STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006332	A. BUILDING: _____ B. WING _____	C 01/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF HINSDALE	600 WEST OGDEN AVENUE HINSDALE, IL 60521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) 300.1220b)3) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and	S9999		

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S9999	Continued From page 2 modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent the development of facility acquired pressure ulcers for R2 and failed to promptly develop a care plan for R3 after R3 developed an acquired pressure ulcer.. This applies to two of three residents (R2, R3) reviewed for pressure ulcers in the sample of three. This failure resulted in R2 developing five facility acquired pressure ulcers, one of which developed in the facility, became unstageable and infected while R2 was in the facility requiring the resident to be hospitalized. The findings include: 1). R2 is an 88 year old woman, admitted to the facility on 12/22/2014 " post left hip surgery after a fall " per the facility ' s nursing documentation dated 12/22/2014. R2 ' S electronic medical record (EMR) showed diagnoses that included rehabilitation, atrial fibrillation, uncomplicated type II Diabetes Mellitus, closed fracture neck of femur, macular degeneration, difficulty in walking, muscle weakness, and dementia without behavioral disturbances.	S9999		

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R2's was noted upon admission date of 12/22/14 with purple discoloration on her sacrum of 8 centimeters (cm.) x 6 cm. which then progressed to a 12.0 x 12.0 cm. unstageable pressure ulcer. In addition, R2 developed five facility acquired pressure ulcers which included two Stage I pressure ulcers; one on R2 ' s right trochanter measuring 6.5 cm. x 5.0 cm., and one on R2 ' s left lateral lower extremity measuring 6.0 cm. x 1.0 cm., and three unstageable pressure ulcers; one on R2 ' s left ischium measuring 8.5 cm. x 4.0 cm., one on R2 ' s right heel measuring 2.5 cm. x 5.0 cm., and one on R2 ' s left heel measuring 4.5 x 5.0., requiring hospitalization for wound infection.
R2 ' s Minimum Data Set (MDS) dated 12/29/2014 showed R2 was moderately cognitively impaired with a score of 8 on her Brief Interview of Mental Status (BIMS). The MDS showed R2 required extensive assistance with transfers, dressing, eating, hygiene, and toileting. R2 had an indwelling urinary catheter, and was always incontinent of bowel.
R2 ' s initial skin assessment signed on 12/23/2015 showed R2 had purple discoloration on her sacrum approximately 8 x 6 centimeters (cm.), front groin pelvic area purple bruising, and three left hip area intact/approximated incisions with staples in place. R2 ' s Braden Scale was 14 on admission, putting R2 at moderate risk for skin breakdown.
On 1/14/2015, at 3:40 p.m., R2 was laying on her back in bed. R2 ' s bed had a low air, loss pressure relieving mattress in place. Z1 (R2 ' s family member) was seated at R2 ' s bedside. Z1 stated she had been sitting at the bedside since 1:30 p.m. and R2 had remained in the same position during that time period, and that no facility staff had been in the room to reposition R2. At 3:45 p.m., Z1 used the call light to call for

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staff assistance. Z1 explained to the facility staff she had been in R2 ' s room for almost three hours and had not seen R2 ' s position changed. Staff complied with Z1 ' s request and repositioned R2.
On 1/15/2015 R2 was intermittently observed laying on her right side, between the hours of 8:30 a.m. and 11:55 a.m.; R2 was not repositioned. Z1 (R2 ' s family member) stated R2 ' s position " had not been changed all morning. "
On 1/15/2015, at 12:30 p.m., E6 (CNA-Certified Nursing Assistant) said R2 ' s last incontinence care and position change was performed " between 6:30 and 7:00 a.m. this morning. " E6 stated she had not repositioned R2 since 7:00 a.m., " because I think the night shift nurse told me to keep R2 on her side. " E6 stated residents should be repositioned every 2 hours.
On 1/15/2015, at 12:05 p.m., E3 (RN-Registered Nurse/Wound Care Nurse) changed R2 ' s pressure ulcer dressings. Loose, wet stool was present in R2 ' s incontinence brief and dried, crusty stool was stuck to R2 ' s buttocks. Incontinence care was performed on R2, prior to the dressing changes. Pressure ulcers were observed on R2 ' s sacrum, right trochanter, right heel, left ischium, left heel, and left lateral lower extremity. Immediately following the wound dressing change, E3 stated residents should be repositioned every two hours. E3 also stated that resident's care plans should be updated "right away" when a resident develops a pressure ulcer, but admitted she does not always do so.
The facility ' s Cumulative Skin Report dated " Week of: 12/29//2014 " showed R2 had a 7.0 cm. x 7.0 cm. unstageable pressure ulcer on her sacrum. The facility ' s Cumulative Skin Report dated " Week of 1/12/2015 " showed R2 ' s sacral pressure ulcer measured 12.0 cm. x 12.0

