LRQ IS VERY DISTENDED, RED AND HOT TO TOUCH. PT PLACED ON CARDIAC MONITOR WITH ST (Sinus Tachycardia, rapid heart rate). PT O2 SAT INCREASED TO 88% AND PT BP HAD NO SIGNIFICANT CHANGE..."

On 9/12/16 at 8:46 am Z5, Paramedic for Ambulance Service, stated when arrived at the facility on 8/28/16 the nurse stated "I am not the normal nurse and handed me (R1's) DNR sheet." Z5 stated the nurse then said to Z5 "Let me show you this" and pulled (R1's) dressing back. Z5 stated R1's abdominal wound was dry and "looked as if it happened days ago. It (the wound) did not look like a fresh wound. Very red. (R1's) abdomen was distended. (R1) was cool and clammy. (R1) had every indicator that (R1) was in Septic Shock. (R1) was non-verbal and very lethargic. In 26 years I've never seen anything like this. Never seen a pain pump hanging out. Half of the pain pump was hanging out of (R1's) wound. The opening (wound) was about six (6) inches long and 1 1/2 inches wide and three (3) inches of the pump was hanging out."

R1's Emergency Room "Disposition" dated 8/28/16 documents "Patient (R1) brought in from nursing home for evaluation of change in mental status and shortness of breath with fever. She (R1) has intrathecal pain pump extruding from the abdominal wall with erythema and discharge around it (pump). Patient was hypotensive and IV (Intravenous) fluids started and septic workup done. Patient has Normal WBC (White Blood

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Count) 9.7 but bandemia of 24. Renal failure with BUN (Blood Urea Nitrogen) 49, Creatinine 4.1... (Z2, R1's Pain Clinic Physician, Surgeon) was contacted and will be coming to remove the pain pump..." The report documents "Sepsis Signs and Symptoms: Hyperthermia >38.3, Altered Mental Status, Tachycardia >90bpm (beats per minute). Sepsis Status: Severe Sepsis: S&Sx (Signs and Symptoms) + Organ dysfunct (dysfunction)..."electronically signed by Z14 Emergency Physician Provider.

R1's Hospital Discharge Summary report dated 9/2/16 documents "Reason for Admission-brought in to ED (Emergency Department) for further evaluation of fever, shortness of breath, altered mental status. Patient (R1) was noted to have Infected pump pocket with dehiscence of wound and expression of pump through wound in RLQ (Right Lower Quadrant)...Intrathecal pain pump explanted on 8/28/16...Subsequently during hospital course, patient's (R1's) symptoms and clinical condition deteriorated...Patient expired and pronounced dead on 9/2/16 at 1259 hours (12:59 pm)... (Final Diagnoses: 1. Septic Shock: likely due to pain pump site infection and/or HCAP (Healthcare associated pneumonia) and/or Complicated UTI (Urinary Tract Infection)...Blood culture 8/28/16: coagulace-negative Staphylococcus, Urine culture 8/28/16: Escherichi coli and Klebsiella pneumoniae, Abdominal wound culture 8/28/16: Staphylococcus aureus, Klebsiella pneumonia, Providencia stuartii, Proteus mirabilis. 2. Acute Respiratory Failure, Hypoxic: 3. Atrial fibrillation with RVR: 4. Acute Kidney Injury, nonoliguric: due to septic shock 5. History of CVA (Cerebral Vascular Accident, Stroke) with right residual weakness 6. Dementia 7. FBSS (Failed Back Surgery Syndrome);

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requiring intrathecal programmable pain pump implantation 6/2016 (June 2016) electronically signed by Z7(Hospitalist/Physician).

R1's "State of Illinois Certificate of Death Worksheet" dated 9/6/16 documents R1's date of death occurred on 9/2/16 as a hospital inpatient and documents "Septic Shock" as the R1's cause of death, certified by Z7.

On 9/12/16 at 9:15 am Z7 (R1's Hospitalist/Physician in Charge on Death Certificate) stated R1 came into the hospital with Septic Shock. Z7 stated the primary site of R1's Septic Shock was the pain pump. Z7 stated the pain pump site was infected.

On 9/7/16 at 3:46 pm Z2 (R1's Pain Clinic Physician/Surgeon) stated R1 was fine when seen at the clinic on 8/1/16. Z2 stated R1 was brought into the emergency room on 8/28/16 with the "pump breaking through the wound and the metal portion of the pump exposed. Never seen anything like this to break open like this. It appeared to be days and days in the making. The edges (of the wound) were retracted and didn't look fresh. I cannot for the life of me know how (R1) was changed and bathed and no one noticed."

On 9/14/16 at 10:05 am E2 DON stated that E2 saw R1's original progress note by E8, which documented R1's open area over the pain pump site measuring 1-2 cm x 0.5 cm. E2 stated there was no "User Defined Assessment (UDA) which is to be completed on all new open areas when found. E2 stated E8 should have completed a UDA on 8/20/16. E2 stated E14 did R1's skin check and documented on R1's Treatment

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Administration Record that R1's skin "was intact." E2 stated if R1 had a dressing on at that time then E14 should have documented the dressing on the skin assessment and reviewed R1's physician orders for treatment. E2 stated if there were no physician orders for R1's wound treatment then E14 should have called Z3 for orders and documented in the progress notes. E2 stated when E12 (CNA) found R1 with leaking dressing on 8/28/16 (on the night shift) E12 should have reported to the nurse immediately and should not have been moved R1 until the nurse found R1 safe to be moved. E2 stated there was no documentation, assessments, treatments or care found in R1's medical record that addressed R1's wound since the initial assessment and treatment on 8/20/16 in the progress notes. E2 stated there is no documentation in R1's record that a physician was reached for treatment orders for R1's wound. E2 stated "If a wound is not treated it (wound) can become infected, septic, necrotic."

On 9/19/16 an Immediate Jeopardy was identified. The immediate jeopardy situation began on 8/20/16 when the facility identified R1's open abdominal wound at the internal pain pump site and neglected to follow policies for skin assessment, wound assessment, and physician notification. R1's wound was untreated for eight days resulting in wound drainage, infection, and the expulsion of an internal abdominal pump. E1 was notified of the Immediate Jeopardy on 9/19/16 at 3:30 pm.

The surveyor was able to confirm through record review and interview that the facility took the

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F 224	Continued From page 30 following actions to remove the immediacy: The Director of Nursing (DON) educated all licensed nurses on the Wound policy including evaluation and treatment on 9/15/16. Two nurses have not return call and have been removed from the schedule until education is completed. The licensed nurses conducted skin audits on all residents on 9/16/16, 9/17/16, 9/18/16, and 9/19/16. In addition to the resident's weekly skin check and additional skin check will be completed by licensed nurses ensuring resident's skin will be evaluated by a licensed nurse twice a week for two (2) months or until resolved. The DON and/or Nurse Manager will review all of the resident skin audits and do random audits weekly.	F 224		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		

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$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to accurately assess skin conditions on the dietary assessment for two of five residents (R2 and R3) reviewed for accuracy of assessments in the sample of five.

