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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.1210a)
300.1210c)
300.1210d)5)
300.1220b)3)
300.3240a)

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)

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1 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 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. (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:	S9999		

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Based on interview and record review the facility failed to implement resident specific interventions to prevent unstageable / deep tissue injury pressure sores.

This applies to two (R1 and R4) of three residents reviewed for pressure sores.

This resulted in R1 obtaining a deep tissue injury to unstageable pressure sore to her left heel on 5/6/15 measuring 2.9 cm x 1.3 cm. and an unstageable wound on the left ischium measuring 8.7 cm x 9.3 cm. on 5/30/15.

The findings include:

R1 was admitted to the facility on 4/22/15 from the hospital with an admitting diagnosis of fluid overload, diabetes mellitus and pacemaker as documented on the June 2015 Physician Order Sheet.

R1's admission assessment on 4/22/15 documented R1 had 0 of 10 on the pain scale rating (0/10) and intact skin other than some bruising to extremities and no known history of pressure sores.

On 6/25/15 at 1:15 PM, E4 (LPN,wound Nurse) stated R1 entered the facility on 4/22/15 with no pressure sores.

On 4/23/15 the first Braden risk assessment for pressure sores was done by E4 and R1 was documented "At risk." E4 stated interventions were moisture barrier after incontinence episodes and "float heels" in bed.

On 4/29/15, R1's Braden risk assessment was

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S9999	Continued From page 3 still "At risk" no new interventions added. On 5/6/15, R1 developed deep tissue injury (DTI) to left heel, foam dressing added no new interventions. On 5/13/15 R1 began to develop reddened area to coccyx, barrier cream was already in use, no new interventions. On 5/24/15 R1 developed open, excoriated areas to the coccyx, E4 stated an antifungal moisture barrier cream was added, no other interventions. On 5/29/15, R1 developed an unstageable wound to the left ischium. New dressings were added. On 6/1/15, E4 stated she assessed R1's ischial wound and then initiated a low air-loss mattress, limiting time out of bed to one hour. On 6/25/15 at 10:45 AM, E4 stated she is the wound nurse in the facility and is not currently wound certified. E4 stated there was not a wound physician who follows the wounds in the facility and directs wound care. E4 stated the primary physician will direct care for the resident. E4 stated the physicians usually just defer to the wound nurse. E4 stated that R1 had developed redness and excoriated areas to the coccyx area but E4 had not been following that area on R1 as part of her wound care. even though R1 was documented and assesed to be high risk. E4 stated it wasn't a pressure sore. The May 2015 treatment assessment record documents that weekly skin assessments were being done by the nursing staff on the 11 PM -7 AM shift with the last weekly check being on 5/27/15 where the staff nurse documented	S9999		

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multiple areas of bruising on R1 as well as small sores on the buttocks and the wound nurse was following. The May 2015 treatment assessment record also documents from May 5th 2015 to may 31, 2015 that each nursing shift confirmed the left heel dressing was intact and that proper offloading of the heel was done.

On 6/1/15 when E4 (wound nurse) assessed R1's reported reddened coccyx area, E4 stated R1 was noted to have an 8.7 cm x 9.3 cm unstageable left ischial wound that is documented as 95% necrotic tissue, the peri wound is macerated and reddened with a moderate amount of malodorous serosanguinous fluid. E4 documented in the wound assessment notes that R1 had a decline in condition and per the "floor staff" R1 was frequently non-compliant with repositioning despite education and that the MD and family were notified by the "floor staff." There s no documented education on the risks presented to R1.

The may 2015 CNA documentation form documents refusal of shower 5/5/15 and multiple episodes of complaints of back pain that the staff nurse was notified about. There is no documentation of R1 refusing care such as repositioning or heel offloading.

On 6/25/15 multiple CNA's who cared for R1 routinely were interviewed and stated when R1 complained of pain she didn't like to be moved.

R1's careplan with a problem start date of 4/28/15 and interventions were dated at 6/16/15. On 6/25/15 at 10:45 E4 (Wound Nurse) stated that's the way the printed out but that the intervention were actually started on 4/28/15. No other care plans reviewed printed that way and no other

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S9999	Continued From page 5	S9999		

problem areas other that pressure ulcers printed that way. The problem under pressure sore documents R1 is at risk for breakdown due to impaired mobility, non compliance with offloading, incontinence and co-morbidities including diabetes, chronic renal insufficiency, fluid overload and dehydration. The intervention are non specific to R1. The interventions listed were:

- assist/encourage repositioning as needed. There is scant documentation to support R1 refusing repositioning and staff being aggressive with it until R1 had an unstageable ischial pressure sore identified on 5/30/15.

-elevate the head of the bed 30 degrees or less unless contraindicated. R1 had documented episodes of back and hip pain in the May 2015 nursing notes and was unable to tolerate laying down at times and would sit up for hours to be comfortable and this was not addressed in the plan of care.

