3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$4,400.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code:300.610a), 300.1010h), 300.1210a), 300.1210b), 300.1210d)1), 300.1210d)2), 300.1210d)3), 300.1210d)5), 300.3220f) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)5) and 300.3240a).

Fine = $2,200

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1010h), 300.1210a), 300.1210b), 300.1210d)3), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Fine = $2,200

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 23rd day of May, 2018.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant,	)	Docket No. NH 18-C0175
v.	)	
COURTYARD HEALTHCARE CENTER, Respondent.	)	

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent: Stephen Sher
Licensee Info: Courtyard Healthcare Center, LLC
Address: 5750 Old Orchard Rd, Ste 420
Skokie, Illinois 60077

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 23rd day of May, 2018.

Sammye Geer
Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003008	A. BUILDING: ______ B. WING ______	C 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments	S 000		
S9999	Final Observations	S9999		

S 000 Initial Comments

Annual Certification and Licensure Survey

Complaint Investigation
1891666 / IL101041

S9999 Final Observations

Statement of Licensure Violations

1 of two Licensure

300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210d)1)2)3)5)
300.3220f)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

Attachment A
Statement of Licensure Violations

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h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

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S9999	Continued From page 2	S9999		

plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3220 Medical Care

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S9999	Continued From page 3	S9999		

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a pressure sore did not increase in size/decline, failed to ensure that wound care treatments were performed according to facility practices, facility failed to ensure that physicians were notified of change in condition of wound status, failed to ensure that a low air loss mattress was functional, failed to ensure that staff obtained wound treatment orders upon admission to the facility, failed to ensure that staff did not place multiple linens on the low air loss mattresses and failed to follow medication orders to promote wound healing which affected four residents (R52, R61, R64, R86) of six residents reviewed for pressure sores in a sample of 22. These deficient practices resulted in worsening of pressure sores for R52, R61, R64 and R86 and caused R52's right and left buttock wounds to develop into Stage 3 pressure ulcers.

Findings include:

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S9999	Continued From page 4 1. R86's Resident Face Sheet documents a medical history which includes Non-pressure chronic ulcers of foot and thigh but does not include R86's diagnosis of a Right Buttock Pressure Ulcer which was identified on 10/23/17. On 3/19/18, the facility submitted a wound care list which documented that R86 was admitted to the facility with a right buttock unstageable pressure sore. On 3/18/18 at 12:45pm, R86 was laying on R86's back on a low air loss mattress. R86's air mattress was deflated and R86 indicated that the mattress was uncomfortable. R86 stated, "I'm sinking." The air mattress had multiple layers of linen: thin sheet, thick cloth incontinence pad, thin blanket folded into fourths and an incontinence brief. On 3/19/18 at 9:44am, V21 (CNA-Certified Nurse Assistant) changed R86's soiled incontinence brief. V4 (Wound Care Nurse) was asked what stage R86's right buttock wound was and V4 stated, "It's a cavity. You'll see when we get in there." This surveyor asked the stage of the wound again and V4 did not answer. As V21 turned R86, it was noted that R86's low air loss mattress was padded with a thin sheet, thin blanket folded into fourths and two thick cloth incontinence pads which were doubled up under R86's right buttock area. V21 finished cleaning up R86's bowel movement. V21 did not remove V21's soiled gloves. As V21 folded one of the thick incontinence pads under R86, it smeared with stool. V21 did not remove the incontinence pad. It remained under R86 during the wound treatment. V21 turned R86 to R86's right side so that V4 could begin treatment on R86's buttock	S9999		

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wound. V4 squeezed two small vials of normal saline into R86's right buttock wound. V4 stated, "This is how I do. I squeeze the two vials into the cavity." V4 and V21 then tilted R86 back towards R86's left and laid R86 flat on the soiled incontinence pad. R86's right buttock wound came in contact with the soiled incontinence pad. V4 stated, "We let the water run out." After patting the wound dry, V4 applied hydrogel inside the buttock wound using a tongue depressor, then on the peri wound area and then inside the buttock wound again. V4 used the same tongue depressor. At this point, R86 was turned to R86's right side and the air mattress was visibly deflated. At 10:05am, V4 confirmed that the mattress was deflated and stated that one of the air cells was the problem. V21 stated "It's fine." It was visible that the low air loss mattress was not supporting R86's weight.

R86's Physician Order Sheet (POS) documented the following wound care treatment: Site-Right buttocks-Cleanse wound with normal saline or wound cleanser. Pat peri wound dry. Apply hydrogel to area, then loosely pack with sterile roll gauze every day and PRN (as needed) if loose or soiled.

This wound care treatment order does not indicate to apply hydrogel to the peri wound area. It indicates to pat the peri wound area dry.

On 3/19/18 at 11:00am, V15 (Environmental Manager) indicated that he called the rental company for a new mattress because of the problem with the mattress. V15 stated, "It's deflated and not inflating properly." When asked who sets the air mattress up, V15 stated, "The company places the frame and the air mattress in the room. And then the wound care nurse goes in

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and sets up the machine for the weight and the types of settings for the resident specific wound. I don't have that knowledge."

On 3/19/18 at 12:50pm, V4 (Wound Care Nurse) confirmed R86's settings for R86's low air loss mattress. R86's weight setting was set to 300 pounds. V4 stated, "Yea, that's about right. (R86) looks about 300 pounds." V4 pushed the up button and demonstrated that the resident's weight could be set at five pound increments. V4 stated, "Now that he's out of it, the mattress looks better. I think the mattress cannot handle all the weight in the middle." V4 stated, "The purpose of the (air) mattress is to provide pressure reduction. If functioning, it prevents wounds from getting worse. I think his weight was just not distributed."

On 3/20/18, the facility submitted a document which indicated R86's weight as 408.2 pounds.