Findings include:

1) R2's Physician's Progress Note dated 9/1/16 at 12:49pm documents R2's diagnoses including Left Hip Surgery, Alzheimer's Disease, Hypertension, Cerebrovascular Accident, Coronary Artery Disease and Atrial Fibrillation.

R2's Wound Report dated 9/8/16 at 10:54am documents R2 has a Stage 2 left heel open pressure area measuring 10 cm (centimeter) by 4 cm.

R2's Dietary Assessment dated 9/8/16 at 2:39pm documents R2's skin as intact.

On 9/20/16 at 2:50pm, E2, Director of Nursing verified the Dietary Assessment did not document R2's Stage 2 left heel pressure ulcer.

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F 278	Continued From page 32 2) R3's Order Recap Report dated 9/12/16 documents R3's diagnoses including Vitamin D Deficiency, Chronic Ischemic Heart Disease, Heart Failure and Colostomy. R3's Skilled Documentation dated 7/6/16 documents R3 has an abdominal wound. R3's Dietary Evaluation dated 7/13/16 documents R3's skin is intact. There is no documentation that the dietician evaluated R3's abdominal wound. On 9/21/16 at 10:40am, E2, Director of Nursing stated she would expect the dietician to assess nutritional needs regarding wounds and make recommendations based on those needs. E2 stated E26, Quality Assurance nurse monitors the wounds and gives a report to the E24, Dietary Manager who then notifies the dietician of skin concerns. E2 verified there is no documented dietician assessment for R3's abdominal wound. The facility's undated Dietary Documentation Policy documents, "... Admit, Quarterly and Sig (significant) change assessment and/or documentation should include the following... skin condition... supplements ordered... Dietary Manager will notify the Dietician for the following conditions... Pressure Ulcers... other non-healing wounds..."	F 278		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to administer wound treatments per physician orders and failed to follow physician's orders for administration of medication. These failures affect three residents (R1, R3, R5) of five residents reviewed for wounds on the sample of five residents and one of five residents (R2) reviewed for accuracy of assessments in the sample of five.

Findings include:

1. R1's Skin Assessment dated 7/14/16 documents R1 is at risk for skin breakdown. R1's Physician Order Sheet dated August 2016 documents the following diagnoses: Cerebral Infarction due to Embolism of Unspecified Cerebral Artery, Abnormal Posture, Age-Related Osteoporosis with Current Pathological Fracture, Vertebra, Hemiplegia Unspecified Affecting the unspecified side, Muscle Weakness, Neuromuscular Dysfunction of bladder, and Urinary Tract Infection.

R1's Care Plan dated 6/21/16 documents "(R1) has potential for impairment to skin integrity r/t (related to) fragile skin and picks at self...Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor)."

R1's Minimum Data Set (MDS) dated 7/14/16 documents R1 is cognitively intact and requires the extensive assistance of two staff for bed

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mobility, transfers, toileting, and bathing.

On 9/4/16 at 3:46 pm E14, Licensed Practical Nurse (LPN) stated R1 has had an open wound on the right elbow intermittently since E14 started at the facility on 1/19/15. E14 stated R1 would sit in the wheelchair and lean to the right, which was R1's normal posture because of R1's back. E14 stated R1's right elbow would bump the door frame as R1 entered the room or bump other resident's wheelchairs or hallway railing. E14 stated R1 wore a "special sleeve from below the elbow to above the elbow with a very thick pad to protect the elbow." E14 stated that the sleeve covered the dressing but when the elbow healed and dressing treatments ended there wasn't anything under the elbow to hold up the special sleeve. E14 stated "there was nothing else that I am aware of that was used to protect (R1's) elbow."

R1's Administration Note dated 5/1/2015 documents "...Res wound to (right) elbow healed."

R1's Progress Notes dated 5/4/15 documents "New order obtained post Res (resident, R1) being seen by (E8, Wound Physician). Res cont to have red, weeping, warm to touch dermatitis to R elbow. (Z8) gave new orders to, Cleanse R elbow with NS, cover rash with Nystop, apply foam pads, and wrap with Kerlix BID. Res also to F/U (follow-up)with dermatology..."

R1's Progress Notes dated 6/25/15 documents "Res was transported via facility transport to (Z12, Dermatologist) office. (Z13) nurse from Z12's office called Writer and ADON (Assistant Director of Nursing) accusing staff of not doing tx

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(treatment) changes on Res R (right) elbow and not providing adequate care....(Z13) stated that (Z12's) staff refuses to remove tx (treatment) to Res RUE (Right Upper Elbow) and will not assess RUE until tx is removed from facility staff... (Z13) cont (continued) to accuse staff of not providing adequate care..."

R1's "Wound Care Specialist Evaluation" dated 8/31/15 documents R1 has a wound on the right elbow. The evaluation report documents "(R1) presents with a wound of the right, sec (secondary) to trauma elbow of at least 24 days duration. There is moderate serous exudate." The wound size is 2.0 x 1.8 x not measurable centimeters (cm) with moderate serous exudate and 50% yellow necrotic, 50% granulation tissue. The report documents that wound progress is "deteriorated."

R1's Care Plan dated 11/23/15 documents "(R1) has a "Dermal rash with open area of R (right) elbow...provide treatment as ordered...."

R1's Nurses Notes dated 10/2/2015 documents "Phoned (Hospital) r/t (related to) intrathecal pain pump change appointment. Pump was not changed r/t possible elbow wound infection. Notified ....of findings.

R1's "Weekly Skin Observations" dated 10/9/2015 08:00 documents R1's "Skin is warm, dry, within normal limits...Skin concerns observed: Right elbow - open wound to right elbow. Skin concerns observed are not new."

On 9/6/16 Z1 (Registered Nurse at Hospital Pain Center) stated "First noticed (R1's) wound on 12/19/14 wound was open with cellulitis of the

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right elbow and was sent to ER (Emergency room) to have that evaluated." Z1 stated that on 9/30/15 R1's elbow wound was still open and was draining. Z1 stated there was a 4 x 4 gauze dressing "nothing of significance" and the gauze was "damp with drainage." Z1 stated Z1 saw R1 next at the Pain Center on 10/8/15 and R1 still had open elbow wound. Z1 stated Z3 (Pain Center Physician/Surgeon) "insisted (R1) go to the wound clinic at (local hospital) for treatment." Z1 stated on 5/2/16 R1's elbow wound was healed and R1 was scheduled to have the pain pump changed on 6/27/16. Z1 stated R1's pain pump could not be changed until the elbow wound was healed.

The following information is a listing of treatments prescribed for R1's right elbow wound in September 2015, October 2015, November 2015, December 2015, and January 2016 with documentation found in R1's Treatment Administration Record that the treatments were not signed off as done:

R1's Physician Orders dated September 2015 documents R1's order for Bactroban Ointment 2% "Apply to to right elbow topically every day and evening shift for wound for 10 days. Cover with gauze and wrap with kerlix." R1's Treatment Administration Record dated September 2015 documents R1's right elbow treatment for Bactroban was not signed off (initialed by nurse) that the treatment was done on 9/1/15, 9/2/15, 9/3/15, 9/4/15, and 9/5/15.

