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BRENTWOOD SUB-ACUTE HEALTHCARE CEN	5400 WEST 87TH STREET BURBANK, IL 60459

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S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 300.1220b)3) 300.3240a) 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 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 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	S9999	Attachment A Statement of Licensure Violations	

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resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
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.
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

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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 Requirements are not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to identify, assess, monitor and treat pressure sores as ordered by the physician and failed to provide preventative measures for 5 of 6 residents reviewed for pressure sores.

These failures resulted in residents experiencing the development of new pressure sores and/or deterioration of opened wounds.

This applies to 5 of the 6 residents (R1, R2, R3, R6 and R10) reviewed for pressure sores inside the sample of 17 resident.

The findings include:

1) Per R1's Minimum data Set (MDS) dated 7/16/15, R1 has multiple medical diagnoses to include generalized muscle weakness and chronic respiratory failure. R1 is on a ventilator via tracheostomy. R1 needs extensive assistance with ADLs (Activities of Daily Living).

On 7/28/15 at 2:50 PM, E4 (Nurse) provided wound care to R1. R1 has 3 dime size open areas or pressure sores in the right sacral area.

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S9999	Continued From page 3 E4 was unable to identify what stages the wounds were and was unable to describe the characteristics of these wounds. E4 stated she's not a wound care nurse. E4 cleansed the wounds with normal saline solution (NSS) and covered the wounds with bordered gauze. The bordered gauze covered only 2 of R1's pressure sores and left the 3rd, which was R1's bottom wound, uncovered/exposed. R1's Physician Order Sheet (POS) dated 7/17/2015 shows, Duoderm to coccyx every 72 hours and as needed for open area. On 7/29/15 at 10:10 AM, E6 (Wound Care Nurse) stated R1 had two stage 2 pressure ulcers on the right sacrum which were acquired in the facility. E6 said R1's top one (wound) measured as 1 centimeter (cm) in diameter and the 2nd one was measured as 0.5 cm in diameter. E6 stated R1 needs Duoderm treatment which would help with the healing process of R1's wounds. E6 said a bordered gauze dressing is not an acceptable treatment for R1's wounds. On 7/29/15 at 1:10 PM, E6 rendered wound care assessment and treatment to R1. R1's middle and bottom dime size pressure sore merged together creating one larger wound. E6 described the top open wound as unstageable due to presence of slough in the wound bed and measured as (L) Length 1cm x (W) Width 2 cm. The larger wound that merged together was described as stage 3 pressure sore and measured as (L) 4 cm x (W) 2.5 cm, with 10% yellow slough and 90% red tissue. R1's Physician Order Sheet (POS) dated 7/17/2015 shows, Duoderm to coccyx every 72 hours and as needed for open area. However, R1 was observed not receiving pressure sore	S9999		

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treatment as ordered by his primary physician and required by his condition.

Progress Notes dated 7/16/15 indicates: Open areas to sacrum were found. Wound care and unit manager notified. There was no evidence in R1's Progress Notes, Nursing Notes, or TAR (Treatment Administration Record) of weekly skin and wound assessments being done consistently for R1.

There was no evidence that the wound physician had seen or assessed R1's pressure sore.
R1's only Braden Score dated 7/10/15, identified R1 as a moderate risk for pressure sores. There is no evidence to show preventative measures were put in place (eg. pressure relieving mattress or low air loss mattress) for pressure sore prevention prior to R1's breakdown.

2). Per R6's MDS (Minimum Data Set) dated 7/9/15, R6 has multiple medical diagnoses to include generalized muscle weakness, acute/chronic respiratory failure with tracheostomy and has stage 4 pressure ulcer in her left mid-back. R6 needs extensive assistance with ADLs.
On 7/28/15 at 1:30 PM E4 rendered wound care to R6. E4 was unable to identify and describe R6's wound characteristics. E4 stated, "I am not a wound care nurse." E4 cleansed with NSS the surrounding area (skin) of R6's stage 4 pressure sore, but not inside the wound. E4 proceeded to apply Santyl ointment to the surrounding area of the wound but did not apply any Santyl ointment into R6's wound.