On 3/19/18 at 1:32pm, V22 (Mattress Technician) stated that the setting should be within five to ten pounds of resident's actual weight. V22 stated, "If weight is not set within range, air cells will not expand. Increased weight, cells expect certain amount of pressure. (Air) cells won't expand due to wrong weight." V22 delivered a new bed frame and new air mattress.

On 3/19/18 at 2:10pm, V23 (Customer Service Representative Air Mattress) stated, "Padding? Top cover works like a sheet. Do not tell the facility to use multiple layers. Generally, tell people just one thin sheet. Multiple layers will impede the air from circulating around the resident." V23 indicated that if settings on bed were at 320 for a 350 pound resident, then the resident will bottom out and air mattress will

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deflate. V23 indicated that if the settings are input incorrectly then the pressure redistribution would not occur.

On 3/20/18 at 10:24am, R86 was lying in bed on R86's back with multiple layers of linen underneath R86: two thin sheets, two thick cloth incontinence pads and a thin blanket folded in fourths. R86 stated, "I feel the difference in the mattress. It feels more firms. I feel more support. And it feels like less strain on my backside. When the mattress wasn't as full, it felt like more pressure on the backside. Like I could feel the frame of the bed. I feel the air circulating now. It feels more like a pillow." R86 indicated that R86's mattress has felt bad for about 3-4 weeks and the facility was aware.

On 3/20/18 at 2:20pm, V21 (CNA-Certified Nurse Assistant) stated, "We were trained only one flat sheet on the air mattress. R86 alert so he wants things done R86's way which is different from everyone else. I let the nurse know." R86's wound care plan does not reflect R86's behavior regarding requesting extra linen on R86's air mattress.

R86's right buttock pressure sore was detected upon R86's return from a local hospital on 10/22/17. R86's Resident Progress Notes indicate that orders for wound treatment for the right buttock pressure sore were not obtained until 10/24/17. Initial wound care for R86's right buttock pressure wore sore were not performed until 10/24/17.
V4 measured the right buttock wound on 10/23/17: Stage 2 pressure ulcer 3.0 centimeters (cm) length by 6.5 cm width by 0.1 cm depth. It is not signed off on the Treatment Administration Record (TAR) or documented in R86's Progress

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Notes that wound treatment was performed to the right buttock pressure ulcer.

R86's Wound History documents that the right buttock pressure sore declined on four separate occasions:
11/2/17: 3.0 cm length by 3.5 cm width by 0.1 cm depth. It is documented that the tissue was epithelial.
11/8/17: 2.5 cm by 1.5 cm by unable to determine (UTD) depth. The character of the wound changed to slough.
The facility documented that R86's wound care was performed daily. There is no documentation indicating that V6 (Physician) was notified from 11/2/17 - 11/8/17 for a change in wound treatment. R86's TAR documents that he continued to receive the same wound care treatment until 11/8/17.

11/8/17 - 11/16/17: 10.5 x 8.3 x UTD. R86's wound size increased by 8 centimeters in length. V7 (Wound Care Physician) was not consulted for a wound evaluation until 11/15/17. There is no documentation that V6 was notified to change the treatment. R86 received the same wound treatment until 11/15/17.

On 11/30/17, R86's right buttock wound measured: 6.5 cm x 8.0 cm x 0 cm. 12/8/17: it increased in size to 10 cm x 8.0 x UTD. There is no documentation that V6 or V7 was notified regarding the decline in the wound.

On 3/20/18, V4 indicated that V4 could not locate V7's wound care notes for the time between 11/15/17 and 12/6/17. V4 indicated that V4 was on vacation and that V7 was possibly on vacation as well. There is no change in R86's wound care orders for that timeframe.

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On 3/8/18: 1 cm x 1 cm x 2 cm with undermining of 4.5 cm.
On 3/14/18: It increased in size to 1.3 cm x 1.4 cm x 7 cm. There is no documentation that V6 or V7 were notified regarding the decline of R86's wound.

On 3/20/18 at 11:20am, V4 measured R86's right buttock wound and stated that the length of the wound was 1.3 cm. This surveyor indicated that she saw the wound extend past 1.5 cm. V4 stated, "That's just fat." The width of the wound measured 0.8 cm in width and 2.5 cm in depth. The undermining was measured at 7 cm. There is no documentation that V6 or V7 were notified regarding the decline of R86's wound.

On 3/20/18 at 2:47pm, V7 was asked, "If the facility is utilizing the air mattress correctly and notifying a physician when the wound worsens, would your expectation be that the wound would heal?" V7 stated, "If the mattress is not set to the correct weight and if there are multiple layers of linens, then the wound will not heal whether avoidable or unavoidable. Sure, this can contribute to the deterioration of the wound." V7 indicated that either she or the primary physician should be notified if a wound declines so treatments can be changed accordingly.

On 3/21/18 at 10:36am, V6 (Physician) stated, "I am the primary physician. I go to see (R86) every month. They are supposed to notify me if the wound gets worse. They have never notified me regarding (R86's) wound. I did not know that (R86's) pressure sore got worse. Nurses should be notifying me all the time so I can arrange for treatments or to go to the hospital for debridement. I did not give them an order for

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wound treatments on 3/19/18. I have not talked to the wound care team at all.

On 3/21/18 at 11:14am, V3 (ADON-Assistant Director of Nursing) stated, "The expectation is that when the wound is discovered, nurse will identify the site and call the physician for initial wound care treatments. Nurse should so it as soon as the wound is identified." V1 (Administrator) stated, "If wounds change, they are assessed daily by the wound care nurse. She's changing the wound every day. Wound care nurse visually notices the decline in the wound. Wound care nurse should not wait a week for a change in the wound to be addressed by (V7)."