R1's Physician Orders dated September 2016 documents an order on 9/8/16 for Santyl Ointment 250 unit/Gram (gm) "apply to right elbow topically every evening shift for open elbow

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wound. Cleanse wound with NS (Normal Saline)/gauze. Apply skin prep to wound edges. Moisturize arm with cerave (moisturizing cream); Apply santyl and bactroban (antibiotic ointment) to wound only; cover with calcium alginate NO silver; apply foam and ABD (Abdominal pad/dressing cover); wrap with kerlix and secure with tape." R1's Treatment Administration Record dated September 2015 documents R1's right elbow treatment as described above was not signed off on 9/14/15.

R1's Physician Orders dated October 2015 documents R1's order dated 10/6/15 for Santyl Ointment 250 unit/Gram (gm) "apply to right elbow topically every evening shift for open elbow wound. Cleanse wound with NS (Normal Saline)/gauze. Apply santyl to affected area, apply wet to dry dressing change daily wrap with kerlix, secure with tape." R1's Treatment Administration Record dated October 2015 documents R1's right elbow treatment as described above was not signed off that the treatment was done on 10/7/15, 10/9/15, 10/16/15, 10/20/15, 10/24/15, 10/29/15, and 10/30/15.

R1's Physician Orders dated October 2015 documents R1's order for Bactroban Ointment 2% "Apply to to right elbow topically every evening shift for wound related to open wound of elbow, complicated. Cleanse wound with NS/gauze. Apply cerave to arm; Apply santyl and bactroban to wound; Apply skin prep to periwound; cover wound with calcium alginate; apply foam dressing and ABD pad; wrap with kerlix then secure with tape; Wound nurse follow." R1's Treatment Administration Record dated October 2015 documents R1's right elbow

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treatment as described above was not signed off that the treatment was done on 10/7/15, 10/9/15, 10/16/15, 10/20/15, and 10/23/15.

R1's Physician Orders dated November 2015 documents R1's order start date for 11/25/15 to clean right elbow with Normal Saline, apply Aquacel AG, pack tunnel at 12 O'Clock use residol on periwound skin wrap with kerlix, change every two (2) days or prn every day shift every two days for altered skin integrity. R1's Treatment Administration Record dated November 2015 documents R1's right elbow treatment as described above was not signed off that the treatment was done on 11/25/15 and 11/29/15.

R1's Physician Orders dated December 2015 documents R1's order to clean right elbow with Normal Saline, apply Aquacel AG, pack tunnel at 12 O'Clock use residol on periwound skin wrap with kerlix, change every two (2) days or prn every day shift every two days for altered skin integrity. R1's Treatment Administration Record dated December 2015 documents R1's right elbow treatment as described above was not signed off that the treatment was done on 12/8/15, 12/10/15, and 12/16/15.

R1's Physician Orders dated December 2015 documents R1's order start date of 12/12/15 for Nystatin Powder to apply to right elbow topically every day and evening shift for wound and pack right elbow wound with Aquacell. R1's Treatment Administration Record dated December 2015 documents R1's right elbow treatment as described above was not signed off that the treatment was done on 12/24/15, 12/27/15, 12/28/15, and 12/30/15.

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R1's Physician Orders dated January 2016 documents R1's order for Nystatin Powder to apply to right elbow topically every day and evening shift for wound and pack right elbow wound with Aquacell. R1's Treatment Administration Record dated January 2016 documents R1's right elbow treatment as described above was not signed off that the treatment was done on the day shift on 1/6/16, 1/8/16 and 1/9/16 nor was treatment signed off as ordered on the evening shift on 1/8/16. The order was discontinued on 1/10/16.

R1's Physician Orders dated January 2016 documents R1's order dated 1/11/16 for Nystatin Powder to apply to right elbow topically every day shift. R1's Treatment Administration Record dated January 2016 documents R1's right elbow treatment as described above was not signed off that the treatment was done on 1/11/16, 1/12/16, 1/13/16, 1/19/16, 1/20/16 and 1/21/16.

R1's Physician Orders dated January 2016 documents R1's order dated 1/4/16 for Acticoat (wound dressing) to apply one application transdermally every day shift every two days for prophylaxis remove dressing and cleanse with Normal Saline; Continue using antifungal to periwound skin, place Acticoat to wound bed, cover with foam or gauze and secure bandage so it doesn't fall down off wound; Change entire dressing every two days and as needed. R1's treatment for Acticoat was not obtained from the pharmacy until 1/7/16. R1's Treatment Administration Record dated January 2016 documents R1's right elbow treatment as described above was not signed off that the treatment was done on 1/4/16, 1/6/16, 1/8/16,

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1/10/16, and 1/12/16.

R1's Physician Orders dated January 2016 documents R1's order dated 1/24/16 for "Wound clinic to see res (resident, R1) per (Z11, Nurse Practitioner). Dressing not to be changed in facility at all. May reinforce dressing but do not remove original dressing. To be done per wound clinic only."

On 9/7/16 at 4:10 pm E9, Registered Nurse, stated resident's wound treatments are recorded on the Treatment Administration Record and initialed by the nurse that performs the treatment. E9 stated "to my understanding if there are no initials (by the nurse) then it (treatment) wasn't done."

2. R3's Hospital Encounter documents R3 was admitted to the hospital on 7/29/16 at 12:34 pm with the diagnoses of "Malignant neoplasm of ascending colon, Abdominal wall abscess, Status post surgery, Intractabel (Intractable) vomiting with nausea, vomiting of unspecified type."

R3's Physician Orders dated June 2016 documents an abdominal wound treatment order to start on 6/17/16 for "Wet to dry dressing change twice daily. Cleanse wound with NS (Normal Saline) and sterile gauze. Place sterile moistened gauze in wound, cover with dry dressing and secure with ABD (Abdominal pad). Monitor for s/s (signs and symptoms) of infection, redness and swelling..." R1's Treatment Administration Record documents the above treatment was discontinued on 8/2/16.

R3's Physician Orders dated August 2016 documents a treatment order to start on 8/3/16

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for "Santyl Ointment 250 unit/GM (gram) Apply to abdominal wound topically every day shift for abdominal wound top with moist gauze and cover with ABD pad."

R3's Treatment Administration Record dated June 2016 documents R3's abdominal wound treatment was not signed off that the treatment was done on 6/20/16 (evening shift), 6/25/16 and 6/26/16 (on day shift).

R3's Treatment Administration Record dated August and September 2016 document R3's abdominal wound treatment was not signed off that the treatment was done on 8/3/16, 8/8/16, 8/12/16, 8/15/16, 8/17/16, 8/21/16, 8/22/16, 8/25/16, 8/26/16, 8/31/16, and 9/1/16.

On 9/7/16 at 11:15 am E5, Registered Nurse (RN), stated according to R3's Treatment Administration Record dated August 2016 "there is no documentation that (R3's) dressing was changed on 8/3/16, 8/8/16, 8/12/16, 8/15/16, 8/17/16, 8/21/16, 8/22/16, 8/25/16, 8/26/16, 8/31/16, and 9/1/16.