R6's POS dated 7/3/15 indicates: Santyl to left upper back wound every shift and as needed.
R6's Wound care specialist notes dated 7/8/15

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indicates: Left mid-back stage 4 pressure sore. Treatment: Hydrogel. R6's wound in the left back is due to kyphosis and poor ability to reposition. R6 needs padding to the back of wheelchair. Follow/support nutrition and hydration.
R6's Wound care specialist notes dated 7/15/15 indicates: Stage 4 pressure ulcer. Treatment: Hydrogel. Monitor nutrition. Keep bacterial load low and keep appropriate moisture with wound. Decrease pressure on the back due to scoliosis.

From 7/28/15 through 7/30/15 between 9:30 AM though 1:00 PM, R6 was observed sitting up in her wheelchair with no back padding.
R6's only Braden Scale dated 7/2/15, identified R6 as a moderate risk for skin breakdown. Wound specialist recommended back padding on R6's wheelchair to alleviate pressure on her back.

On 7/29/15 at 10:15 AM E6 stated the following for R6's wound: Clean the wound bed, dab the wound bed with NSS in a gauze, clean the wound from inner to outer area. Then apply Santyl ointment to the wound bed and cover with dry dressing. Santyl ointment is not supposed to be applied to the surrounding area or outside area of the wound.

On 7/29/15 at 1:45 PM E6 (Wound Care Nurse) stated, "We do comprehensive skin assessments on admission. We notify physician and family if there's a skin breakdown. We (wound care) do our assessments and treatment recommendations, then we do weekly skin and wound assessments."

7/30/16 at 9:55 AM E6 stated that Santyl ointment and Hydrogel are two different medications with different purposes. Santyl ointment is a debriding agent while Hydrogel is to keep the wound moist.

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Whoever carried out the order for R6 should have clarified the order with the wound doctor. E6 added that she just changed the order as of today to Hydrogel as originally ordered/recommended by the wound physician.

On 7/31/15 at 12:25 PM Z6 (R1's and R2's primary physician) stated that all wounds or skin breakdown must be referred to wound care specialist. Z6 stated he did not know what the facility did in the absence of the wound care doctor, and someone should cover when the wound doctor is not available. Z6 also stated he couldn't remember if the facility had notified him with regards to R1's and R6's skin breakdown.

The facility's Policy and Procedure for Skin Management showed the following instructions for the nursing staff: "Overview: Residents who are at risk or with wounds and/or pressure ulcers and those at risk for skin compromise are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes....Practice Guidelines: ...Following admission, the Braden Scale For Predicting Pressure Sore Risk will be completed weekly for additional 3 weeks (for a total of 4 weeks including admission), quarterly, annually and with a significant change of status for their risk for development of pressure ulcer.

Facility was unable to provide evidence of accurate wound report or wound tracking upon request until the third day."

3). R3's Face Sheet shows R3 was admitted on 7/8/2015 with the following diagnoses: chronic respiratory failure, dependence on respirator, cognitive deficit, encephalopathy and

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convulsions.

Braden Scale dated 7/8/2015 states, "Very high risk" for pressure sore development.

Progress Note dated 7/17/2015 states, "Patient noted with open area to coccyx area, area was cleaned with Normal Saline and duoderm was applied." R3 acquired the pressure sore in the facility.

Physician Order dated 7/17/2015 states, "cleanse coccyx wound with normal saline then apply duoderm every three days for coccyx wound." The Treatment Administration Record dated 7/17/2015 through 7/27/2015 did not contain signatures for the wound treatments. There is no evidence that the treatments were implemented.

R3's Care Plan for skin breakdown dated 7/17/2015 states, "complete a full body check weekly and document. Reposition in bed/adult recliner frequently for comfort and pressure reduction."

However, R3's clinical record contained no weekly skin notes, no wounds notes and there was no description of R3's wound.

On 7/28/2015 starting at 10:00 AM with tour guide E13 (Activity Director), R3 was laying on a standard bed. R3 was on a ventilator and had a tube feeding infusing.

On 7/28/2015 at 10:30 AM, E11 (Nurse) was assigned to care for R3. E11 said she did not know who had wounds on the unit. E11 stated the wound care nurse would know and said go ask the certified nursing assistants on the unit.