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cm., and five facility acquired pressure ulcers were present. These included two Stage I pressure ulcers; one on R2 ' s right trochanter measuring 6.5 cm. x 5.0 cm., and one on R2 ' s left lateral lower extremity measuring 6.0 cm. x 1.0 cm., and three unstageable pressure ulcers; one on R2 ' s left ischium measuring 8.5 cm. x 4.0 cm., one on R2 ' s right heel measuring 2.5 cm. x 5.0 cm., and one on R2 ' s left heel measuring 4.5 x 5.0.
On 1/15/2015 at 11:05 a.m., E2 (DON-Director of Nursing) said residents should be repositioned every 2 hours.
On 1/15/2015 at 1:15 p.m., E4 (RN-Director of Care Delivery, 1st Floor) said residents should be repositioned and checked for incontinence every 2 hours.
On 1/15/2015 at 3:10 p.m., Z4 (MD-Primary Physician for R2) said he was aware of R2 ' s facility acquired pressure ulcers. Z4 said frequent repositioning of R2 was important to prevent pressure ulcers, and that not being respositioned could have played a role in the development of her pressure ulcers. Z4 said he is aware that R2 can be uncooperative with care, but R2 should still be repositioned every 2 hours.
On 1/9/2015, E3 (RN/Wound Nurse) documented R2 acquired a pressure sore on her left ischium and left heel.
On 1/13/2015, E3 (RN/Wound Nurse) documented R2 acquired pressure sores on her right ischium, right heel, and left lateral lower extremity.
E3 created a care plan addressing R2 ' s pressure ulcer of the sacrum on 12/26/2014. Interventions initiated on 12/23/2014 included " encourage and assist as needed to turn and reposition, and special mattress/cushion on bed/wheelchair. " R2 ' s care plan was not updated after the initial care plan was created on

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12/26/2014, as R2 ' s sacral pressure ulcer worsened, as noted in E3 ' s nursing documentation on 1/9/2015; " decline to sacral wound " and on 1/13/2015 "sacral unstageable pressure ulcer wound now 12.0 x 12.9 cm. " R2 ' s care plan did not address an alternate plan of care when R2 refused repositioning or dressing changes.
The facility's nursing documentation dated 1/16/2015 at 11:27 a.m., showed R2 was sent to a local hospital due to her wounds after being seen by Z2 (MD-Wound Doctor) and Z4 (MD) on 1/16/2015. Follow up documentation on 1/16/2015 at 7:05 p.m. showed R2 was admitted to the hospital with wound infection.
The facility ' s policy entitled " Skin Practice Guide " dated 1/2013 showed: " Phase 3: Implement - Positioning, Mobility, Restraints . . . Minimize direct pressure over vulnerable areas and actual pressure ulcers, maintain head of bed elevation at less than 30 degrees, unless contraindicated, reposition frequently; use friction reducing devices for assistance, elevate or float heels, even if patient is on specialty support surface. " The facility ' s Skin Practice Guide also showed residents have " a right to refuse the care designed in the care plan. In this case, staff performs several tasks, including: designing an alternate plan, offering alternatives and documenting the patient ' s comprehension of options presented. This revised strategy needs to be described in the care plan and documented in the patient ' s medical record. Update the care plan to reflect any changes in the patient ' s risk status. "
2). R3 is an 87 year old woman admitted to the facility on 10/22/2014 post left hip surgery for fracture after a fall. E3 ' s (RN/Wound Nurse) documentation on 10/23/2014 showed R3 was admitted to the facility with diagnoses that

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included " atrial fibrillation, coronary artery disease, peripheral vascular disease, hypertension and kyphosis . . . with scattered blanchable erythema to buttocks and sacral area. Patient at risk for skin breakdown, related to above comorbidities, limited mobility related to hip fracture and reluctance to be repositioned. "
R3 ' s MDS dated 10/29/2014 showed R3 was cognitively intact with a BIMS score of 14, and required extensive assistance with transfers, ambulation, dressing, hygiene, bathing and toileting. R3 was frequently incontinent of bowel and bladder.
The facility ' s Cumulative Skin Report dated Week of: 12/08/2014 showed R3 had a facility-acquired Stage II pressure ulcer on her coccyx measuring 0.5 x 0.5 cm.
E3 ' s nursing documentation showed R3 had developed a Stage II pressure ulcer on her coccyx on 12/08/2014.
A care plan was created on 1/14/2015 by E3 to address R3 ' s coccyx pressure ulcer that developed a month earlier on 12/8/2013. Prior to 1/14/2015, there was no care plan in place to address R3 ' s pressure ulcer or risk for skin breakdown " related to recent hip surgery, diabetes, impaired mobility or incontinence. "
The facility ' s " Skin Practice Guide " showed " Phase 2: Plan. . . When the interdisciplinary team designs the comprehensive care plan to address the problem(s) associated with potential or actual skin alteration, a measurable goal is developed and a target date is established. . . . Regardless of the interventions that are put in place, a key factor to success is the timely review of the interventions as the patient ' s condition and needs change. "

(B)