On 9/7/16 at 11:26 am and 1:45 pm E2 DON (Director of Nursing), stated treatments are signed off on the resident's Treatment Administration Record by initials of the nurse. E2 stated if there are no initials for the treatment then the treatment wasn't done. E2 confirmed R3's Wet to dry dressing for the abdominal wound was not documented as done on 6/20/16, 6/25/26, and 6/26/16. E2 confirmed that R3's Santyl treatment was not documented as done on 8/3/16, 8/8/16, 8/12/16, 8/15/16, 8/17/16, 8/21/16, 8/25/16, 8/26/16, 8/31/16 and 9/1/16. E2 stated "If it's not documented it didn't happen."

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On 9/7/16 at 1:10 pm E5, Registered Nurse, after cleansing R3's abdominal wound with Normal Saline and E5 picked up the sterile gauze and placed it into a container with Normal Saline and packed the gauze into R3's abdominal wound. E5 then secured the abdominal pad covering R3's wound.

On 9/20/16 at 10:12 am E2 DON stated R3's Physician Order for the abdominal wound treatment "did not say to pack the wound." E2 stated E5, RN, should not have packed R3's abdominal wound."

3. According to the electronic Medical Diagnosis list, R5 has multiple diagnoses including Dementia, Chronic Obstructive Pulmonary Disease and Non-pressure Chronic Ulcer, and receives Hospice services.

On 9/8/16 at 10:00am, E4 (Licensed Practical Nurse) did the treatments to R5's pressure sores and the chronic wound on the right hip. The hip wound was a pea-size crater from which E4 removed the dressing and small amount of packing. E4 reported that the treatment for R5's wound was packing with Dakin's solution (bleach) and dressing to cover. After cleansing the area with normal saline, took packing from the bottle labeled Iodoform (iodine)gauze, and wet it from the bottle labeled Sodium Hypochlorite (bleach) solution. E4 lightly packed the wound and covered with foam dressing.

The electronic Physician's Order by Z4 (wound doctor) dated 8/30/16 states, "Cleanse right hip wound with normal saline. Loosely pack top of wound with iodoform. DO NOT PACK THE

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ENTIRE WOUND. Cover with bordered foam dressing daily and PRN (as needed."

On 9/8/16 at 12:20am, E4 looked at the bottles used for R5's treatment and confirmed she took the Iodoform gauze and wet it with the Dakin's solution, and packed the wound. E4 looked at the Physician's Order and the TAR (treatment administration record) and found the order dated 8/30/16 and stated, "They changed it. It was just the Dakin's solution. I didn't even look at the order."

On 9/8/16 at 1:00pm, E2 (Director of Nursing) confirmed that R5's treatment order was changed and that E4 should have checked the order.

The untitled facility policy titled "Skin Assessment Policy and Procedure" documents " ... It is the policy of this facility to monitor the skin integrity for signs of injury and irritation...Purpose to continually inspect the resident's skin for early signs of pressure ulcer development and other abnormalities...Residents who are determined "AT RISK" for the development of pressure ulcer will have a head-to-toe skin assessment done by a licensed nurse weekly and documented on the Treatment Administration Record (TAR)..."

The undated facility policy titled "Wound Assessment Policy and Procedure" documents "It is the policy of the facility to do ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities...A description of the wound will be noted and the physician will be notified for an appropriated treatment order to be implemented... Upon any change in wound status the assessment will be updated, the physician will

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be notified promptly to obtain treatment orders that will be implemented..."

4. R2's Physician's Progress Note dated 9/1/16 at 12:49pm documents R2's diagnoses including Left Hip Surgery, Alzheimer's Disease, Hypertension, Cerebrovascular Accident, Coronary Artery Disease and Atrial Fibrillation.

R2's Progress Notes dated 9/5/16 at 4:42pm document R2 was sent to the hospital for an evaluation of the left hip. R2's left hip site of previous fracture was noted to be swollen, bruised and warm to touch. At 8:36pm, R2 returned to the facility with diagnoses of Postoperative Hematoma of subcutaneous tissue and Supratherapeutic International Normalized Ratio (INR).

R2's Emergency Care Center Discharge Instructions dated 9/5/16 document, "... Hold Coumadin (Anticoagulant) today and get repeat INR tomorrow. Call {Z15, R2's Orthopaedic Physician} with results and further instructions on further Coumadin use..."

R2's Progress notes dated 9/6/16 at 5:45pm document, "...received an order from {Z15's} office r/t (related to) resident's {R2's} PT (Prothrombin Time)/INR results from this morning PT 31.0 INR 2.9, Coumadin was held last night... was given new orders of Coumadin 2mg (milligrams) PO (by mouth) daily..."

R2's Progress notes dated 9/6/16 at 5:59pm documents, "Coumadin 4mg was given prior to receiving new Coumadin order." R2 was given Coumadin 4mg before receiving the order to administer Coumadin 2mg.

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F 282	Continued From page 45 On 9/20/16 at 2:10pm, E2, Director of Nursing stated she would expect the nurses to wait to administer Coumadin until an order is received based on the PT/INR lab results. The facility's undated Medication Administration Policy documents, "... Verify Physician order... Administer the medication..."	F 282		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assess, treat, and provide services for one of five residents (R1) reviewed for wounds on the sample of five residents. These failures resulted in R1's abdominal wound left untreated for eight (8) days. The wound become infected, R1's internal abdominal pain pump protruding through the wound, with subsequent Septic Shock and R1's death. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 9/20/16, the facility remains out of compliance at severity	F 309		

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level two. The facility is in the process of evaluating the effectiveness of staff re-education for resident skin and wound assessments, physical assessments, change in condition and physician notification.

Findings include:

R1's Physician Order Sheet dated August 2016 documents the following diagnoses: Cerebral Infarction due to Embolism of Unspecified Cerebral Artery, Abnormal Posture, Age-Related Osteoporosis with Current Pathological Fracture, Vertebra, Hemiplegia Unspecified Affecting the unspecified side, Muscle Weakness, Neuromuscular Dysfunction of bladder, and Urinary Tract Infection.

R1's Minimum Data Set (MDS) dated 7/14/16 documents R1 is cognitively intact and requires the extensive assistance of two staff for bed mobility, toileting, and bathing. The MDS documents R1 has an indwelling urinary catheter and is at risk for pressure ulcers. R1's Skin Assessment dated 7/14/16 documents R1 is at risk for skin breakdown.

R1's Care Plan initiated on 6/21/16 documents "(R1) has potential for impairment to skin integrity r/t (related to) fragile skin and picks at self...Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor)." Care Plan Focus initiated 6/29/16 documents R1 "has potential/actual impairment to skin integrity of the abdomen r/t (related to) surgical wound (pain pump placement)...Weekly treatment documentation to include measurement

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of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage) and any other notable changes or observations."

R1 ' s TAR (Treatment Administration Record) documents that no skin check was completed on 8/5/16.

On 9/13/16 at 1:15 pm E12 CNA (Certified Nursing Assistant) stated E12 worked on 8/20/16 from 2:00 pm to 10:00 pm. E12 stated E12 noticed a small "open wound where the incision was for (R1's) pump (right abdomen) and saw a little piece of silver." E12 stated E12 didn't know what it was and "it scared me. I went and told the nurse (E8)."