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On 7/28/2015 at 10:30 AM, E12 (Certified Nursing Assistant) was assigned to care for R3. E12 did not identify R3 as having a pressure sore.

On 7/28/2015 at 1:35 PM, E12 (CNA) and E27 (Restorative Aide) were observed placing a low air loss mattress on R3's bed. E27 (Restorative Aide) said R3 is just now receiving a low air loss mattress because R3's family was complaining about R3 not being on one (low air loss mattress).

On 7/29/2015 at 8:55 AM, E15 (Nurse) said R3's dressings were changed by the treatment nurse (E16).

On 7/29/2015 at 8:56 AM, R3 was laying in bed with two large duoderm dated 7/29/2015 on the buttock area. The right buttock area duoderm did not cover the entire wound. R3 began to have episodes of incontinence which leaked out over the uncovered wound area. E12 (CNA) and E27 (Restorative Aide) provided incontinent care for R3.

On 7/29/2015 at 11:30 AM, E6 (Wound Care Nurse) said she was not familiar with R3's wounds and had just returned from a leave of absence. E6 said E16 (another Wound Care Nurse) did the treatment for R3 early this morning (on 7/29/2015). E6 said she would re-do R3's treatment today because she (E6) was informed the dressing did not cover all the areas of R3's wound. E6 (Wound Care Nurse) said R3 should have been placed on a low air loss mattress since admission because of R3's high risk for the development of pressure sores. E6 was asked if R3 had weekly skin and wound assessments. E6 said there should be weekly documentation of wounds and weekly skin assessments for residents. E6 (Wound Care Nurse) stated again

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she was on leave for a few months and E16 (Wound Care Nurse) was responsible for the wound care program while she was gone.

On 7/29/2015 at 11:36 AM, E16 (Wound Care Nurse) said R3 had a small opening on the sacral area. E16 (Wound Care Nurse) said the unit nurse was responsible for doing resident's wounds treatments. E16 said residents who have wounds should be turned every two hours and have a low air loss mattress as part of their pressure sore prevention plan.

On 7/29/2015 at 1:55 PM, E6 (Wound Care Nurse) and E17 (CNA) did the treatment for R3's wounds. R3 had one 11 centimeter (cm) in length by 11cm in width deep reddened tissue and opened areas to the sacrum. R3 had two stage 2 pressure sores, one located on the left buttocks (measuring 0 .5 cm in length by 0.5 cm in width) and one on the right buttocks (measuring 0.4 cm in length by 0.5 cm in width). The pressure sore on the right buttock area was not all covered by the duoderm. E6 confirmed R3's dressing should cover R3's entire wound. E6 (Wound Care Nurse) said E16 did R3's dressing change but E16 did not notify the doctor of R3's additional wounds.

On 7/30/2015 at 1:25 PM, E15 (Nurse) said she noted R3's skin breakdown on 7/17/2015. E15 (Nurse) said it was just a little redness at the beginning of R3's breakdown. E15 (Nurse) said she did not know how to describe the wound and just documented an open area. E15 could not answer when the wound deteriorated or if treatment was given/changed to prevent R3's wound from further deterioration.

On 7/30/2015 at 12:48 PM, R3 was laying in bed.

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Z3 (R3's family member) said no one has turned R3 in 4 hours. Z3 stated someone from R3's family has been with R3 all morning, but no staff has repositioned R3. Z3 said this is not the first time this has occurred. Z3 said staff could have done more to prevent R3's pressure sores from happening. Z3 stated R3 should have had an air mattress in the beginning, but the facility would not provide one. Z3 said R3 came in without a pressure sore and now R3 has bed sores.

On 7/30/2015 at 11:53 AM, E6 (Wound Care Nurse) said there is no tracking or monitoring of R3's wounds. E6 could not answer how the wound deteriorated but states again that she was on leave of absence and it should have been done.

On 7/31/2015 at 12 PM, Z7 (Physician) for R3 refused an interview.

4). R2 has numerous medical diagnoses including Chronic Respiratory Failure, Dysphasia, Hypertension, Diabetes Mellitus, G-Tube (Gastrostomy tube), Urinary Obstruction secondary to Benign Prostatic Hypertrophy. On 7/28/15 at 11:20 am, E8 (RN) stated that R2 is dependent on staff for all care.

