STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006712	A. BUILDING: _____ B. WING _____	C 12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE CENTER	1675 EAST ASH STREET CANTON, IL 61520

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. 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 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.	S9999		

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on record review and interview, the facility	S9999		

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failed to thoroughly assess, follow their policy for wound care, and seek physician directions in a timely manner for one of five resident, (R19) reviewed for pressure ulcer care in a sample of fifteen. This failure resulted in inaccurate assessment of the wound, delay of pressure ulcer treatment, and deterioration of the pressure ulcer.

Findings include:

R19's physician orders show R19 was admitted to the facility on 6/20/14 with diagnoses of Fractured Sacrum and Coccyx without Spinal Cord Injury, Kyphoscoliosis (Outward curvature of the spine), and Scoliosis (Lateral curvature of the spine). Physician orders also document R19 was discharged from the facility on 9/26/14.

A Progress Note dated 8/07/14 at 11:18 p.m., states, "Crease between leg and buttocks has a skin tear approximately 3 cm (centimeter) wide and 2 cm long. (R19) states (R19) thinks this was from (R19's) underwear rubbing against skin. Dressing applied and will request wound nurse to evaluate." A Skin/Wound Assessment form dated 8/07/14 does not include an assessment of R19's left buttock wound but states, "Surgical incision has closed/healed."

Another Progress Note, dated 8/14/14 at 10:40 p.m., states, "Put dressing over wound, will leave on report sheet asking for wound nurse to check to see if different treatment needs applied." A Progress Note, dated 8/19/14 at 6:10 p.m., states, "Dressing change to bottom. Color is black with borders red. Foul odor noted. No drainage at this time. Size is larger, 4.5 cm by 3.5 cm."

A policy titled Pressure Ulcer Prevention,

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Identification, and Treatment dated 5/20/11 states, "Documentation of pressure ulcer must occur upon identification and at least once a week until healed. Assessment is to include: a) characteristics: (i.e. size, depth, color, drainage) b) presence of granulation tissue, necrotic tissue, c) treatment and response to treatment, and d) prevention technique (i.e. turning and positioning, skin care, protective devices). The DON (Director of Nursing)/Designee and nurses are to make pressure sore rounds every week and discuss each residents' progress and make necessary changes. A weekly skin report will be completed."

A Skin/Wound Assessment dated 8/21/14 documents R19 has an open area on R19's left gluteal fold measuring 5.0 cm by 6.5 cm. The Assessment classifies the wound as a skin tear. E6 (Wound Care Nurse) documented on the form, "Found in charting on (8/07/14) states resident had skin tear from (R19's) underwear. Today (8/21/14) is the first (this) wound nurse knew of wound. 100 (percent) wound bed white slough. Surrounding tissue dark red fading to pink. Resident (complained of) pain/burning with dressing change. Minimal serous drainage. (Treatment): (honey based product), gauze, (wound prep) to surrounding tissue, then (occlusive type dressing) to seal from urine/ (bowel movement) entering wound."

On 12/04/14 at 3:18 p.m., E6 (Wound Care Nurse) stated, "I put down it was a skin tear because that's how they say it started out. I wasn't aware of it until I read the nurses' notes. That's how I found out about it. It (R19's left gluteal wound) was there a couple weeks before I knew about it. (R19) said it was from the elastic of (R19's) underwear. It was right there in the butt crease. I was concerned that the wound

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deteriorated as quickly as it did. The corporate nurse looked at it and said it wouldn't be classified as a skin tear but a pressure sore because of where it was, how it looked, and how it was deteriorating. I only put it as a skin tear because that's what the resident told me." E6 reported when staff find an open area they are suppose to complete a "skin sheet" and turn it into E6. E6 stated staff did not complete a skin sheet for R19's left gluteal fold wound. E6 stated, "One of the nurses finally told me." E6 indicated Z1 (R19's Attending Physician) was not notified of R19's open area on the left gluteal fold until 8/19/14. E6 reported R19's left gluteal wound was unstageable.

A policy titled Pressure Ulcer Prevention, Identification, and Treatment dated 5/20/11 states, "The policy states an ulcer is "Unstageable" when there is full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.

A policy titled Pressure Ulcer Prevention, Identification, and Treatment dated 5/20/11 states, "When a pressure ulcer is identified, whether in-house, or upon a resident's admission, the area will be assessed and initial treatment started per physicians orders. The physician is to notified when A) pressure ulcer develops, B) when there is a noted lack of improvement after a reasonable amount of time, C) and/or upon signs of deterioration. Physician order for treatment will include: a) specific site, b) how area is to be cleansed, c) type of treatment, d) how often treatment is to be completed, e) include care of (tissue surrounding wound)."

On 12/05/14 at 12:20 p.m., Z1 (R19's Attending Physician) stated Z1 examined R19 on 8/19/14.

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Z1 stated, "(R19) had a pressure ulcer on a prominent area of the buttock. It was a pretty deep ulcer. I started antibiotics. It was a pretty ugly looking by that time (8/19/14)." The Medication Review Report shows, on 8/19/14, Z1 gave an order stating, "Wound nurse to evaluate buttocks wound, determine whether it needs debridement. Get wound culture. Bactrim (Double Strength by mouth twice daily for ten days). Do not start antibiotic until after wound culture." A laboratory report dated 8/20/14 shows heavy growth of Methicillin Resistant Staph Aureus (MRSA) in R19's left gluteal fold ulcer culture.

A Skin/Wound Assessment dated 9/05/14 documents the wound measurements are unchanged but the wound bed has "100 (percent) soft, brown slough". A 9/12/14 wound assessment shows R19's left gluteal fold wound measured 5 cm by 8.5 cm. A 9/18/14 wound assessment states R19's gluteal fold wound measured 5.5 cm by 9.1 cm with 90 (percent) of the wound be covered with yellow/brown slough and 10 (percent) red granulated tissue. R19's wound assessment dated 9/26/14 documents R19's left gluteal fold wound measured 5.5 cm by 9.5 cm and "(Four) open areas have occurred due to tape. Edges flat, no drainage. Painful to touch." The opens areas due to tape are documented as a) 1.4 cm by 1.4 cm by 0.1 cm, b) 0.7 cm by 2.7 cm by 0.1 cm, c) 0.9 cm by 2.3 cm by 0.1 cm, and d) 2.5 cm by 1.5 cm by 0.1 cm.

(B)