On 9/12/16 at 4:59 pm E8, Registered Nurse (RN), stated the CNA (E12) that put R1 to bed on 8/20/16 reported to E8 that R1 had an open area over the pain pump. E8 stated "I went in and looked and saw an opening in (R1's) skin and I could see the metal part of the pain pump." E8 stated E8 left a message on Z3's (R1's Primary Care Physician) cell phone. E8 stated E8 informed the oncoming, night shift nurse of R1's open area over the pain pump site "since I had not heard from (R1's) doctor. " E8 stated E8 could not remember the name of the night shift nurse. E8 stated "When I said (to oncoming nurse) that (R1) had pain pump surgery she (oncoming nurse) didn't know."

R1's Nurses Notes dated 8/20/16 at 8:31 pm documents "MD (Medical Doctor) called to make aware of open skin area around internal pain pump that patient states was placed a few weeks ago. left message on MD cell phone. Skin does not appear irritated. Cleanse with iodine, warm

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soapy water, and antibiotic ointment and dressing applied to protect from infection. Waiting for MD to reply to phone message." R1's Nurses Notes dated 8/20/16 at 8:37 pm document "the opening is about 1-2 cm (centimeters) in length and 0.5 cm in width."

The untitled facility policy titled "Skin Assessment Policy and Procedure" documents "Intact, healthy skin is the body's first line of defense. It is the policy of this facility to monitor the skin integrity for signs of injury and irritation...Purpose to continually inspect the resident's skin for early signs of pressure ulcer development and other abnormalities...Residents who are determined "AT RISK" for the development of pressure ulcer will have a head-to-toe skin assessment done by a licensed nurse weekly and documented on the Treatment Administration Record (TAR)..."

The undated facility policy titled "Wound Assessment Policy and Procedure" documents "It is the policy of the facility to do ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities...To document an accurate, ongoing assessment of wounds in the medical record...Procedure 1. The presence of wounds, ulcers, and/or other skin abnormalities will be indicated on the admission nursing assessment, weekly skin assessment or identified at any other time. 2. A completed wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairments in the skin integrity. 3. A description of the wound will be noted and the physician will be notified for an appropriated treatment order to be implemented. 4. A weekly comprehensive assessment of each wound will be done until healed including site,

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classification/type, stage, measurements, drainage, odor, healing process, and condition of surrounding skin. 5. Upon any change in wound status the assessment will be updated, the physician will be notified promptly to obtain treatment orders that will be implemented. 6. Care Plan will be updated with changes."

The facility's undated "Change in Resident Condition" policy documents "Our facility shall promptly notify the resident, his or her Attending Physician or designee, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

On 9/6/16 at 3:30 pm and 9/8/16 at 11:25 am Z1, Registered Nurse at Hospital Pain Clinic, stated R1 had internal pain pump replaced on 6/27/16. Z1 stated R1 and was last seen at pain clinic on 8/1/16 and "at that time the pump wound in the abdomen was healed." Z1 stated R1 was to return to the clinic for follow up on 9/1/16 and there were no other instructions. Z1 stated R1's incision site was healed and did not require a dressing. On 9/12/16 at 8:30 am Z1, Registered Nurse at Pain Clinic, stated R1 had an internal pain pump for several years for Chronic Intractable Lumbar Back Pain.

R1's Hospital Pain Medicine Center "Discharge Instructions" dated 8/1/16 documents "Follow up: 1 (one) month." R1 ' s attached session data report from the Pain Medication Center dated 8/1/16 documents pump model and medications.

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On 9/8/16 at 11:20 am Z3 (R1's Primary Care Physician) stated Z3 saw R1 on 8/8/16 for a Urinary Tract Infection. Z3 stated Z3 was unaware of R1's open abdominal wound on 8/20/16. Z3 stated Z3 had nothing faxed regarding R1's wound and received no phone messages. Z3 stated "any concerns with the pain pump should have been directed to the pain clinic doctor (Z2, R1's Pain Clinic Physician/Surgeon). No one notified me."

On 9/12/16 at 2:20 pm Z4 (Wound Physician) stated no one notified Z4 of R1's wound on 8/20/16. Z4 reviewed E8 nurses note dated 8/2016 and stated R1's wound should have been cleaned with Normal Saline, or wound cleanser, or betadine and not soap and water.

On 9/12/16 at 11:25 am Z1, RN/Pain Clinic, stated when R1's open area was found on 8/20/16 the pain center should have been notified. Z1 stated "We would have had (R1) seen at the pain center for the doctor (Z2) to evaluate and give orders for treatment. No one notified us that (R1) has an open area over the pump."

On 9/12/16 at 2:40 PM E2, DON (Director of Nursing), stated E8 should have notified E2 of R1's open wound when E8 did not receive a treatment order from Z3. E2 stated "I would give the order to send (R1) out (to emergency room). E2 stated there should have been communication with E8 (off going nurse) and the oncoming nurse (E 21, RN). E2 stated E8 should have cleaned R1's wound with Normal Saline and not soap and water then covered the wound until orders were received from Z3.

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On 9/12/16 at 1:20 PM E21, RN, stated E 21 started working at the facility on 8/11/16. E 21 stated "I didn't know (R1) had a pain pump till 8/28/16. No nurse ever told me (R1) had a dressing or a wound or a pain pump." E 21 stated "(E8, RN) never told me on 8/20/16 about (R1's) open wound and the call to the doctor (when came on duty)."

On 9/8/16 at 3:35 PM E15, Licensed Practical Nurse (LPN) stated E 15 worked the day shift on 8/20/16. E15 stated "I knew (R1) had a pain pump on right side of abdomen. I did not check the site during my shift. I don't know if (R1) had an open area. No one reported to me from the previous shift that there was a skin issue (for R1)."

R1's shower/skin notification sheet dated 8/22/16 does not indicate "Yes" or "No" as to whether R1's skin was intact. The sheet does not document that R1 had a dressing over the pain pump site on right abdomen.

On 9/8/16 at 9:30 am E12 CNA stated E12 gave R1 a shower on 8/22/16. E12 stated R1 had a white dressing on the right side and pointed to E12's right lower abdominal area. E12 stated the dressing "must have had a water proof cover because I gave her a shower." E12 stated E12 did not see any drainage on the dressing and R1 gave no indication that the abdominal area hurt. E12 stated R1 was alert and oriented. E12 stated R1 had a urinary catheter that was draining yellow urine without odor.

On 9/8/16 at 11:05 am E14 LPN, stated E14 last saw R1 on 8/26/16 on the second shift. E14 stated "I did (R1's) skin assessment on 8/26/16.

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(R1) had a dressing (over pain pump area) that was clean, dry, intact, no drainage." E14 stated E14 did not remove the dressing. E14 stated E14 did not recall if there was a date recorded on the dressing to identify when the dressing was placed. E14 stated "I was under the impression that the dressing was not to be removed" according to orders from Z2 (R1's Physician/Surgeon at Pain Clinic). E14 stated "As far as I know we were not allowed to touch that dressing (over R1's pain pump incision site). I don't' recall (R1's) current physician orders. (R1) was alert and oriented, no fever and did not complain of pain." E14 stated when an open wound is found on a resident the "Wound doctor is notified. The Primary Care Physician is notified and family and we then implement treatment orders."