On 7/29/15 at 9:35 AM R2 was observed laying in bed on his back. E9 turned R2 to do a bodycheck and a small open area was discovered on R2's right buttock. E9 stated that she was not aware of this open area and that she would notify the wound care team. When questioned as to who does skin checks on residents, E9 stated that the wound care team did the skin checks, as well as nursing staff. E9 stated that it appeared to be a Stage 2 wound. E9 could not say when R2's last skin check was done.

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Physician's Order Detail dated 7/30/15 reflects an order for Duoderm to be applied topically to the right coccyx every shift for treatment of the pressure ulcer after a normal saline cleanse.

On 7/28/15 at 11:20 AM E9 stated R2 had been on her unit for several weeks, and she had never seen R2 out of bed. E9 could not say why R2 did not get up, other than stating that R2 was a fall risk. R9 was observed 3 times during the day shift on 7/28/15 (9:55 AM, 12:30 PM, 1:45 PM) and 4 times on 7/29/15 (8:40 AM, 9:35 AM, 10:30 AM, 1:30 PM), to be in bed for all those observations. R2 was never observed out of bed on 7/28/15, 7/29/15 or 7/30/15 (9:00 AM, 11:45 AM). At 10:00 AM on 7/29/15, E8 (CNA) stated that she was caring for R2 that day and had cared for him in the past, but not for a week or so. She stated she was not aware of the open area just discovered on R2 as she had not given R2 his bath yet and had only repositioned him that morning. She hadn't observed his buttock area that day. E8 stated R2 had gotten out of bed in the past but she was unable to say when. She stated she could not recall when she had gotten R2 up and stated that it had been a while.

R2's Weekly Pressure Ulcer Record dated 7/29/15 indicates the site assessed was the right buttock. This was documented as a new wound which was facility acquired. This was described as pressure-type wound and staged as a Stage one, despite the area being open. The measurements were 1.5 cm in length by .5 cm wide, with no depth. Description of site documents, "open red area to right side of buttocks."

R2's Braden Scale for Predicting Pressure Sore

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Risk dated 6/27/15 scores R2 as a 15, which is at risk for pressure sore development. This document describes R2 as bedfast, with slightly limited mobility.

On 7/30/15 at 10:35 AM, E6 (Wound Care Nurse) stated that R2 had no other skin assessments prior to the one done 7/29/15 after his right buttock open area was discovered. E6 stated that typically a skin assessment would be done on admission and then weekly.

5.) On 7/28/2015 at 1:17 PM, R10 was observed incontinent of stool. R10's dressing in her sacral area had come off due to her incontinence. The certified nurses aide (E28) caring for R10 was interviewed. E28 stated she last changed R10 at 10 AM, which was approximately 3 hours ago. R10's opened wound was observed to have a large amount of slough with necrotic areas. E29 was R10's nurse. E29 said she did not usually change resident's dressing because there was a treatment nurse. E29, after taking a long time to locate supplies, changed R10's dressing. R10's nurse (E29) cleaned R10's sacral wound with normal saline and applied a Hydrocolloid dressing. R10 also had necrotic wounds on her right and left heels which were covered with foam dressing. E29 stated R10's dressing changes were being done every 72 hours.

E6 was interviewed on 7/29/2015 at 9:45 AM. E6 stated R10 was admitted to the facility with a sacral wound on 6/26/2015. E6 said R10 was seen by the wound care physician on 7/08/2015 and 7/15/2015 and assessed R10 to have an unstageable pressure sore with slough measuring 18 cm x 12 cm in the sacrum/left buttock areas. E6 said the physician also assessed R10 to have developed a new unstageable wound on the right

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	IL6001127	A. BUILDING: _____ B. WING _____	07/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD SUB-ACUTE HEALTHCARE CEN	5400 WEST 87TH STREET BURBANK, IL 60459