On 3/21/18 at 11:20am, V2 (DON-Director of Nursing) and V3 indicated that a resident's wound should never come in contact with soiled sheets and that a pressure sore should always be cleaned from the inside to the outside to prevent cross contamination.

R86's wound care plan documents: Approach: Apply dressings per (doctor) order.

The facility submitted a document on pressure sores that list the expectations of the Wound Care Group: Contact your physician if your wound site becomes painful, odorous, larger, or if the amount of fluid coming from the wound increases.

The manufacturer specifications for the low air loss mattress indicates that it can handle a weight up to 500 pounds. This pamphlet also documents: The electronic controller provides a real time display of the air pressure for both the inflated and deflated air cells. The deflated cells

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provide pressure relief, while the inflated air cells support the patient's weight. The amount of pressure needed to support a patient can be set automatically, based on the patient's weight, or can be set manually through custom configurations in Advanced Settings.
Troubleshooting guide: 3. Patient is sinking or bottoming out: The pressures may be set too low for the patient's weight. a) Verify weight setting in Patient Setup. See Section 4.4.2. Adjust if set weight is not accurate to the patient's actual weight.

2. R61 is a 73 year old, male, admitted into the facility on 10/26/2016 with diagnoses of Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris and Pressure Ulcer of Sacral Region, Stage 4.

R61's MDS (Minimum Data Set) dated 01/29/2018 documented:
Sec. C - BIMS (Brief Interview for Mental Status) score of 10 which means moderately impaired cognition
Sec. G - Needs extensive assistance from two persons physical assist during transfer, dressing, hygiene and toileting. R61 is using wheelchair for locomotion.
Sec. H - Incontinence of bowel and bladder
Sec. M - 0150: R61 is at risk of developing pressure ulcers; R61 has one Stage 4 pressure ulcer present upon admission into the facility.
Sec. M - 1200: Skin and Ulcer Treatments - pressure reducing device for bed; pressure ulcer care.

R61's POS (Physician Order Sheet) dated 03/16/2018 documented:
Site: Coccyx - cleanse wound with normal saline solution or wound cleanser. Pat peri wound dry

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then apply collagen. Cover with foam dressing daily and PRN (when needed) if loose or soiled once a day.

R61's Care Plan on Pressure Ulcer dated 12/6/2016 documented intervention: Pressure reduction mattress.

R61's Wound History documented: Pressure sore on the coccyx area was first observed on 12/06/2016, categorized as Unstageable, and was present upon readmission from hospitalization.

R61's Wound Care Specialist Initial Evaluation dated 12/07/2016 documented:
Unstageable (Due to Necrosis) Coccyx measuring 6cm (centimeters) x 7cm x 0.2cm.
Additional Information: Wound not acquired in house, patient returned to facility with wound, per chart review patient recently hospitalized for AMS (altered mental status) likely related to dementia. A surgical excisional debridement of subcutaneous tissue was performed. Treatment - santyl once daily, dry protective dressing once daily; Recommendations: low air loss mattress; off-load wound, reposition per facility protocol.

Further review of R61's wound history revealed:
12/08/2016 - Unstageable pressure wound on the coccyx measuring 6cm x 7cm; treatment - santyl ointment
12/29/2016 - Unstageable pressure wound on the coccyx measuring 6.4cm x 7.5cm x 2.0 cm; treatment - santyl ointment
04/20/2017 - Stage 4 pressure wound on the coccyx measuring 3.4cm x 2.5cm x 1.6cm; treatment - silver alginate with foam dressing
04/27/2017 - Stage 4 pressure wound on the

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S9999	Continued From page 13 coccyx measuring 4cm x 2cm x 1cm treatment - silver with foam dressing 05/26/2017 - Stage 4 pressure wound on the coccyx measuring 3cm x 1.5cm x 1.7cm; treatment - silver alginate with foam dressing 06/01/2017 - Stage 4 pressure ulcer on the coccyx measuring 3.3cm x 1.6cm x 0.5cm; undermining depth 1.5cm location 3 o'clock; treatment -silver alginate with bactroban 08/25/2017 - Stage 4 pressure ulcer on the coccyx measuring 2cm x 1.5cm x 0.60cm; undermining depth 1.5cm location 0.6 o'clock 08/31/2017 - Stage 4 pressure ulcer on the coccyx measuring 2.5cm x 1.5cm x 0.6cm; undermining depth 1.0 cm location 3 o'clock; treatment - collagen with foam dressing 09/20/2017 - Stage 4 pressure ulcer on the coccyx measuring 2cm x 0.9cm x 0.5cm; undermining depth 1cm location 3 o'clock; treatment -collagen 10/02/2017 - Stage 4 pressure ulcer on the coccyx measuring 2.5cm x 1.4cm x 0.5cm; undermining 1cm. location 3 o'clock; treatment - collagen with foam dressing 10/27/2017 - Stage 4 pressure ulcer on the coccyx measuring 2cm x 1.2cm x 0.4cm; undermining depth 1cm location 3 o'clock; treatment - collagen with foam dressing 11/02/2017 - Stage 4 pressure ulcer on the coccyx measuring 2.5cm x 1.5cm x 0.4cm; undermining depth 1cm location 3 o'clock; treatment - collagen with foam dressing 11/16/2017 - Stage 4 pressure ulcer on the coccyx measuring 2.7cm x 1.5cm x 0.3cm; undermining depth 1cm. location 3 o'clock; treatment - collagen with foam dressing 11/29/2017 - Stage 4 pressure ulcer on the coccyx measuring 3cm x 2cm x 0.3cm; undermining depth 1cm location 3 o'clock; treatment - collagen with foam	S9999		