On 9/8/16 at 9:45 am E1, Administrator stated E1 talked with E14 on 9/7/16. E1 stated E14 said E14 did R1's skin assessment on 8/26/16 and there was a small bandage over the internal pump area. E1 stated E14 should have looked for R1's physician orders for the wound. E1 stated E14 should have looked at the wound, measured the wound, and called Z3 (R1's Primary Care Physician) for orders.

On 9/8/16 at 2:55 pm E12 CNA stated E12 "came in early on the third shift (8/28/16) between 2-3:00 am. E12 stated E12 was providing care to R1's roommate sometime before 4:00 am when E12 heard R1 called "(E12)." E12 stated "I went to (R1) and asked 'What you need (R1)?' E12 stated R1 said "(E12 I don't feel good." E12 stated R1 "looked sweaty and let me wash (R1) up. (R1) was wearing a hospital gown that there was brown stain (on the gown) and thought for a

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minute that (R1) had a BM (bowel movement). I looked and it was the dressing on (R1's) right abdomen over the pump. The dressing was full. The whole dressing was saturated and it (drainage) came through on the gown. I didn't smell an odor. I put clean gown on (R1)." E12 stated E12 rolled R1 onto R1's right side to finish R1's bed bath and provide perineal care. E12 stated R1 did not have a bowel movement. E12 stated E12 then called for E18, CNA, to "help me pull (R1) up in bed." E12 stated (E18) then went to get E13, Licensed Practical Nurse. E12 stated E12 remained with R1 until E13 came in R1's room. E12 stated "I told E13 about the drainage on R1's dressing over pump area." E12 stated E12 then left R1's room. E12 stated when it was time to get residents up for day shift "I was (R1's) aide on days. I asked (E11, Licensed Practical Nurse, LPN) if I can get (R1) up. E11 said 'Yes.'" E12 stated "Me (E12) and (E18) got (R1) up into the wheelchair." E12 stated R1 still had the same dressing on that was saturated with brown stain. E12 stated E12 then took R1 to the dining room for breakfast. E12 stated "(R1) was groggy. (R1's) eyes were closed." E12 stated R1's urinary catheter was draining a brownish color of urine. E12 stated E12 brought R1 from the dining room ... Then about 11:00 am I put (R1) back into bed. Another aide (E18) helped me put (R1) back into bed. The brown stain was coming through (R1's) gown. (R1) never complained. I changed (R1's) gown and I told (E11) about (R1's) dressing. The next think I know they (ambulance) were coming to get (R1)."

On 9/13/16 at 9:20 am E18 CNA, stated E18 worked from 10:00 pm on 8/27/16 to 6:00 am on 8/28/16. E18 stated R1 "wasn't looking right. She (R1) was sweating and I got a towel and

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washed her fact then I went and told (E13, LPN) that (R1) wasn't looking her normal self." E18 stated E18 saw E13 go into R1's room and gave R1 a breathing treatment. E18 stated E18 went to help E12, CNA, get R1 up for breakfast. E18 stated there was a brown stain on R1's gown. E18 stated the brown stain came from the leaking dressing on R1's right side. E18 stated E12 got R1 cleaned up then ready for breakfast. E18 stated R1 stood up "but needed more help than usual."

On 9/12/16 at 1:40 pm E13, LPN, stated E13 worked from 6:00 pm on 8/27/16 to 6:00 am on 8/28/16. E13 stated "I was (R1's) nurse. E13 stated E13 did not know if R1 had a dressing or not. E13 stated E13 gave R1 a breathing treatment that morning and put oxygen on per nasal cannula at two (2) liters per minute. E13 stated R1's oxygen saturation level was 90% before the breathing treatment and 96% after the breathing treatment. E13 stated "No one ever informed me that (R1) had a dressing over the pain pump."

On 9/12/16 at 12:40 pm E17 CNA stated E17 worked on 8/28/16 on the day shift from 6:00 am to 2:00 pm. E17 stated "I saw (R1) during breakfast in the dining room. (R1) looked a little sleepy. I don't know whether she ate or not." E17 stated sometime after breakfast E12 walked past me and mentioned (R1) wasn't feeling good. E17 stated "(R1) was in bed lying on her back and I smelled an odor like a sore or something. There was drainage on (R1's) gown on the right side. It was dark brown like coffee and smelled like an open sore. (R1) was breathing hard and had oxygen on. (R1's) eyes were closed. (R1) could shake her head but wasn't talking. This

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was not (R1's) normal. She always talked a lot. It wasn't like her to be quiet. She was always fussing with clothes and always had something to say. So this wasn't her normal." E17 stated "This was close to 9:00 am. So I stayed with (R1) and E20 (CNA) went to get (E11). E11 came and said to me that (R1) was smiling early in the morning. (E11) was concerned about (R1) and looked at the drainage then I left (R1's) room."

On 9/12/16 at 1:08 pm E20, CNA, stated E20 worked on 8/28/16 from 6:00 am to 2:00 pm. E20 stated R1's dressing over the pump site "was wet." E20 stated E20 smelled an odor that "smelled like infection to me." E20 stated the drainage was "brownish looking" and leaked onto R1's gown. E20 stated "I remember telling (E11, LPN) and (E11) looked at it (R1's dressing)."

On 9/8/16 at 4:00 pm E11 LPN stated E11 was R1's nurse on 8/28/16 during the 6 am to 2 pm day shift. E11 stated E11 did not receive any information that R1 had a dressing or drainage over the internal pump site in R1 lower right abdomen when came on duty. E11 stated "No one reported to me until after lunch (on 8/28/16) when E12, CNA or E17, CNA, told me (R1) had drainage, nasty smelling around (R1) pain pump with drainage on (R1's) gown. I went in (into R1's room) and removed the dressing (over the pain pump) and the pain pump was sticking out of the skin." E11 stated R1's open wound was about 2 1/2 inches by 1 1/2 inches. E11 stated E11 did not measure the area. E11 stated "I cleaned the area (R1's wound) with Normal Saline and gauze and left it (wound) open." E11 stated R1 was "having difficulty breathing." E11 stated R1's oxygen saturation level was 96%. E11 stated R1's Blood Pressure was 60/40, Temperature

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was 98.2 degrees Fahrenheit, and Pulse was 76 beats per minute. E11 stated E13, LPN/night shift nurse, said to E11 that "(R1) was having trouble breathing. E13 did not say a word about the drainage at the pump site. Don't know if (E13) knew about it. I did (R1's) vitals myself and called (ambulance) then called family, then (Z3) (R1's Primary Care Physician)." E11 stated R1 had the pain pump for years for back pain.

R1's Nurses Notes dated 8/28/16 document the following: at 12:44 pm "...vs (Vital Signs) t (Temperature) 98.1 (degrees Fahrenheit) p (Pulse) 76 r (Respirations) 28 bp (Blood Pressure) 60/40." ... at 12:47 pm " (Z3, R1's Primary Care Physician) called, order received to send pt (patient, R1) out for evaluation." ...at 12:49 pm "das (Decatur Ambulance Service) called to transport pt to er (emergency room) at (local hospital) for evaluation." ...at 1:00 pm documents "das here resident transported to (local hospital) per stretcher for evaluation."

