STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001085	A. BUILDING: _____ B. WING _____	C 08/03/2017

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RIVER NORTH OF BRADLEY H & R	650 NORTH KINZIE BRADLEY, IL 60915

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S 000	Initial Comments Complaint 1774620/IL95854- F157G, F223G, F314G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)3 300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

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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.

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:

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

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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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 Regulations were not met as evidenced by:

Based on interview and record review the facility failed to protect a resident from neglect by failing to make timely notifications to the physician of the development of a black area of tissue to the right heel, monitor this wound and implement interventions to prevent further deterioration of the wound. the facility failed to assess and monitor the development of a black area of tissue to a heel, implement interventions to prevent further deterioration of the wound and promptly notify the physician of the development of a wound.

This applies to one of three residents (R4) reviewed for wounds in a sample of six.

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This failure resulted in R4 developing an infected pressure ulcer to the right heel requiring a hospital admission for surgical debridement and antibiotic treatment.

Findings include:

The Order Summary Report dated August 2, 2017 documents R4 with diagnoses to include Multiple Sclerosis. A Progress Note dated June 8, 2017 documents R4 with fractures to the 2nd, 3rd, and 4th metatarsals of the left foot and to wear an orthopedic boot.

The Minimum Data Set dated June 13, 2017 documents R4 requiring extensive assistance of two staff persons for bed mobility and transfers and mobile with a wheelchair with one staff person's assistance.

On August 2, 2017 at 10:42am, E8 RN (Registerd Nurse) confirmed E8 was first made aware of the black area to R4's right heel around July 14, 2017, which E8 stated was possibly the last day before E8 went on vacation. E8 stated R4's heel had a black half dollar sized area of tissue. E8 stated, "I didn't call the physician." E8 stated on July 26, 2017 E8 returned from vacation on that date and saw R4's heel wound again and it was slightly bigger. E8 stated on July 30, 2017 a Nursing Assistant (E7) reported E8 needed to look at R4's wound to the right heel which E8 assessed and was now open. E8 stated Z2 (Physician) was notified and instructed E8 to send R4 to the hospital. E8 confirmed E8 never contacted the physician prior to July 30, 2017 and should have. E8 stated, "I do not recall any treatment or intervention being done for her after the day it was discovered."

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On August 2, 2017 at 3:03pm, E3 (Director of Nursing) stated the process for Pressure Ulcer Treatment was not followed: not contacting the physician, getting treatment orders promptly, monitoring and assessing the wound and implementation of interventions to prevent the further deterioration of the wound.

On August 2, 2017 at 10:27am, E6 (Day Nursing Assistant) stated, "On July 26, 2017 I got (R4) up and took off her socks. (R4) had a black area to the right heel about the size of a small plum." E6 stated this was reported to E21 (Midnight Nurse) who said she would pass it onto E8 (Day Nurse) to evaluate since it was change of shift. E6 stated later in the shift, while E8 was passing medications, E6 asked E8 if she had seen R4's heel and E8 said she had not seen it yet.

R4's Body Check form dated July 26, 2017, completed by E6 documents R4 with a black area to the posterior right heel. All July 2017 Body Check forms prior to this do not document any evidence of the presence of a Pressure Ulcer.

On August 3, 2017 at 1:12pm, E3 (Director of Nursing) stated E8 was on vacation July 18, 2017 and returned on July 26, 2017.

On August 3, 2017 at 11:47am, E11 (Treatment Nurse) stated E11 is generally notified of a wound or pressure ulcer by the floor nurse. At the time a wound is identified the physician and family are notified and treatment orders are obtained. E11 stated E11's first observation of a wound includes measurements, assessment of wound characteristics and assessment for additional individualized interventions. E11 stated after the initial assessment the wound is then monitored

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and weekly assessments are documented and in between the wound is monitored and physician is notified of any changes. E11 stated black tissue is considered an unstageable wound and the wound needs to be offloaded. On August 3, 2017 at 12:27pm, E11 confirmed no offloading interventions were added because E11 was not notified to assess R4. E11 confirmed if E11 had assessed R4, interventions to offload the right heel would be initiated.

The Progress Note dated July 30, 2017 at 7:41am, documents R4 with a foul odor and drainage to a black area on the heel; physician contacted and R4 was sent to the hospital.

On August 2, 2017 at 2:46pm, Z2 (Physician) stated, "I was first called July 30, 2017-message was heel wound with drainage. I sent (R4) out for an evaluation. I was not aware prior." Z2 stated, "If I had been made aware of a black area to the foot, even closed, I would send to the ER (Emergency Room) for evaluation. In my experience wound assessments are not always accurate. I couldn't see her; it would be most appropriate way to get an accurate assessment and treatment...If evaluated when first observed the outcome possibly could have been better...They should have called sooner so it could be treated."

The Emergency Room Provider Note dated July 30, 2017 documents R4's Physical Exam as large eschar (dead skin) over right heel and the area is foul smelling.

The hospital Admission History and Physical dated July 30 2017 documents R4 with a 2-3 inch non-healing ulcer to the right heel. Areas of exposed tissue with overlying necrotic tissue and

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purulent discharge. Diagnosis of Wound Infection and treatment to include the antibiotics Vancomycin and Zosyn.

On August 3, 2017 at 8:50am, Z3 (Podiatrist) stated R4 is being treated in the hospital and had eschar (dead skin) to the right posterior heel upon admission which Z3 surgically debrided. Z3 stated antibiotics were started for Cellulitis because the wound was infected. Z3 stated R4 has limited movement due to Multiple Sclerosis and is at risk to develop pressure wounds which progress quickly. Z3 stated R3's heel definitely had pressure to the posterior heel area too long and probably started as a blister. Z3 stated if the pressure ulcer had been identified sooner it could have been offloaded quicker. Z3 stated R4's wound is a full thickness Stage IV Pressure Ulcer. Z3 stated R4 is now at an increased risk to develop a life threatening infection now that the wound has been debrided.

R4's Braden dated June 29, 2017 documents R4 at risk for skin breakdown related to being chairfast, makes slight changes in position independently and potential problem with friction and sheer due to skin sliding to some extent on sheets, chair, etc. during positioning.

The Care Plan dated June 7, 2017 documents R4 at risk for skin alteration related to decreased mobility and does not include interventions to offload heels. The Order Summary Report dated August 2, 2017 and the July Medication Administration and Treatment Records do not include treatment orders or interventions for the care of R4's wound. The Progress Notes dated July 2017 do not include any assessments or documentation of the characteristics, monitoring

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or physician notification of the wound until July 30, 2017 when R4 was sent to the hospital for evaluation.

On August 2, 2017 at 3:03pm, E3 (Director of Nursing) stated the process for Pressure Ulcer Treatment was not followed: not contacting the physician, getting treatment orders promptly, monitoring and assessing the wound and implementation of interventions to prevent the further deterioration of the wound.

On August 3, 2017 at 9:23am, E1 (Administrator) stated the facility has investigated R4's care and has substantiated neglect.

The facility Abuse Policy dated September 2016 documents the facility affirms the right of our residents to be free from neglect. Residents must not be abused by anyone, including facility staff. Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or results in the deterioration of a resident's physical or mental condition.

The policy Change in Resident's Condition or Status dated December 2016 documents the nurse will notify the resident's physician when there has been a significant change in the residents' physical condition. A significant change of condition is a major decline in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions.

The Pressure Ulcer/Skin Breakdown Clinical

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S9999	Continued From page 8 Protocol dated March 2014 documents the physician will authorize pertinent orders related to wound treatments, identify medical interventions related to wound management; for example treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, etc. (A)	S9999		