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S9999	Continued From page 14 01/12/2018 - Stage 4 pressure ulcer on the coccyx measuring 3.2cm x 1.5cm x 0.4cm; treatment - collagen with foam dressing 03/08/2018 - Stage 4 pressure ulcer on the coccyx measuring 1.8cm x 1cm x 0.4cm; undermining depth 1cm location 3 o'clock; treatment - silver alginate 03/16/2018 - Stage 4 pressure ulcer on the coccyx measuring 2cm x 1cm x 0.4cm; undermining depth 1cm. location 3 o'clock; treatment - collagen with silver alginate R61's Wound Care Specialist Evaluation Notes documented the following: 02/02/2017 - Stage 4 pressure ulcer on the coccyx measuring 5cm x 7cm x 3cm; Wound progress - Deteriorated; Surgical excisional debridement was performed; treatment - santyl once daily, dry protective dressing once daily, calcium alginate once daily; Recommendations - off-load wound, reposition per facility protocol. 11/15/2017 - Stage 4 pressure ulcer on the coccyx measuring 2.7cm x 1.5cm x 0.3cm. Wound progress - Deteriorated Treatment - dry protective dressing once daily, foam once daily; silver collagen once daily Recommendations - Continue off-load wound, reposition per facility protocol, low air loss mattress, multivitamin once daily PO (by mouth). 01/10/18 - Stage 4 pressure ulcer on the coccyx measuring 3.2cm x 1.5cm x 0.4cm; Wound progress - Deteriorated; Surgical excisional debridement was performed on the wound; treatment - dry protective dressing once daily, collagen dressing once daily; Recommendation - Continue reposition per facility protocol, off-load wound. 02/14/2018 - Stage 4 Pressure Wound Coccyx with measurements: 2cm x 0.8cm x 0.4 cm; undermining 1cm. at 3 o'clock. Surgical excisional	S9999		

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debridement was performed; treatment - Dry protective dressing - once daily, silver alginate - every two days
02/21/2018 - Stage 4 Pressure Ulcer Coccyx with measurements: 2cm x 1cm x 0.4cm; undermining 1cm at 3 o'clock; surgical excisional debridement was performed; treatment - dry protective dressing, once daily, silver alginate every two days. Wound progress noted as Deteriorated. Assessment and Plan of Care Recommendation documented Stage 4 Pressure Wound Coccyx Deteriorated due to surface area, inflammation, incontinence
02/28/2018 - Stage 4 Pressure Ulcer Coccyx with measurements: 1.8cm x 1cm x 0.4 cm; undermining 1cm. at 3 o'clock; treatment - dry protective dressing, once daily, silver alginate and every two days
03/07/2018 - Stage 4 Pressure Wound Coccyx with measurements: 1.8cm x 1cm x 0.4cm; undermining 1cm at 3 o'clock; treatment - dry protective dressing, once daily, silver alginate every two days; Wound progress - no change
03/14/2018 - Stage 4 Pressure Wound Coccyx with measurements: 2cm x 1cm x 0.4cm; undermining 1cm at 3 o'clock; treatment - dry protective dressing apply once daily for 30 days, silver collagen apply once daily for 30 days; recommendation - off-load wound, reposition per facility protocol, low air loss mattress; Wound Progress documented Deteriorated.

On 03/18/18 at 11:58 AM, R61 was observed in bed, on low air loss mattress; mattress was covered with white sheet as top sheet. A cloth underpad was placed under R61's buttocks and hip area. R61 was wearing an incontinent brief. R61 was asked regarding any pressure sores present on R61's back. R61 verbalized that R61 has a wound on

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S9999	Continued From page 16 R61's lower back. R61 stated, "Staff cleans my wound every day and they change me regularly but my wound makes me feel messed up. I cannot do anything and I need assistance from staff." On 03/19/18 at 10:00 AM, R61 was observed lying on bed, on low air loss mattress. The mattress is covered with a white blanket sheet. On top of the blanket sheet was a cloth underpad placed under R61's lower back. On top of the cloth underpad, an incontinent brief was also observed laid under R61's lower back. R61 was also wearing an incontinent brief. At this time also, V4 (Licensed Practical Nurse, LPN/Wound Care Nurse) is about to do wound care treatment on R61. V4 removed R61's incontinent brief. There was no dressing observed on R61's wound on the coccyx area. V11 (Certified Nurse Aide, CNA) stated that when R61 did the morning care on R61, the wound dressing fell off because it was soaked with feces. V11 was asked if V11 reported it to V4 or to the charge nurse. V11 stated, "I just saw V4 right now. No, I didn't tell her or to the other nurse. I know, I am supposed to tell the wound care nurse or to the nurse on duty. V4 continued doing the wound treatment. V4 cleansed R61's wound with saline, applied the ordered treatment then covered with foam dressing. The wound on the coccyx area is open, beefy red in appearance, with moderate amount of serous discharges. On 03/20/18 at 11:38 AM, Wound Care was again observed on R61 performed by V4 assisted by V11. Wound measurements were taken by V4 showing 2.0cm x 1.5cm x 1cm undermining 0.8cm about 1:00 o'clock. Wound care was	S9999		

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performed afterwards.

V11 was asked regarding linen covers for R61's mattress. V11 stated, "Should be one top sheet only. At this time, it was observed that R61's mattress was covered with only one sheet. V11 was asked regarding yesterday's bed coverings. V11 stated, "Yesterday was different, I know, I put so many sheets but today is only one sheet. We need to put only one top sheet because this is a special mattress."

On 03/21/2018 at 10:10 AM, V11 was also interviewed regarding R61's pressure sore. V11 stated, "He (R61) needs to be reposition every two hours, change incontinent brief every two hours and during changing of the brief, skin assessment is done and if there is a skin breakdown, the nurse need to be notified. We document skin assessment in the shower sheet. (R61) air mattress should be covered with one large sheet only."

