STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001663	A. BUILDING: ______ B. WING ______	C 03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET HIGHLAND, IL 62249

(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	S9999		

Statement of Licensure Violations

300.610a)
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 300.1210 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. 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

Attachment A
Statement of Licensure Violations

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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

These requirements were not met as evidenced by:

Based on observation, record review, and interview, the facility failed to reassess the clinical condition for more frequent turning and repositioning, and failed to provide appropriate pressure relieving interventions to prevent the development of pressure ulcers for two of three residents (R1, R2) reviewed for pressure ulcers in the sample of 16. This failure resulted in R2 developing a Stage III pressure ulcer to the left buttock, and Unstageable pressure ulcer to the coccyx, and Deep Tissue Injury (DTI) to the right and the left heels.

Findings include:

1. R2's Physician's Order Sheet (POS) for 3/2015 documents diagnoses, in part, as "Carrier of

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MRSA (Methicillin Resistant Staphylococcus Aureus), Senile Dementia and Parkinson's Disease." The Minimum Data Set (MDS), dated 2/05/2015, documents R2 is severely impaired with cognition, requires extensive assistance for bed mobility, transfers, personal hygiene, has an indwelling urinary catheter and is incontinent of bowel. R2's Care Area Assessment (CAA), dated 2/05/2015, documents R2 is at risk for developing pressure ulcers, but has no documented pressure related areas.

On 3/04/2014 at 10:25 AM, R2 was in bed positioned to the left side. R2 had an alternating air loss mattress. R2's heels were directly on the mattress. On 3/04/2015 at 11:13 AM, 11:36 AM and at 12:15 PM, R2 was in bed lying on her back, with her heels resting directly on the mattress. An isolation sign was posted on the door of R2's room with personal protective equipment (PPE) in the hall near the door.

On 3/04/2015 at 12:16 PM, E7, Certified Nurses Aide (CNA) stated, "Normally (R2) stays in bed. She's not due for anything until 1:00 (PM)." On 3/04/2015 at 12:55 PM, R2 remained positioned on her back with her heels directly on the mattress. R2's incontinent brief was soiled with feces. A foam heel protector was in place to R2's right foot, but not on the left foot. A pillow was on the floor at the foot of R2's bed. When asked if she was in pain, R2 stated, "My feet hurt."

On 3/04/2015 at 1:25 PM, E3, Assistant Director of Nursing (ADON) applied PPE and entered R2's room. R2's left heel was still lying on the mattress. E3 reported R2 was on respiratory isolation for MRSA in the nares.

On 3/04/2015 at 1:50 PM, E11, Registered Nurse

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(RN) applied PPE and removed R2's dressing from her coccyx area. A quarter sized open area was on R2's coccyx covered with yellow slough. A healing open wound was on R2's left buttock. R2's rectal area was dark red. R2's right heel had a large unstageable black area (eschar). R2's left heel had a smaller dark brown area with surrounding dark purple tissue.

The Weekly Pressure Ulcer Management Report for 2/2015 documents on 2/15/2015 R2 had a facility acquired, unstageable pressure ulcer to the left buttock, measuring 2.0 cm (centimeter) X 1.0 cm with slough, a facility acquired and an unstageable pressure ulcer to the coccyx, measuring 4.0 cm X 2.0 cm, with slough.

The Weekly Pressure Ulcer Report for 2/2015 documents on 2/18/2015 R2 developed a facility acquired SDTI, (suspected deep tissue injury) pressure ulcer to the right heel, measuring 5.0 cm X 5.5 cm, dark purple and a SDTI to the left heel, measuring 2.0 cm X 3.0 cm, dark purple.

R2's Care Plan, dated 2/02/2015 and updated 2/16, 2/17, 2/19 and 2/24/2015, documents R2 is to be turned and repositioned every 2 hours while in bed. There is no turning and repositioning schedule for R2 documented when she is in the wheelchair at all. An intervention was added to R2's Care Plan on 2/19/2015 as "free float heels when in bed" to address the SDTI to both heels.

On 3/06/2015 at 8:10 AM, E4, RN/Wound Nurse reported R2 was identified as a high risk for pressure ulcers on admission (1/29/2015), but was not placed on an alternating air loss mattress until 2/18/2015 after the development of the pressure ulcers. E4 reported the repositioning schedule completed by the staff is documented

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electronically in the computerized system entitled, "Administration Documentation History Detail." E4 reported when the facility uses agency staff there may be a lack of documentation in the electronic recording system for R2.

