STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014518	A. BUILDING: _____ B. WING _____	C 02/22/2018

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MEADOWBROOK MANOR - NAPERVILLE	720 RAYMOND DRIVE NAPERVILLE, IL 60563

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S 000	Initial Comments Complaint Investigation 1870511/IL99761 1870940/IL100237	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 300.1220b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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	S9999		

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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 Requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to identify, treat and notify the physician of a facility acquired wound. This

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failure affects one resident (R2) of three residents reviewed for wounds and resulted in R2 acquiring one Stage 3 buttock pressure ulcer with surrounding Deep Tissue Injury and one Stage 3 gluteal fold wound. The facility also failed to implement interventions, preventative measures and initiate a skin impairment care plan for one resident (R4) of three residents reviewed for wounds.

Findings include:

Physician's Order Sheet (POS) dated 12/1/17 indicates R2 was admited to Hospice on that date.

POS dated 1/19/18 indicates to discontinue Bacitracin and foam dressing and start Phytoplex Z-Guard (hydrating skin cream) to peri-area and buttocks daily.

Nurse Progress Notes dated 1/26/18 at 3:35pm indicates R2 has an open area on her left buttock due to MASD (Moisture Associated Skin Damage).

POS dated 1/26/18 indicates orders received to "Apply Calazime (moisture barrier cream) to left buttock daily and as needed."

POS dated 1/31/18 indicates "Apply Calazime Cream Daily and as needed to buttocks."

No other nursing progress notes, assessments, monitoring or tracking of this "open area" identified on 1/26/18 were found or provided.

On 2/7/18 at 1:45pm R2 was observed in bed. V8, CNA (Certified Nurse Assistant) stated that she was R2's assigned CNA for the day but did

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not actually see R2's skin because Hospice Aide took care of R2 on that day. V8 stated that R2 was already up in her chair when she started her shift at 6am. V8 stated the Hospice Aide told her and V9, LPN that R2 had open areas on her buttocks and that V9 put cream on R2's wounds.

At that time R2 was noted to have an oval-shaped ulcerated open wound with scattered slough throughout the wound bed on left inner buttock. Wound noted with dark red/purple non-blanchable discoloration surrounding entire ulceration. Right inner buttock was noted with crescent-shaped, non-blanchable light purple/red discoloration directly opposite left buttock wound. Right gluteal fold was noted with irregular-shaped open area/wound bed covered with approximately 75% slough and reddened edges.

R2's wounds were again observed on 2/8/18 with V6, Wound Care/LPN (Licensed Practical Nurse) and V10, RN (Registered Nurse/Wound Care Nurse). At that time V6 stated that the wound on R2's left buttock was a "Stage 3" and the wound on right gluteal fold was caused from the elastic from the incontinent brief constricting on the skin and due to moisture. V6 stated "That's why (R2) shouldn't have diapers on, shouldn't be sitting up for more than 2 hours and shouldn't be on the early get up list."

On 2/8/18 at 1:30pm V9, LPN (Licensed Practical Nurse) stated that (on 1/7/18) she was told about R2's open areas by R2's Hospice Aide. V9 stated that she checked the treatment book, saw a treatment and applied it to R2's open areas. V9 stated that she later talked with V6, Wound Care Nurse about R2's wounds because "I really thought maybe something else should be put on them (besides Calazime)." V9 stated that V6 told

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S9999	Continued From page 5 her they were not new wounds and that she had seen them earlier that day. On 2/8/18 at 1:50pm V10, RN stated that she initially found the area on R2's left buttock (on 1/26/18) and that it was superficially open; "Not like now." V10 agreed that the wound found on 1/26/18 and the left buttock wound were in the same location. V10 stated she does not know how the wound on R2's right gluteal fold was not noticed. V10 stated that nurses and CNA's should be looking at R2's skin everyday and report any new wounds or changes. No assessments of wounds, physician notification or treatments were initiated despite Hospice Aide notifying V9, LPN and who discussed R2's wounds with V6, Wound Care Nurse on 2/7/18. No care plan was initiated on 1/26/18 or anytime after for left buttock skin impairment. On 2/8/18 at 10:50am V6, LPN/Wound Care Nurse stated that when there is a new wound or if a wound changes the care plan should be initiated or revised immediately. Wound Assessment Details Report dated 2/8/18 at 12:09pm indicates: Facility Acquired right gluteal Stage 3 pressure ulceration (identified on 2/8/18) 75% slough; light serous exudate and erythema (red) surrounding wound. Facility Acquired left buttock wound identified on 1/26/18; partial thickness wound 50% pink/red, 40% slough. Skin/Wound Note dated 2/8/18 at 12:27pm indicates open area noted to (R2) left buttock Stage 3 pressure area due to incontinence of	S9999		

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bowel/bladder and right gluteal due to mechanical force of "diaper" irritation.

On 2/8/18 at 1:30pm V6, LPN stated that both wounds were classified as Stage 3 and only pressure wounds can be staged.

On 2/8/18 at 2:37pm V5, Wound Care Physician stated "Really all wounds are avoidable."

2) Nursing Admission Assessment dated 5/16/17 indicates R4 was admitted with no skin issues. Skin Observation Report dated 5/21/17 indicates no sacral skin impairments.

Nurse Note dated 7/5/17 at 11:45am indicates "open area to buttocks, was reddened over the weekend and opened up on Tuesday (7/4/17)." Note indicates wound consult ordered and seen by V5, Wound Physician on that date with new treatment initiated.

Skin/Wound Problem: Irritation - Weekly Progress Report dated 7/4/17 indicates "redness to buttocks due to incontinence, barrier cream applied."

Report dated 7/12/17 indicates redness to buttocks, cream applied and staff to continue monitoring. Report does not indicate size/extent, response to treatment, preventative measures or reason incontinence is cause of irritation since R4 required an indwelling urinary catheter during stay at faciliy from 5/16/17 to 7/14/17. No Care Plan for skin impairment was found or presented.

On 2/21/18 at 1:45pm V6, Wound Care Nurse stated that she was new to Wound Care when R4 developed his wound and was unfamiliar with

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documenting wound specifics. V6 stated that the buttock irritation came from stool incontinence - either frequent stools or stool left in contact with the skin too long. V6 stated she did not do care plans at that time and wasn't really sure who did them.

On 2/21/18 at 10:25am V18, Care Plan Coordinator stated that until approximately October 2017, Wound Treatment team was doing own care plans - preventative and active skin problems.

Physician Wound Care note dated 7/5/17 indicates nursing reported R4 with sacral ulcer and "area opening on Tuesday (7/4/17)." Note indicates "Irritation of buttocks - sacrum closed, ischium closed."

On 2/21/18 at 11:00am V5, Wound Care Physician stated that R4 had irritation from scooting or shearing on the buttocks. V5 stated not sure where moisture would be coming from if R4 had an (indwelling) catheter. V5 stated that the only time she saw R4 was on 7/5/17 and "anything can happen in 10 days" (referring to allegation of Stage 3 pressure ulcer on 7/14/17).

Facility Policy Pressure Sores dated/revised 10/2010 indicates:

4. Wound Care nurses will perform weekly skin assessments and will document their assessment on the reverse side of Treatment Administration Record.
5. CNA will report to nurse if any skin issues or skin breakdown are noted during routine care, showers.
6. Interdisciplinary Team will develop a comprehensive plan of care based on

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S9999	Continued From page 8 assessments and clinical condition of the resident. 10. Skin abnormalities such as skin tears, abrasions or other minor skin issues noted when providing routine care will be addressed and interventions done immediately using clinical standards of nursing practice. (B)	S9999		