R1's Hospital Emergency Room report dated 8/28/16 documents R1 arrived at the emergency room on 8/28/16 at 1:33 pm. The report documents "EMS (Emergency Medical Services) stated that the patient (R1) is septic with fever and SOB (Shortness of Breath). EMS stated that the patient has a pain pump on the right side of her abdomen." R1's abdominal assessment documents "Distended: Non-Tender: Normal Bowel Sounds: Other (Pain pump partially exposed in abdominal wall with erythema...)."

R1's Ambulance Incident Log Report dated 8/28/16 documents response to the facility on 8/28/16 at 12:46 pm. The report documents at 12:48 pm "Going Septic-Pain Pump draining and

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B/P (Blood Pressure) 60/40 R (Respirations) 28 P (Pulse) 76- 96% on 2 LPM (Liters of oxygen per minute) and going downhil (downhill). The report "Narrative" documents "...FOUND PT (Patient, R1) IN NH (Nursing Home) AND RN (Registered Nurse) STAFF STATES SHE IS NOT REAL FAMILIAR WITH THE PT. RN STATES PT HAD A PAIN PUMP A COUPLE DAYS AGO AND IT HANGING OUT OF THE INCISION SITE. PT HAS HX (History) OF CA (Cancer) AND IS A DNR (Do Not Resuscitate). ALS (Advanced Life Support) ASSESSMENT PERFORMED AND VITALS OBTAINED AS NOTED. PT HAS APPROX 4 1/2 INCH ROUND SILVER OBJECT HANGING OUT OF INCISION SITE IN LRQ (Lower Right Quadrant of Abdomen) PT O2 (Oxygen) SAT (Saturation) 80% ON O2 2 L'S (Liters)/NC (Nasal Cannula)...PT LRQ IS VERY DISTENDED, RED AND HOT TO TOUCH. PT PLACED ON CARDIAC MONITOR WITH ST (Sinus Tachycardia, rapid heart rate). PT O2 SAT INCREASED TO 88% AND PT BP HAD NO SIGNIFICANT CHANGE..."

On 9/12/16 at 8:46 am Z5, Paramedic for Ambulance Service, stated when arrived at the facility on 8/28/16 the nurse stated "I am not the normal nurse and handed me (R1's) DNR sheet." Z5 stated the nurse then said to Z5 "Let me show you this" and pulled (R1's) dressing back. Z5 stated R1's abdominal wound was dry and "looked as if it happened days ago. It (the wound) did not look like a fresh wound. Very red. (R1's) abdomen was distended. (R1) was cool and clammy. (R1) had every indicator that (R1) was in Septic Shock. (R1) was non-verbal and very lethargic. In 26 years I've never seen anything like this. Never seen a pain pump hanging out. Half of the pain pump was hanging

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out of (R1's) wound. The opening (wound) was about six (6) inches long and 1 1/2 inches wide and three (3) inches of the pump was hanging out."

R1's Emergency Room "Disposition" dated 8/28/16 documents "Patient (R1) brought in from nursing home for evaluation of change in mental status and shortness of breath with fever. She (R1) has intrathecal pain pump extruding from the abdominal wall with erythema and discharge around it (pump). Patient was hypotensive and IV (Intravenous) fluids started and septic workup done. Patient has Normal WBC (White Blood Count) 9.7 but bandemia of 24. Renal failure with BUN (Blood Urea Nitrogen) 49, Creatinine 4.1... (Z2, R1's Pain Clinic Physician, Surgeon) was contacted and will be coming to remove the pain pump..." The report documents "Sepsis Signs and Symptoms: Hyperthermia >38.3, Altered Mental Status, Tachycardia >90bpm (beats per minute). Sepsis Status: Severe Sepsis: S&Sx (Signs and Symptoms) + Organ dysfunct (dysfunction)..." electronically signed by Z14 Emergency Physician Provider.

R1's Hospital Discharge Summary report dated 9/2/16 documents "Reason for Admission-brought in to ED (Emergency Department) for further evaluation of fever, shortness of breath, altered mental status. Patient (R1) was noted to have Infected pump pocket with dehiscence of wound and expression of pump through wound in RLQ (Right Lower Quadrant)...Intrathecal pain pump explanted on 8/28/16...Subsequently during hospital course, patient's (R1's) symptoms and clinical condition deteriorated...Patient expired and pronounced dead on 9/2/16 at 1259 hours (12:59 pm)... (Final Diagnoses: 1. Septic Shock:

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likely due to pain pump site infection and/or HCAP (Healthcare associated pneumonia) and/or Complicated UTI (Urinary Tract Infection)...Blood culture 8/28/16: coagulase-negative Staphylococcus, Urine culture 8/28/16: Escherichi coli and Klebsiella pneumoniae, Abdominal wound culture 8/28/16: Staphylococcus aureus, Klebsiella pneumonia, Providencia stuartii, Proteus mirabilis. 2. Acute Respiratory Failure, Hypoxic: 3. Atrial fibrillation with RVR (Rapid Ventricular Response): 4. Acute Kidney Injury, nonoliguric: due to septic shock 5. History of CVA (Cerebral Vascular Accident, Stroke) with right residual weakness 6. Dementia 7. FBSS (Failed Back Surgery Syndrome);requiring intrathecal programmable pain pump implantation 6/2016 (June 2016) electronically signed by Z7 (Hospitalist/Physician).

R1's "State of Illinois Certificate of Death Worksheet" dated 9/6/16 documents R1's date of death occurred on 9/2/16 as a hospital inpatient and documents "Septic Shock" as the R1's cause of death, certified by Z7.

On 9/12/16 at 9:15 am Z7 (R1's Hospitalist/Physician in Charge on Death Certificate) stated R1 came into the hospital with Septic Shock. Z7 stated the primary site of R1's Septic Shock was the pain pump. Z7 stated the pain pump site was infected.

On 9/7/16 at 3:46 pm Z2 (R1's Pain Clinic Physician/Surgeon) stated R1 was fine when seen at the clinic on 8/1/16. Z2 stated R1 was brought into the emergency room on 8/28/16 with the "pump breaking through the wound and the metal portion of the pump exposed. Never seen anything like this to break open like this. It

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appeared to be days and days in the making. The edges (of the wound) were retracted and didn't look fresh. I cannot for the life of me know how (R1) was changed and bathed and no one noticed."

On 9/14/16 at 10:05 am E2 DON stated the E2 saw R1's original progress note by E8, which documented R1's open area over the pain pump site measuring 1-2 cm x 0.5 cm. E2 stated there was no "User Defined Assessment (UDA) which is to be completed on all new open areas when found. E2 stated E8 should have completed a UDA on 8/20/16. E2 stated E14 did R1's skin check and documented on R1's Treatment Administration Record that R1's skin "was intact." E2 stated if R1 had a dressing on at that time then E14 should have documented the dressing on the skin assessment and reviewed R1's physician orders for treatment. E2 stated if there were no physician orders for R1's wound treatment then E14 should have called Z3 for orders and documented in the progress notes. E2 stated when E12 (CNA) found R1 with leaking dressing on 8/28/16 (on the night shift) E12 should have reported to the nurse immediately and should not have been moved R1 until the nurse found R1 safe to be moved. E2 stated there was no documentation, assessments, treatments or care found in R1's medical record that addressed R1's wound since the initial assessment and treatment on 8/20/16 in the progress notes. E2 stated there is no documentation in R1's record that a physician was reached for treatment orders for R1's wound. E2 stated "If a wound is not treated it (wound) can become infected, septic, necrotic."

