STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005797	A. BUILDING: _____ B. WING _____	C 04/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIGOLD REHABILITATION HCC	275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401

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S 000	Initial Comments Original Complaint Investigation 1822129/IL#101536 Statement of Licensure Violations: 300.610 a) 300.1210 b)d)5) 300.3240 a)	S 000		
S9999	Final Observations 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were NOT met as evidenced by:

Based on observation, interview, and record review, the facility failed to obtain a physician ordered treatment when a pressure ulcer was identified, remove a feces soiled dressing, and follow a physician prescribed treatment order for two of three residents (R2, R3) reviewed for pressure ulcers in the sample of three.

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S9999	Continued From page 2 These failures resulted in R2's pressure ulcer worsening from a Stage three to unstageable. Findings include: The facility's Decubitus/Pressure Area policy, dated 5/2007, documents, "Notify the physician for treatment orders. The physician's orders should include: Type of treatment; Frequency treatment is to be performed; How to cleanse; Site of application; No as needed order is acceptable for a pressure ulcer. The order must have specific frequencies; Initiate physician order on treatment sheet. National Pressure Ulcer Advisory Panel's Pressure Injury Stages, dated 4/2016, documents, "Stage 3 Pressure Injury: Full-thickness skin loss: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." National Pressure Ulcer Advisory Panel's Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, dated 2014, documents, "Select a wound dressing based on the: Ability to keep the wound bed moist: Need to address bacterial bioburden; Nature and volume of wound exudate; Condition of the tissue in the ulcer bed; Condition of periulcer skin; Ulcer size, depth and location; Presence of tunneling and/or	S9999		

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undermining; Goals of the individual with the ulcer." The guide also documents, "Change the wound dressing if feces seep beneath the dressing."

1. R2's Weekly Wound Tracking, dated 4/5/18, documents that R2 has a Stage three facility acquired pressure ulcer to R2's coccyx that was discovered on 4/3/18 and it measures 1.8 cm (centimeters) x 0.2 cm x 0.4 cm.

R2's Physician's orders, dated 4/2018, documents that a physician ordered treatment was not obtained for R2's pressure ulcer to R2's until 4/10/18.

On 4/10/18 at 3:30 p.m., V5 (Licensed Practical Nurse) stated that she identified the pressure ulcer on 4/3/18, but she did not obtain a physician ordered treatment for the wound.

On 4/9/18 at 11:25 a.m., R2 was incontinent of bowel. V9 (Certified Nursing Assistant-CNA) and V10 (CNA) provided incontinent care to R2. R2 had a border gauze dressing in place to R2's coccyx at this time. With R2 being incontinent, the lower one third of the dressing was covered in brown feces and was pulled away from the skin. A wound with depth was observable underneath the soiled area of the dressing. V9 and V10 proceeded to put an adult brief on R2, redress him, and transfer R2 into R2's wheel chair with the soiled dressing still in place.

On 4/9/18 at 1:30 p.m. V11 (Licensed Practical Nurse) was walking out of R2's room, and stated that she just changed R2's pressure ulcer dressing because it was soiled. V11 also stated that (V9 and V10) notified V11 that (R2's) dressing was soiled before lunch, but she just got

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it changed.

On 4/10/18 at 11:40 a.m., V3 (Assistant Director of Nursing) stated, "If a dressing is soiled it should be changed right away. The CNAs, if they notice it, tell their nurse, and the nurse should change it immediately. (R2) should not have gotten up until his dressing was changed."

On 4/10/18 at 1:25 p.m., An abdominal pad dressing was removed from R2's coccyx area. R2 had a round open area with depth to R2's coccyx area. The wound bed of this pressure ulcer was 100% covered with black/grey tissue (eschar/necrotic). This black/grey tissue was all along the wound edges also. V4 (Licensed Practical Nurse) was present and measured R2's wound. The wound was 4 cm x 2.5 cm, and she was unable to determine the depth due to the black/grey tissue covering the wound bed.

On 4/10/18 at 1:40 p.m., V4 (Licensed Practical Nurse) stated, "When we found the pressure ulcer last week it was only a Stage three, and there was no black tissue. The pressure ulcer has worsened since we found it last week." V4 stated R2's pressure ulcer would now be unstageable.

On 4/10/18 at 5:00 p.m., V6 (R2's Physician Assistant) stated, "Not getting an order for a treatment for the wound and leaving a soiled dressing on is poor wound management."

2. On 4/9/18 at 11:15 a.m., R3 was lying in bed. R3 stated, "I have a sore on my bottom, but I don't think I have a bandage on it. They never take care of it."

The facility's Monthly Wound Tracking Report, dated 4/5/18, documents that R3 has a facility

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S9999	Continued From page 5 acquired Stage one pressure ulcer to R3's left buttock that measures 0.3 cm x 0.2 cm x 0.1 cm. R3's Physician's orders, dated 4/2018, document that R3 has an order to cleanse R3's buttock wound with wound cleanser then apply a hydrocolloid dressing every three days until healed. On 4/9/18 at 1:15 p.m., V17 (Licensed Practical Nurse) removed R3's adult incontinent brief. R3 had a round shallow open area to R3's left buttock that was uncovered with no dressing covering the wound. V17 stated that R3 had not had a dressing in place since her shower at 9:30 a.m. that morning. V17 also stated that the wound was a Stage two pressure ulcer. On 4/10/18 at 11:40 a.m., V3 (Assistant Director of Nursing) stated, "If the staff knew (R3's) dressing was off during her shower, the nurse should have gotten a new one on no later than when (R3) got back to her room to get dressed after the shower." (B)	S9999		