STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006365	A. BUILDING: _____ B. WING _____	C 06/11/2015

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WAVERLY PLACE OF STOCKTON	501 EAST FRONT STREET, PO BOX #38 STOCKTON, IL 61085

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S9999	Final Observations Statement of Violations: 300.610a) 300.1010h) 300.1210b)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. 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 300.1010 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

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Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Findings Include:

On June 10, 2015 at 8:00 AM, R1 was at a local hospital. There were two Duoderms (dressings) in place to the upper buttocks. The surrounding skin was reddened from the top of her buttocks down to 1/4th of her thighs. R1 had a darkened purple area on her right heel that measured 1 in x 0.5 in. R1 stated, "I need help to turn in bed. My bottom is very raw and sore and I have a sore on my right heel. They wrapped my right heel with gauze after I got the sore."

On June 10, 2015 at 9:05 AM, Z1 (Registered Nurse at local hospital) stated, "R1 has a stage two pressure ulcer to her buttocks. The one wound measures 0.5cm x 0.5cm and the other wound measures 1 cm x 2 cm. The stage 2 wound on her buttock was documented on admission."

On June 8, 2015 at 10:02 AM, Z4 (Case manager at a local hospital) stated, "She has a pressure ulcer on her right heel. It is purple and unstageable."

The nurse chart assessment from the local hospital dated June 3, 2015 at 9:00 AM, states, "Open areas to coccyx and right medial heel ulcer that is not open, purple in color approximately quarter in size."

The physician admission documentation from the local hospital dated June 3, 2015 at 10:36 AM,

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states, "Skin: Positive for cellulitis, ecchymosis, erythema, rash, ulceration, warm to touch of the buttocks, right hip and right heel." at 10:45 AM, "There is diffuse erythema and maceration and superficial ulceration over both buttocks and posterior proximal thighs as well as an early decubitus on the right heel." "Disposition: Decubitus ulcer, pressure, (buttock)-bilateral, decubitus ulcer, pressure, (heel)-right."

On June 9, 2015 at 11:10 AM, E2 (Director of Nursing-DON) stated, "R1 has a stage 2 pressure ulcer on her bottom that we discovered on June 2nd. We just discovered it the day before she went to the hospital on June 3rd." at 3:15 PM, "When a nurse finds a new wound I expect them to assess, measure, call medical doctor for orders, update the family, implement orders, and document the assessment. It was acquired here at the facility. The admit nurse completes a skin and admission assessment." On June 11, 2015 at 11:10 AM, "The skin assessment policy is used as the prevention program. We also rely on nurses training and critical thinking skills to contact the medical doctor when more orders are needed."

On June 9, 2015 at 11:50 AM, Z3 (Medical Doctor) stated, "I first became aware of her wounds on June 2, 2015. I did not know the severity until I saw her."

The facility's progress notes dated June 3, 2015 at 1:20 AM states, "New orders were received. Wound center consult to be done for right heel and incision and dermatitis. Buttocks treated with antifungal cream and butt paste/barrier cream.

The facility's nurse assistant notes for the AM, PM, and Night shift for May states,"resident was

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cooperative and did not refuse assistance."

On June 10, 2015 at 1:45 PM, E4 (CNA) stated, "The nurses are supposed to do skin assessment. We keep an eye on resident's skin everyday. If we notice something out of the ordinary we report it to the charge nurse right away. When R1 came to the facility she had spots on her coccyx area. They were reddened and raw. They were not opened. I reported it to the nurse, I don't remember the nurse's name. We don't document the skin checks, the nurses document the skin checks and skin assessments. I thought the spots on her coccyx looked better when she left. We were applying skin protectent every incontinent episode."

On June 10, 2015 at 2:27 PM, E6 (CNA) stated, "We perform skin checks every time we do care. Her skin on her buttocks was slightly red on admission. I notified the nurse but do not remember which nurse. On June 2nd her bottom was opened and red, her right heel had a blister. Her buttocks was redder on her last day on June 3rd. I told the nurse but do not remember who. We repositioned her every two hours and float her heels. She sometimes refused repositioning. That would be documented on the CNA sheet each time she refused."

On June 10, 2015 at 2:50 PM E5 (Certified Nursing Assistant-CNA) stated, "I perform skin checks about every two hours. When R1 was first admitted her bottom was red and it started to look better and then it progressed to almost blister like. She refused to be repositioned. I charted that in the CNA charting and told the nurse that as well. She had a blister or pressure ulcer on her right heel."

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S9999	Continued From page 5 On June 10, 2015 at 3:30 PM, E7 (Licensed Practicing Nurse-LPN) stated, "I did a skin assessment when she first came in and on the third day because of loose stools. Her buttocks was excoriated on admission. The third day skin assessment was documented under progress notes. The excoriation to her buttocks remained the same and there was no other skin issues noted." The facility's nurse aides information sheet not dated states, "Skin Care special: Hip incision and routine. Needs encouragement to get out of bed and reposition." The facility's nursing admission screening/history dated May 21, 2015, states, "Skin: Note all skin issues: Right trochanter (hip) surgical incision 5.5cm X 1cm, Right trochanter (hip) surgical incision 8cm X 1cm." The facility's braden scale effective date May 22, 2015 at 1:02 PM states, "Score:17, Category: At risk." The facility's use of pressure sore risk management (undated)states, "Purpose is to identify resident at high risk for skin breakdown and ensure implementation of prevention program. Residents identified at risk, start program or if a significant change in residents condition." The facility's skin assessment policy (undated) states, "Skin assessments will be done for all new admissions, quarterly review, and significant changes of condition. Residents will be determined to be at risk according to the Braden Scale."	S9999		

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S9999	Continued From page 6 On June 11, 2015 at 11:10 AM, E1 (Administrator) stated, "The prevention program for R1 included repositioning every 2 hours and as needed and pillows used as support. She was on a pressure relieving mattress upon admission. She needs encouragement to get out of bed and reposition." (B)	S9999		