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	IL6005292	A. BUILDING: _____ B. WING _____	03/05/2015

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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)5) 300.1220b)2) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 are not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and prevent the development of a left and a right heel ulcer. These failures resulted in R1 developing bilateral deep tissue injuries to the left and right heels. The	S9999		

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facility also failed to implement treatments to promote healing for R2.
Findings include:

1. On 3/5/2015 at 9:25am, E15 (Licensed Practical Nurse) was changing R1's left and right heel dressings. E2 (Director of Nursing - DON) pointed to the yellow colored areas on R1's left and right heel wounds and stated, "this is slough." R1's right heel (lateral posterior area) and left heel (posterior area) both had slough covered deep tissue injury to of foot.
On 3/4/2015 at 8:40am, R1 was lying in the bed on her left side. R1's heel protectors were on the floor next to the bed.
On 3/4/2015 at 8:41am, E5 (certified nursing assistant - CNA) pulled back the blanket to expose R1's feet. R1 was wearing socks and her heels were resting on the mattress. E5 stated, "Heel protectors are used when the resident is up in the chair. We never put them on in the bed."
On 3/4/2015 at 8:43am, E3 (Assistant Director of Nursing-ADON) said, "R1 needs heel protectors on when in bed."
The MDS (Minimum Data Set) dated 8/21/14 shows R1 needs extensive assistance of 2 persons to move to and from a laying position, turning side to side, and for positioning her body while in bed.
A blank Braden Scale for predicting pressure sore risk for R1 was presented by the facility on 3/5/2015. No Pressure Sore risk had been done by the facility.
R1's Full Body Assessment dated 8/14/2014 shows there were no wounds present on the heels on admission.
R1's Physician Telephone Orders dated 8/18/14 show, "Float heels while in bed."
The Care Plan for R1 initiated 8/28/14 directs the certified nursing assistants to begin the use of

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"pressure reducing boots to bilateral feet when in bed and as needed to prevent pressure to heels."
On 9/9/14 an intervention to float the heels off the bed was added.
R1's nurse's notes dated 9/4/14 shows, " left heel has fluid filled blister 4.5cm x 3cm and (a) right heel blister, no fluid, 4.3cm x 4cm." R1's Wound Assessment Flow Sheet dated 9/6/14 shows a 4cm L (length) by 3cm W (width) by 0.3cm D (depth) wound, with a black wound base to the right heel.
The Wound Assessment Flow Sheet dated 9/6/14 shows a 4cm L (length) by 3cm W (width) by 0.3cm D (depth) wound, with a black wound base to the right heel.
The Wound Assessment Flow Sheet dated 9/14/14, shows a 9 L(length) 8 W(width) DTI (deep tissue injury), with an eschar (thick dark colored dead tissue) wound base to R1's left heel.
R1's nurse's notes dated 9/5/14 show, "Per Z1 (Primary Physician) skin prep to bilateral heels every shift, float heels while in bed."
The facility's Comprehensive Wound Program policy (undated) shows, "Any high risk resident or a resident with a wound will receive the appropriate pressure relieving devices as deemed appropriate by the facility, designated wound nurse and Director of nursing."
On 03/05/15 at 1210pm, Z1 (Primary Physician) stated, "Heel protection should be used at all times. Heel protectors stop localized pressure."
2. The Minimum Data Set (MDS) of 7/17/14 shows R2 was admitted on 7/10/14 with the following diagnoses: Cerebral Vascular Accident, Diabetes, Depressive Disorder, Pressure Ulcer to heel, Legal Blindness, Coronary Atherosclerosis, Contracture of the joint at multiple sites, a history of colonic polyps, and Dysphagia.
On 3/4/15 at 10:05 AM, E11 (Licensed Practical Nurse-LPN) applied skin prep and a foam