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F 309	Continued From page 61 On 9/19/16 an Immediate Jeopardy was identified. The immediate jeopardy situation began on 8/20/16 when the facility identified R1's open abdominal wound at the internal pain pump site and failed to obtain physician orders, failed to assess, treat and provide services for R1's wound for eight days resulting in wound drainage, infection, and expulsion of an internal abdominal pump. E1 was notified of the Immediate Jeopardy on 9/19/16 at 3:30 pm. The surveyor was able to confirm through record review and interview that the facility took the following actions to remove the immediacy: Nurses will or have been inserviced by E2, Director of Nursing (DON) on Skin Assessments, Wound policy and the evaluation and treatment of wounds, resident change in condition and Physician notification. Certified Nursing Assistants (CNAs) obtained vital signs for all residents on 9/19/16 that were reviewed by licensed nurses. The licensed nurses conducted physical assessments on all residents on 9/19/16. Licensed nurses also conducted skin assessments on all residents on 9/16/16, 9/17/16, 9/18/16 and 9/19/16. The DON conducted skin check audits on 9/19/16. Licensed nurses will perform weekly skin checks with an additional skin check ensuring resident's skin will be evaluated by a licensed nurse twice weekly. The DON and/or Nurse manager will review all resident skin audits and do random skin audits weekly. The DON will also review and update care plans.	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

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Based on observation, interview and record review the facility failed to perform hand hygiene and clean equipment prior to R3's wound treatment. This failure affects one of five residents (R3) reviewed for wound care on the sample of five.

Findings include:

R3's Hospital Encounter documents R3 was admitted to the hospital on 7/29/16 at 12:34 pm with the diagnoses of "Malignant neoplasm of ascending colon, Abdominal wall abscess, Status post surgery, Intractabel (Intractable) vomiting with nausea, vomiting of unspecified type."

R3's Physician Orders dated June 2016 documents an abdominal wound treatment order to start on 6/17/16 for "Wet to dry dressing change twice daily. Cleanse wound with NS (Normal Saline) and sterile gauze. Place sterile moistened gauze in wound, cover with dry dressing and secure with ABD (Abdominal pad). Monitor for s/s (signs and symptoms) of infection, redness and swelling..." R1's Treatment Administration Record documents the above treatment was discontinued on 8/2/16.

R3's Physician Orders dated August 2016 documents a treatment order to start on 8/3/16 for "Santyl Ointment 250 unit/GM (gram) Apply to abdominal wound topically every day shift for abdominal wound top with moist gauze and cover with ABD pad."

On 9/7/16 at 1:10 pm E5 RN (Registered Nurse), stated E5 was going to change R3's dressing and gathered supplies from the wound cart and entered R3's room. E5 placed a tube of Santyl,

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Normal Saline, Abdominal Pad, sterile gauze, and scissors that appeared to be children's scissors with plastic handles directly onto R3's bedside table without a barrier. E5 did not ensure a clean field for R3's dressing change. E5 applied gloves after performing hand hygiene and removed R3's old dressing stating there was a moderate amount of serosanguinous drainage on the soiled dressing. E5 stated R3's open abdominal wound was "beefy red with drainage." E5 removed the soiled gloves and returned to the wound cart outside of R3's room without performing hand hygiene. E5 opened the top drawer of the wound cart and picked up a packet of cotton applicators. E5 then applied hand sanitizer to both hands on the way back into R3's room and applied gloves. E5 cleaned R3's wound with Normal Saline and gauze and removed contaminated gloves. E5 regloved without performing hand hygiene and picked up the tube of Santyl (which was not designated for R3) and applied a small amount to the cotton applicator and applied into R3's abdominal wound. E5 then picked up the sterile gauze and placed it into a container with Normal Saline and placed the gauze into R3's abdominal wound. E5 then picked up the unclean, plastic handled scissors and inefficiently trimmed off the excess sterile gauze that was protruding from R3's abdominal wound. E5 had difficulty cutting through the wet gauze with the dull scissors. E5 then placed the unclean scissors onto R3's bed. E5 applied the abdominal pad to R3's wound and secured with dressing tape that E5 trimmed using the same scissors E5 had placed on R3's bed. E5 then removed the contaminated gloves, opened the blinds, gathered up supplies (Santyl, Normal Saline, Abdominal Pad, sterile gauze, and scissors) and went into R3's bathroom and set the supplies on the corner of R3's lavatory

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counter. R3 performed hand hygiene and regathered supplies and returned to the wound cart placing supplies back into the cart.

On 9/7/16 at 1:30 pm E5 stated E5 should not have taken the (wound cart) tube of Santyl into R3's room and then placed the santyl back into the cart. E5 stated the scissors should have been cleaned with a germicidal wipe before using on R3's sterile gauze dressing and before returning the scissors to the wound cart. E5 stated E5 should have performed hand hygiene before returning to the wound cart for the cotton applicators and each time after removing gloves. E5 stated by not washing hands and cleaning the scissors there was a potential for cross contamination.

The undated, untitled policy documents "All residents who are having dressing changes done will have the procedure done using a clean technique...The dressing change steps are ...Ensure you have a clean field available. Wash hands when entering the room...Apply gloves. Remove soiled dressing. Remove gloves and wash hands. Apply clean gloves. Complete dressing change per Physician order. Remove gloves. Clean up supplies and waste receptacle. Wash hands...Maintain infection control practices with handwashing and disposal of soiled dressing..."

The undated, untitled policy documents "Handwasing is a standard practice to prevent the spread of infectious diseases...The use of gloves does not replace handwashing...Appropriated ten to fifteen-second handwashing must be performed under the following conditions:...After handling used dressings...After removing

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F 441	Continued From page 66 gloves...	F 441		
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 496		

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failed to complete verification with registry to ensure Certified Nursing Assistant competency evaluation requirements were met for one staff member hired as a Certified Nursing Assistant working in the facility. This has the potential to affect all 64 residents who reside in the facility.

Findings include:

E28, Certified Nursing Assistant (CNA) Health Care Worker Registry Check dated 9/21/16 documents E28 has, "no competencies on record."

E28's Background Check dated 6/14/16 documents E28 has, "No certifications on record."

On 9/21/16 at 2:10pm, E29, Business Office Manager stated E28's hire date was 7/24/13. E29 stated there were no competencies in E28's employee file. E29 stated she had just rechecked the registry on 9/21/16 and called the Illinois Department of Public Health (IDPH) who verified there are no Certified Nursing Assistant (CNA) competencies on file for E28.

The Facility Data Sheet dated 9/7/16 documents 64 residents reside in the facility.