3. R64 is a 66 year old, female, admitted into the facility on 07/11/2017 with diagnoses of Generalized Muscle Weakness; Type 2 Diabetes Mellitus without complication and Pneumonitis due to Inhalation of Food and Vomit. MDS dated 07/18/2017 Section M showed that R64 has no pressure ulcer at the time of admission in the facility.

R64's MDS dated 02/06/2018 documented:
Sec. C - BIMS score of 3 which means severely impairment cognition.
Sec. G - total dependence from two persons physical assist during transfer, dressing, toileting, hygiene and bathing; R64 uses wheelchair for locomotion due to impairment on both upper and lower extremities

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Sec. H - R64 has an indwelling urinary catheter and incontinent of bowel
Sec. M - M0150 - R64 is at risk for developing pressure ulcers; R64 has one Stage 4 pressure ulcer
Sec. M - 1200 - Skin and Ulcer Treatments - pressure reducing device for chair; turning/repositioning program; application of ointments/medications other than feet.

R64's Wound History notes dated 08/17/2017 documented that a wound pressure on the coccyx was first observed on 08/15/2017, facility acquired and was categorized as Unstageable, with measurements 4.0cm x 3.0 cm; treatment: santyl ointment with foam dressing.

R64's Resident Progress Notes dated 08/15/2017 documented: "Resident (R64) is with sdti (suspected deep tissue injury) 4.0cm x 3.0 cm. utd (unable to determine) depth with blancheable redness to surrounding tissue with small excoriated area to left buttock, 0.3cm. x 0.3cm and informed new order written, low air loss mattress ordered revised turning schedule posted in room, vitamins and labs ordered, bolsters requested for bed to protect resident with positioning."

R64's POS dated 08/15/2017 - 08/17/2017 documented: Site coccyx - cleanse wound with normal saline or wound cleanser. Pat peri wound dry. Apply foam dressing to wound bed. Cover with border gauze daily and PRN if loose or soiled.

R64's Care plan dated 08/23/2017: assess the pressure ulcer for stage, size, presence/absence of granulation tissue and epithelization, and condition of surrounding condition; Keep clean

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S9999	Continued From page 19 and dry as possible. Minimize skin exposure to moisture; Administer vitamins and minerals per MD orders. Further review of R64's wound history of pressure ulcer on the coccyx revealed: 11/23/2017 - Stage 4; measurements: 2.4 x 1.5 x 1.5; undermining depth 2.5 cm. location 12 o'clock; treatment - metrogel with calcium packing 11/29/2017 - Stage 4; measurements: 3 x 2 x 2; undermining depth 2cm location 12 o'clock; treatment - metrogel with calcium and foam 01/04/2018 - Stage 4; measurements: 1.5 x 1.0 x 0.80; no undermining; treatment - calcium alginate foam dressing 01/12/2018 - Stage 4; measurements: 2.5 x 1.5 x 0.8cm; undermining depth 2.0 cm location 12 o'clock 03/08/2018 - Stage 4; measurements: 0.8 x 0.5 x 0.6; undermining depth 2cm location 12 o'clock; treatment - calcium alginate with foam 03/16/2018 - Stage 4; measurements: 3 x 2 x 0.8; undermining depth 2cm location 12 o'clock; treatment - honey, calcium and foam R64's Wound Care Specialist Evaluation Notes dated 03/14/2018 documented: Wound size: 3cm x 2cm x 0.8cm; undermining 2cm at 12 o'clock; Surgical excisional debridement was performed on R64's wound on the coccyx. Wound progress - Deteriorated Dressing Treatment Plan - Foam apply once daily for 30 days, calcium alginate apply once daily for 30 days, leptospermum honey apply once daily for 30 days Recommendations - Off-load wound, reposition per facility protocol, Multivitamin once daily PO; Vitamin C 500mg. twice daily PO.	S9999		

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POS dated 03/16/2018: Site -coccyx - cleanse wound with normal saline solution or wound cleanser, pat dry, apply medihoney with calcium alginate, cover with foam dressing daily and PRN if loose or soiled once a day.

Further review of POS dated 08/15/2017 showed that R64 has orders for MVI 1 tablet PO (by mouth) every AM (morning) once a day and Vitamin C 250 mg. (milligrams) PO every AM once a day.

On 03/18/18 at 10:58 AM, R64 was observed lying in bed. R64 was turned to the left side. R64 is using a low air loss mattress; the pump indicated a static mode. The mattress was covered with a top sheet. Under R64's lower back area, a white sheet folded into fourths was observed placed. R64 was wearing an incontinent brief.

On 03/19/18 at 10:12 AM; R64 was again observed lying in bed, awake. The mattress was covered with a top sheet. Under R64's lower back area, a white sheet folded into fourths was placed. R64 was also wearing an incontinent brief. A wedge pillow was placed under R64's left shoulder. R64 was turned to right side. The pump for the mattress indicated a static mode.

V12 (Restorative Aide/CNA) and V13 (Certified Nurse Aide, CNA) was about to reposition R64 to the left side when V13 checked R64's incontinent brief was already wet with urine. Incontinence care was observed. After performing incontinence care on R64, V12 started to change the bedding linens. V12 placed the top sheet covering the mattress; a white blanket folded into fourths was placed underneath R64's lower back and put on a

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new diaper on R64. Afterwards, V12 placed a wedge pillow on the right shoulder and turned R64 to the left side.

At 11:30 AM, Wound Care was observed as performed by V4 assisted by V13 on R64. V4 washed hands then donned gloves. V4 removed old dressing. The wound was open, deep and necrotic with serous discharge noted. V4 started to cleanse the wound with saline, removed gloves and washed hands. V4 donned gloves, applied the medihoney with calcium alginate, and then covered with foam dressing.