-monitor weights and labs as ordered. This was not consistently done.

-nutritional supplementation per registered dietician.

-observe and assess regularly. This is not clear on who should observe what and what assessment needs to be done for R1.

-Registered Dietician consult.

-serve diet as ordered. R1 was documented to have a consistent poor appetite.

-Therapeutic surfaces to bed and wheelchair as appropriate. This is not clear as to what

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therapeutic surfaces are needed and appropriate for R1 to prevent and heel pressure sores.

-weekly skin assessments.

After this careplan was initiated by E4 (Wound Nurse) on 4/28/15, R1 developed two unstageable pressure sores while in the facility and the only interventions added to the care plan were "Treatment as ordered."

The facility policy title "Skin Management" with a revised date of 12/2013 documents that the facility will assess residents for risks of pressure sores by identifying the specific factors and initiate interventions based on those factors. R1 came into the facility high risk and remained high risk and subsequently developed two unstageable pressure sores where more aggressive interventions were not put into place until the second unstageable pressure sore had developed. The facility skin management policy also documents the Braden Scale is the designated risk assessment tool and tissue tolerance testing would be completed on residents who are unable to position themselves while lying or sitting. There is no documented tissue tolerance testing done on R1.

There are no physician assessments of either wounds. Z1 (Primary Physician) had seen and assessed R1 on 5/13/15, 5/18/14, 5/26/15 and 5/29/15 and none of these assessments mentions R1s unstageable heel or ischial wound.

On 6/25/15 at 12:15 PM, Z1 stated he does not recall R1 having a sacral or ischial wound. Z1 stated he was aware of the heel wound but was concerned with her fluid overload status when he had seen her. Z1 could not remember if he had

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seen R1's wounds. R1 was transferred to the hospital on 6/2/15 due to unresponsiveness and hypotension and was found to have bactremia by positive blood cultures in the hospital.

R4 has a medical hisotory of open reduction internal fixation of the right elbow, Guillan- Barre syndrome and chronic anxiety as documented on the June 2015 physician order sheet.

R4's admission report from the hospital (undated) documents skin as left elbow elastogel and reddened buttocks.(R4 was admitted 4/8/15).

The facility admission assessment form dated 4/8/15 documents skin as: "bottom of heels red." and a surgical incision., bruises. No pressure ulcers.

The facility 4/8/15 treatment record documented, ""Right elbow incision healing, staples out, slightly red, no drainage. Both heels red, not open and blanches easily...." There is no other documentation on R4's elbow. R4's surgical incision is distal to the bony prominence of the elbow.

The facility nursing note dated 4/14/15 documents, "Right elbow noted with blanchable dark erythema, surgical site healed. Pt states she frequently rubs elbow against and presses elbow into the mattress." No interventions put in place to protect the elbows.

R4's care plan titled "Skin integrity." is undated and documents the problem as:
"R4 was admitted with surgical wound to rt elbow and deep tissue injury to right elbow. R4 is at risk for breakdown in skin integrity related to impaired mobility, incontinence and comorbidities. The

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inteventions listed are non specific and not individualized to the prevention and helaing of R4's unstageable right elbow pressure ulcer. The interventions listed are:

-Weekly skin assessments
-Monitor for changes
-Moisture barrier cream
-Elevate the head of the bed 30 degrees
-Assist/encourage repositioning
-monitor nutritional status
-Hydration
-Notify physician and family of change
-Treatment as ordered
-Assess an document weekly.

There are no specific interventions to prevent pressure to the elbows / bony prominences.

On 6/30/15 at 10:00 Am E4 (Wound Nurse) stated she had thought R4 was admitted with the pressure ulcer but confirmed there was no documentation to support that.

The facility "Wound Rounds" notes dated 4/9/15 documents R4 to have a Braden Score (Pressure ulcer risk factor assessment) of 14 being moderate risk. The preventive interventions listed were:
Nutrition-none
Friction and Shear- protect elbows if being exposed to friction

There are no documented interventions put in place to prevent the elbows from friction and shearing.

The first wound assessment detail report was done 4/17/15 and documents the wound was identifed 4/8/15 even though all supporting

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S9999	Continued From page 9 documentation stated R4 did not have a pressure sore on admission to the facility. The 4/23/15 documentation of the wound has the wound measured at 3.2cm x 2.6 cm and was described as, "Boggy with deep maroon filled blister. Periwound noted with yellow discoloration and bogginess." Foam dressing was added at that time. On 5/17/15 the purple maroon discoloration is documented as improved and now draining. It is not documented if the physician or family was notified. On 5/19/15 the dressing treatment was revised. On 5/25/15 the wound was documented as opened with partial thickness tissue loss. On 6/1/15 the wound is documented to have 95% slough. moderate amount of seroussanguinous drainage and macerated periwound. Dressing again revised. The careplan interventions were not revised during this period. (C)	S9999		