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dressing to the stage II pressure ulcer on R2's right buttocks. The open area measured 0.4 x 0.4 cm with light pink tissue. There was an area of reddened tissue around the open area that measured 4 x 5 cm. No drainage was present. On 3/3/15 at 10:05 AM, E11 stated she believes the open area "was due to shearing."
The facility's Wound Documentation Sheet of 2/24/15 shows a skin shear to R2's right buttocks.
The facility's Wound Assessment Flow Sheet dated 2/24/15 shows a stage II pressure ulcer to R2's upper right buttocks measuring 0.5 x 0.7 x 0.1 cm with no drainage present.
The facility's Braden Scale Sheet (tool used for determining a resident's risk of pressure ulcer development) of 11/27/14 shows R2 had a Braden score of 12 (high risk).
R2's Pressure Ulcer Care Plan of 2/24/15 shows R2 had a stage II pressure ulcer on his right coccyx area. Interventions included administering medications and treatments as ordered and monitoring for effectiveness, monitoring nutritional status, serving diet as ordered, and monitoring and recording intakes.
The Dietary Recommendations for Physician Approval Sheet of 12/2/14 shows R2's Body Mass Index (BMI) was 16.3 and he had lost 16 pounds in 5 months. The sheet shows R2 had an albumin level of 3.0 (low) and had open wounds to the coccyx and heel areas. The Dietitian recommended adding Pro Stat (liquid protein) 30 ml twice daily, and an 8 ounce fortified shake (whole milk, ice cream and other nourishing ingredients) once daily. The Dietary Recommendation Sheet was agreed to by R2's Physician on 12/8/14.
The Nutritional Assessment Consultant Sheet of 12/2/14 shows R2's was "considered a high nutrition risk and may benefit from additional high protein supplement to meet increased nutrient

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needs for wound healing."
R2's Potential for Alteration in Skin Integrity Care Plan of 1/29/15 lists encouraging good nutrition and hydration in order to promote healthier skin as an intervention.
The Physicians Order Sheets of 12/1/14 - 3/31/15 show Pro Stat 30 ml twice daily and an 8 ounce fortified shake daily was never initiated.
On 3/5/15 at 10:55 AM, E11 (Licensed Practical Nurse-LPN) stated "I don't see the Dietitian recommendations written on the January and February Medication Administration Records (MARs). "
The facility's February Meal Intake Sheet for R2 has 9 of 28 days filled out for the breakfast meal, 7 of 28 days filled out for the lunch meals and 3 of 28 days filled out for the supper meal.
On 3/5/15 at 3:00 PM, E2 (DON) stated " The CNAs have not been filling out the intake sheets like they are supposed to. "
The Minimum Data Set of 1/13/15 shows R2 is always incontinent of bowel and bladder.

Section 300.625 Identified Offenders

c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:

d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.

e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing

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S9999	Continued From page 6 name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry. (Section 2-201.5(c) of the Act) f) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements: g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part. i) For current residents who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report and Recommendation provided by the Department of the State Police. j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act) m) The facility's reliance on the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act shall not relieve or indemnify in any manner the facility's liability or responsibility with regard to the identified offender or other facility residents. n) The facility shall evaluate care plans at least	S9999		

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quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.

q) The facility shall develop procedures for implementing changes in resident care and facility policies when the resident no longer meets the definition of identified offender.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure an identified offender's finger print back ground check was obtained.

This applies to 1 resident (R18) reviewed for background checks in the supplemental sample.

The findings include:

The facility admission log shows R18 was admitted to the facility on 2/2/15.

R18's Criminal history background check dated 2/3/15 shows convictions for Domestic Battery and Aggravated Incest. The facility did not obtain a fingerprint background check for R18.

On 3/5/15 at 1:00 PM, E14 (Business Office Manager) said she completes the resident back ground checks. E14 said if a resident has a hit on their background check the facility obtains a consent for a fingerprint background check to be completed. E14 said they did not obtain a finger

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S9999	Continued From page 8 print background check for R18 because "we were told he outlived his sentence" and did not need one. E14 said she "assumed the convictions occurred at the same time and I did not look at the date of the convictions." E14 said she did not know that the Domestic Battery charge occurred in 2010. E14 said R18 was an identified offender according to his background check and the Identified Offender Conviction List. E14 and E1 (Administrator) said R18 should have had a fingerprint obtained and the state agency should have been notified of the Identified Offender status. E14 and E1 said they did not notify the state agency of R18's Identified Offender status. The facility policy "Abuse Prevention Program" (December 2013) states, "The facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions." (B)	S9999		