At 02:05 PM, R64 asked V4 regarding static mode indicated on R64's pump for the mattress stated, "Static mode is non-alternating. The mode of the pump should be in alternating mode."

On 03/20/18 at 03:05 PM, V12 was asked regarding beddings for low air loss mattresses. V12 stated, "We need to put a top sheet, then a draw sheet or a flat sheet and adult brief on residents. We were trained by V4 to put a top sheet, a draw sheet plus of course resident wearing the incontinent brief.

4. R52 is an 83 year old, male, admitted into the facility on 01/29/2015 with diagnoses of Other Epilepsy, Not Intractable, Without Status Epilepticus; Chronic Ischemic Heart Disease, Unspecified and Unspecified Dementia without Behavioral disturbance.

MDS dated 01/26/2018 documented the following:
Sec. C - BIMS score of 10 which means moderately impaired cognition.
Sec. G - needs extensive assistance from two person physical assist during transfer and

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dressing; needs extensive assistance from one person physical assist during provision of hygiene, toileting and bathing. R52 uses wheelchair for locomotion due to impairment on lower extremities.
Sec. H - has indwelling urinary catheter and is frequently incontinent of bowel
Sec. M - M0150 showed that R52 is at risk of developing pressure ulcers; M0210 showed that R52 has no pressure ulcers. M1200 skin and ulcer treatments - pressure reducing device for chair, turning/repositioning program, application of ointments/medications other than to feet.

R52's Resident Progress notes dated 01/30/2018 documented: "R52 is with abraded tissue to right buttocks measuring 1.5cm x 1.3cm x 0.1cm over previously damaged tissue, dressing applied, tolerated well."

R52's Resident Progress notes dated 02/06/2018 documented: "R52 is with abraised area of skin to left buttocks 1.5cm x 3.0cm, new order in place."

R52's Wound Care Specialist Evaluation Notes documented the following:
02/07/2018 - Shear Wound of the Left Buttock measuring 2.5cm x 3 x 0.1; treatment - collagen dressing every three 3 days, hydrocolloid every three days; Shear Wound of the Right Buttock measuring 2 x 2 x 0.1; treatment - collagen dressing every 3 days, hydrocolloid every three days.
02/21/2018 - Shear Wound of the Left Buttock measuring 10 x 5 x 0.1cm. Wound progress - Deteriorated; Surgical Excisional debridement was performed on R52's left buttock wound; treatment - calcium alginate once daily, dry protective dressing once daily, santyl once daily.
03/14/2018 - The shear wound on the right and

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left buttocks were now categorized as Stage 3 Pressure Wound.

R52's POS dated 03/16/2018 documented: Site Right buttock - cleanse wound with normal saline or wound cleanser. Pat peri wound dry. Apply santyl to wound bed. Cover with 4x4 and border every other day and PRN if loose or soiled. May use foam with dressing once a day; Site Left buttock - cleanse wound with normal saline or wound cleanser. Pat peri wound dry. Apply santyl with calcium alginate to wound bed. Cover with 4x4 and border gauze daily and PRN if loose or soiled.

R52's care plan dated 01/05/2017 related to Pressure Ulcer documented interventions: Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences; Keep bony prominences from direct contact with one another with pillows; Keep linen clean, dry and wrinkle free; Keep clean and dry as possible. Minimize skin exposure to moisture.

On 03/18/18 at 01:46 PM, R52 was observed lying in bed, awake, on low air loss (LAL) mattress. The mattress is covered with a top sheet. R52 was wearing a diaper. Under R52's lower back, a cloth underpad was placed.

03/19/18 at 10:03 AM, R52 was observed asleep on bed; on LAL mattress. The mattress was covered with a top sheet. A white sheet folded into fourths was placed under R52's lower back. R52 was wearing an incontinent brief. R52 was turned to left side.

03/19/18 at 11:40 AM, Wound care was observed as performed by V4 assisted by V14 (CNA) on R52. V4 removed the old wound dressing. R52

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removed gloves and washed hands. V4 donned gloves, cleansed wound then removed gloves and washed hands. Subsequently, V4 donned gloves, applied the treatment as ordered, then removed gloves.

At 02:05 PM, V4 was interviewed regarding pressure sores. V4 stated, "R52, R61 and R64 - they are all using LAL mattresses to reduce the pressure on the prominences to prevent further pressure ulcers. On the mattress, we should have a white sheet on top and an underpad or a sheet and a draw sheet in addition to the incontinent brief residents were wearing. V15 (Maintenance Director) was in-serviced regarding the use of mattress and the pump. To prevent pressure ulcers also, staff needs to reposition residents; skin should be clean and dry and apply moisturizers as ordered and the use of the special mattresses. Staff needs to follow the wound care protocol also. The pump needs to be in the alternating mode, not static mode."

At 2:20 PM, V15 was interviewed: "Yes, the company that rents the pump and mattresses did an in-service on me regarding pump and mattresses' set-up but not on the beddings to be used on the mattress and the settings in the pump.

At 02:32 PM, V2 (Director of Nurses) was asked regarding wound care. V2 stated, "V4 who is the Wound Care Nurse works as the wound care nurse in the facility from Mondays to Fridays. Two weeks ago, she (V4) works only 4 times a week, that excludes Wednesdays, Saturdays and Sundays. Therefore, the floor nurses need to do the wound care treatment on residents. Expectations on staff: they should be doing check and change every two hours but it depends on

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the resident if its every two hours or PRN (when needed); reposition residents every two hours and or PRN; note if there are new skin issues to be noted and reported to the doctor and get a treatment order. CNAs do check and change as well; report any unusual skin changes; CNAs need to report any uncovered wound to nurses. With regards to the LAL Mattress - the specialty air mattress, staff needs to check if the power is on. The pump should be in alternating mode. The mattresses coverings - there should be only one linen covering the mattress, like a draw sheet."