The Administration Documentation History Report for R2 in 2/2015 and 3/2015 fails to document R2 was repositioned on 2/02, 2/08, 2/09, 2/13, 2/17, 2/19, 2/20, 2/21, 3/02, and 3/03/2015.

On 3/05/2015 at 11:00 AM, Z2, Special Wound Consultant/Nurse Practitioner (NP) reported facility staff should make sure R2's heels are floated. Z2 stated, "It wouldn't hurt to reposition (R2) more often than every 2 hours. (R2) has chronic issues with diabetes, chronic incontinence and poor dietary intake."

On 3/05/2015 at 3:18 PM, Z4, Physician reported he would recommend repositioning R2 every 2 hours, but may need to reposition R2 more often to heal the wounds. When asked if he felt R2's ulcers were unavoidable, Z4 refused to answer and stated, "Let me talk to the nurses." Z4 left the room and did not return with a response.

The Basic Metabolic Profile, dated 2/03/2015, were unremarkable with no indications of dehydration. The Physician's Order (PO), dated 1/30/2015, documents a fasting blood sugar level, Chem 8 (basic metabolic profile) be done every three months. R2's clinical record has no PO or laboratory reports for a protein or albumin level for R2 to see if she is malnourished.

R2's Nutrition Screening and Assessment, dated 2/08/2015 from E13, Registered Dietitian (RD), documents, in part, "Admitted at 190.4 pounds, height 63 inches, IBW (ideal body weight)

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104-127 pounds, BMI (basic metabolic index) 34. No indication of pressure ulcers. Abnormal labs (1/28/2015) include decreased Hgb (hemoglobin), does not appear to be nutritionally related."

2. R1's POS for 3/2015 documents diagnoses, in part, as "Diabetes Mellitus, Cerebral Vascular Accident (CVA) and History of Sacral Decubitus." The MDS, dated 12/25/2014, documents R1 is moderately impaired with cognition, requires extensive assistance for bed mobility, transfers and personal hygiene, has limited range of motion to the lower extremities, and is incontinent of bowel. The CAA, dated 9/19/2014, documents R1 is at risk for pressure ulcers due to needing assistance of 2 staff with turning and positioning.

On 3/04/2015 at 8:28 AM, 10:15 AM, 11:00 AM, 11:25 AM, and 12:15 PM, R1 was seated in the dining room in a wheelchair. R1 had bilateral foam heel protectors to both feet. R1 was obese.

On 3/05/2015 at 9:07 PM, R1 was transferred to bed by E5, CNA and E12, RN with a mechanical lift. At this time, E12 reported R1 is totally dependant on staff for turning and repositioning in the bed and the wheelchair. E12 stated, "What caused his foot ulcer is the foot rest of the wheelchair. We reposition him in bed every 2 hours. When he's in the wheelchair, we try to reposition him with a (mechanical lift) and shift his weight. He doesn't like to go back to bed." R1 had a dressing to his left foot.

The Change of Condition SBAR (Situation Background Assessment Response) PU (pressure ulcer), dated 1/20/2015, documents R1 has a new facility acquired, fluid filled blister to the left heel, measuring 3.0 cm X 3.0 cm, with treatment as "Cleanse left heel with NS (normal

Illinois Department of Public Health

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saline), Skin prep daily." The Pressure Ulcer Evaluation Record, dated 1/20/2015, documents R1's left heel intact blister as a DTI (deep tissue injury). The Pressure Ulcer Evaluation Record, dated 1/26/2015, documents R1's left heel as a Stage II, open blister.

R1's Care Plan for an actual pressure ulcer, updated 2/12/2015, documents R1 is to be repositioned every 1 hour while in the wheelchair and every 2 hours while in bed.

The Nutritional Progress Notes for R1 from E13, dated 1/26/2015, document, in part, "Current weight 230 # (pounds). No significant weight changes recently. Has a Stage II decubitus on left heel 2.0 X 3.0 cm. Appetite is fair to good. Current regimen meets/exceeds estimated needs.

On 3/6/2015 at 8:30 AM, E4, reported R1's left heel ulcer was caused by ill fitting shoes, and that R1 no longer is wearing shoes at this time.

The facility's policy and procedure, entitled, "Pressure Ulcer," dated 2006, documents, in part, "PURPOSE-To prevent skin breakdown and development of pressure sores. EQUIPMENT-Skin lotion as necessary, and per the resident's preference, elbow protector, heel protector, appropriate support surface for bed, appropriate support surface for chair, foot cradle, pillows."

(B)