(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
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and left heels in the facility, one on 7/08/2015 and the second one on 7/15/2015. E6 said the wound care specialist ordered R10's sacral wound be treated with an ointment dressing. E6 said she was on leave when the wound care specialist wrote R10's order, but R10's wound care specialist order should have been followed. E6 could not explain why the nursing staff had not followed up to ensure the wound care specialist order had been implemented in the care of R10's wound. E6 said that the nurses were responsible for ensuring that the residents received the treatment ordered by the wound care specialist in her absence. E6 stated she had no record/documentation done by the facility's nursing staff to show as evidence that weekly skin assessments continued to be done as required after 7/15/2015. E6 said skin checks should be done weekly or every 7 days, but R3 had none done. E6 provided documentation of R10's POS and TAR (Treatment Record Sheet) which showed R10 was treated with a Hydrocolloid dressing from date of admission on 6/26/2015 till 7/28/2015 every third day. E6 said this was not the treatment recommendation by the wound care specialist. E6 stated R10's were reassessed when she returned to duty on 7/29/2015 which was approximately 13 days since R3's last assessment. E6 said she measured R10's wound on the sacrum and observed R10's wound had increased in size and was 8.5 cm x 12.5 cm with a depth of 0.2 cm. E6 said R10's heel wounds were Deep Tissue Injuries, which also increased in size. E6 said in the absence of the wound care specialist, she called R10's primary physician, Z5. E6 said Z5 ordered daily Santyl dressing changes on 7/30/2015 because R10's sacral wound had the presence of a lot of slough. After signs of deterioration of R10's wound, the wound care

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specialist orders were implemented. E6 did not have evidence of a comprehensive wound assessment being done for R10.

R10's primary physician (Z5) was interviewed on 7/31/2015 at 12 PM. Z5 is also the facility's medical director. Z5 said the wound care team was responsible for directing the care of resident's wounds, and the floor nurses should follow up to ensure the treatment and orders given by this team are followed. Z5 said the wound care specialist recently became unavailable and the nursing staff should contact the primary physician for wound care orders. Z5 stated resident's should have skin check/assessments done weekly. Z5 was asked about R10's care needs. Z5 described R10 as a resident who was unresponsive and in poor medical condition. Z5 said R10 was at risk for her skin to break down quickly and she required weekly skin assessments to ensure treatment of new pressure sores.

Review of R10's Face Sheet showed R10 is a 91 year old female with diagnoses including Dementia, Diabetes, Cardiovascular Accident, Dysphasia and Gastrostomy.
Review of R10's care plan dated 7/08/2015 showed, "R10 was at risk for skin break down because of her incontinence and immobility." This plan of care identified R10 having a "Stage 2 Coccyx wound." R10's plan of care did not show it was updated to address her unstageable wounds in her sacral/left buttocks area or heels. The treatments for R10's heels were not included. Staff failed to show evidence of monitoring R10 for incontinence every 2 hours, changing her promptly and consistently monitoring for changes in R10's wound as her plan of care directed.

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S9999	Continued From page 15 During the Daily Status Meeting with administrative staff (E1/administrator and E2/director of nursing) on 7/30/2015 and 7/31/2015, the facility's pressure sore program for residents was discussed. E2 confirmed that she identified 27 residents having pressure sore on the 671 (Resident Census and Condition) form when the survey team entered the facility on 7/28/2015, and by 7/30/2015 the number increased to a total of 35 residents (who were identified as having pressure sores at more than a stage I). E2 nor E1 could explain why the facility's system for monitoring, assessing and treating pressure sores had failed. E1 and E2 identified one treatment nurse to take care of approximately 27 to 30 residents but could show no evidence this one nurse could manage so many medically complex residents. E1 said the facility was working on increasing the number of knowledgeable nurses to work on the wound care team. E1 and E2 identified E16 as being the treatment nurse during E6's absence from the building, but could not explain why E16 did not complete all the tasks needed to prevent such poor outcomes in the residents' care. E2 said the floor nurses were there to provide wound care with the treatment nurses, but E2 said a lot of the nurses did not know how to stage or identify the type of pressure sores residents could develop. When asked to provide the training schedule, E1 nor E2 presented any evidence to show that the facility provided the nursing staff with any training/inservice needed to function as a treatment nurse or part of the treatment team. (B)	S9999		