On 03/20/2018 at 2:35 PM, V7 (Wound Care Physician) was interviewed regarding R52, R61 and R64. V7 stated, "I know them (R52, R61 and R64). I am familiar with their wounds. I do the rounds in the facility every week. As a Wound Physician, I expect that staff will provide residents good hygiene, repositioning/off-loading; receives good incontinence care and provision of special mattresses. Staff needs to make sure that only a flat sheet or a pad is on the mattress, not multiple layers. I always communicate my orders and assessment to the Wound Care Nurse, the Director of Nurses and the Assistant Director of Nurses and to the Administrator, as well."

On 03/21/2018 at 9:55 AM, R52 was again observed in bed, awake, head of bed is elevated at a 45 degree angle. R52 is using a LAL mattress. A top sheet was observed covering the mattress. A cloth underpad was placed under R52's upper and lower back. R52 was wearing an incontinent brief.

At 9:56 AM, R64 was again observed lying in bed. The mattress is covered with a top sheet. Under R64's upper and lower back was a cloth underpad placed underneath. R64 was also

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wearing an incontinent brief.

At 9:58 AM, V16 (LPN) was asked regarding pressure ulcer interventions. V16 stated, "I am a PRN nurse. I work twice every two weeks. The nurses on the floor do the wound care if the wound care nurse is not in the facility. We signed off the treatment that it was done for the day in the treatment sheet. If CNAs found anything unusual in a resident's skin, they must report it to the nurse and the nurse will do further assessment. A skin care sheet is filled out and a copy is placed in the wound care nurse's mailbox. If the wound care nurse is available, she will call the physician regarding skin changes and any new treatment orders but if the wound care is not in the facility, the floor nurses will call the physician. The wound care nurse does the care plan and interventions and are relayed to the floor nurses and nurses' aides for care plan implementation."

At 10:20 AM, V17 (CNA) was asked regarding R52's and R64's pressure ulcer preventions. V17 stated, "In order to prevent further ulcer development on R52 and R64, they must be turned and reposition every two hours. The mattress should be covered with a top sheet only and the incontinent brief should not be closed to prevent moisture. I know, I already removed the underpads on R52 and R64 just now. Also, R52 and R64 need to be changed every two hours or when needed. R64 has a wedge pillow placed under (R64) right hip so (R64) could be turned to the left side." V17 also stated that skin assessment is done every shift and unusual skin changes are needed to be reported to the nurse for further assessment.

On 03/21/2018 at 10:32 AM, V2 was asked

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regarding communication of orders from V7. V2 stated, "V7 does her rounds every Wednesday, the notes were all printed out the next morning. V4 prints all the wound notes, review those notes and checks all the plan of care recommendations. Then, V4 will enter all the orders in the computer. If V4 is not available, I and V3 (Assistant Director Of Nurses) will do the printing and entering of orders. Any changes in the plan of care will be disseminated to the floor nurses and CNAs."

At 2:35 PM, surveyor showed V2 the current order for Vitamin C on R64 which was Vitamin. C 250mg. once a day. V2 was asked regarding the medication order. The Wound Care Specialist notes dated 03/14/2018 documented: Recommendations - Vitamin C-500 mg twice daily PO. V2 stated, "Yes, V4 should carry out the vitamin C order for R64 and should be entered into the computer, and if (V4) happened to be not available, myself or V3 should take care of that."

Weekly Skin Assessments dated January 2018 to March 2018 were reviewed:
R52 has no weekly skin assessment documentation dated 2/4/18; 2/18/18 and 2/25/18.
R64 has no weekly skin assessment documentation dated 2/25/18.

On 03/21/2018 at 10:38 AM, V6 (Physician) was also interviewed regarding pressure ulcer prevention in the facility. V6 stated, "I am always made aware of the pressure sore issues in the facility. During quality assurance meetings, the wound care nurse comes and we discussed issues on pressure sores. I expect that the wound care team is more involved; the residents are taking their medications as ordered and the wound care team should be following the wound

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care protocol."

At 3:46 PM, V18 (Physician) was asked regarding R64's pressure ulcer. V18 stated, "I have been taking care of (R64) for 3 to 4 months now. Yes, I have been notified periodically regarding (R64) pressure sores by the Wound Care Nurse and the Wound Care Physician. I expect that the facility is doing the off-loading, providing R64 with good nutrition and medications, and also R64 on a special mattress that minimizes the pressure on (R64) bony prominences. Facility needs to minimize the risk on R64 of having pressure sore development and gets it worsened by implementing pressure sore prevention interventions."

At 3:55 PM, V19 (Physician) was interviewed regarding R61's pressure sore. V19 stated, "(R61) has been under my care for quite some time now. I am fully aware of (R61) pressure sore. Facility needs to minimize the risk for R61 to develop pressure sores and prevent another pressure sore to be developed. Also, facility needs to implement interventions like turning and repositioning R61 on a regular basis, follow wound protocol and use of special mattresses which could all promote wound healing on R61."

On 03/22/2018 at 9:20 AM, V20 (Sales Representative) was interviewed regarding special low air loss mattress and the pump used by R64. V20 stated, "The pump should not be in a static mode because it makes the mattress a regular mattress. It is recommended that the LAL mattress should be covered with one sheet to make it more effective. It should also be in an alternating mode so air distribution is alternated between two different sides thereby off-loading different areas of the body."

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Facility's policy on "Wound Prevention Program", dated 11/2017, documented: "Policy: Resident whose clinical condition increase the risk for impaired skin integrity and pressure ulcers are being assessed and identified and implement preventative measures and or provide appropriate treatment modalities for ulcers according to standard of care."

Facility's policy on "Physician Orders" dated 7/16, documented: "Procedure: 1. The physician will authorize complete, legible medication orders. 2. Each medication, treatment or lab orders will be entered in the resident's medical record and administered as ordered."

(B)

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300.1210a)
300.1210b)
300.1210d)3)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating

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the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care

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and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or

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agent of a facility shall not abuse or neglect a resident

These Regulations were not met as evidence by:

Based on interview and record review, the facility failed to follow their fall prevention program for one resident (R460) in a sample of 22 residents reviewed for falls and accidents by not assessing or putting interventions in place for a resident with a history of falls in the facility. Furthermore, the facility failed to communicate and coordinate care with the resident's physician and hospice service related to the resident's history of falls in the facility and injuries obtained. This failure resulted in R460 having to be emergently transferred to local hospital with an abrasion, contusion, and small laceration on the face.

Findings include:

Physician Order Report dated 1/19/18 shows R460 as an 89 year old resident with diagnoses of malignant neoplasm of prostate, restlessness and agitation, hypertension and dementia. R460 was admitted to hospice services on 5/29/17 and expired in the hospital on 2/10/18.

Emergency Medical Services report dated 1/19/18: "BLS Unit 32 dispatched to an emergency fall. Upon arrival, the 88 year old male patient was found in semi-fowlers position. Patient had an abrasion, contusion, and small laceration on the right side of the face near the eye. Patient complained of pain in the foot but that the pain existed before the fall. "

Emergency Room Patient Discharge Transition Record dated 1/19/18 states, "Chief Complaint: Fall. Primary diagnosis: Abrasion of head.

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Disposition Notes: Disposition decision is discharge (to hospice unit): Condition at discharge: Serious."

Physician Order Report dated 3/18/18 included new diagnoses of unspecified focal traumatic brain injury.
Review of facility hospice records show no evidence of facility documentation notifying the hospice agency of the three separate fall incidents that occurred to coordinate care with the hospice agency.

When interviewed on 3/20/18 at 11:00am, V2 (Director of Nursing), was asked about the lack of communication with the hospice agency, V2 stated, "They (nurses) should be informing the hospice staff of everything going on with (R460)...They have a separate binder (regarding documentation), they don't document in our electronic system." V2 was asked to find any communication between the facility and hospice agency about the three separate fall incidents to coordinate care. V2 stated, "I'm still looking but I can't find any notes on it."

Hospice record dated 11/27/17 titled, Interdisciplinary Care Plan states, "(R460) has the terminal condition of cerebral vascular disease. His son placed (R460) and his step mother into a retirement community last year when he observed them becoming more forgetful and falling-especially (R460)."

No documentation was provided from the facility of a care plan for R460 related to falls or behaviors.

3/18/18 interview at 10:00 am with V10 (family member) states, "I placed my dad in the facility so

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he can be taken care of with dignity and respect at the end of his life. Instead they managed to let him fall three times and they tell me because he's been agitated or something. If that's the reason, then why didn't they watch him closer so he doesn't fall and hurt himself? I was told that putting him on hospice, he'd get more care and people to care for him but instead he's being found on the floor all the time. That's not being cared for if you find my dad on the floor all the time."

3/21/18 interview at 3:15 pm with V9 (Attending Physician) states, "Yes, I'm the doctor for (R460) he was on hospice and had history of strokes and had Parkinson's disease. (Review of facility and hospital records show no diagnoses of history strokes or Parkinson's disease.) V9 was asked if she was informed about (R460) expiring, V9 stated, "No but I didn't need to be informed because he died on hospice and died in the hospital." When asked if she was informed about the falls that occurred in the nursing home V9 stated, "Either myself or my nurse practitioner is called, but I can't tell you for sure." V9 was reminded that R460 sustained three un-witnessed falls in the facility and asked her expectations of staff in carrying out doctors orders, V9 replied, "Well (R460) is a hospice resident, I don't normally order anything, but if you ask my expectations, then I can tell you I expect that the staff keep him from falling by having fall precautions in place because he shouldn't be falling. He's hospice and he's dying, why is he falling?"

All MDS (Minimum Data Set) from 6/5/17 through 12/11/17 (Section E: Behaviors) R460 is assessed with "no behaviors exhibited", however for each fall incident (6/7/17, 12/18/17, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 35 1/9/18)that occurred, "unsafe behavior" is marked as a risk factor for all falls R460 sustained. Facility policy and procedure dated October 2016 titled, Falls Prevention Program, states: "Fall prevention program will be implemented to assure that safety of all residents in the facility whenever possible. This program should include measure which determines the individual needs of each resident by assessing the risks for falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. As part of the initial assessment, identify individuals with a history of falls and risk factors for subsequent falling. Identify the root causes of the fall incident which could be related to resident's current or declining medical condition or worsening behavior. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction or if the individual continues to fall despite attempted interventions, notify the physician. Collect and evaluate any information until either the cause of the falling is identified, or can be speculated as to what was the resident trying to do causing the fall, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The staff with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as a late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003008	A. BUILDING: ______ B. WING ______	C 03/22/2018

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S9999	Continued From page 36	S9999		

major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall."
Additional policy and procedures titled, Hospice and Nursing Facility Services Agreement, states, "Coordination of Services: In order to ensure that the needs of Hospice Patient are addressed and met twenty-four (24) hours a day, Nursing Facility, through its Administrator and/or designated representative shall coordinate, communicate, and document their activities hereunder with the Hospice Administrator and/or designated representative.
Nursing facility shall immediately notify the Hospice upon occurrence of any of the following events:
(i) A significant change in Hospice patient's physical, mental, social, or emotional status;
(ii) Clinical complications appear that suggest a need to alter the Plan of Care.
(iii) A need to transfer a hospice patient from the nursing facility, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related to conditions; or
(iv) A hospice patient dies."

(B)