BELHAVEN NURSING & REHAB CENTER	0048215
Facility Name	I.D. Number
11401 SOUTH OAKLEY AVENUE, CHICAGO, ILLINOIS 60643	
Address, City, State, Zip	
	4/11/07
Reviewed By	Date of Survey
COMPLAINTS #0781136, 0781306, IRI OF 2/23/07, AND LICENSURE SURVEY	
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1210a)b)1)2)3)5) **300.1210 General Requirements for Nursing and Personal Care**

a) The facility must 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 assessment and plan of care. 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:

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day a week basis:

1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

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.

BELHAVEN NURSING & REHAB CENTER — Facility Name
0048215 — I.D. Number

CONT.

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.

Based on observations, record review and interview the facility failed to provide necessary care and services to residents to prevent pressure sores and treat new sores for R11, R6, R13, R4 and R8. Findings include the following:

1. R11 was readmitted to the facility January 15, 2007 with the following diagnosis: Hypertension, Cerebral Vascular Accident, Chest Pain, Urinary Incontinence, Angina, and Post Hip Fracture. R11 was observed on April 2, 2007 in her room with E22 (Nurse) and E23 (CNA) at 10:55am. R11 was noted with a dressing to the left ankle dated March 31, 2007. R11 was turned and the wound to the Left Upper Buttock was noted with a gauze dressing with dried blood and dirty. The 4 by 4 dressing was crumpled and dirty and R11 was also noted to be grossly incontinent of urine. At 12:00 noon R11's wounds to the buttock were observed to be foul smelling and the dressing when removed was saturated with drainage and blood. The wound was noted to be covered with a large amount of slough, E17 (treatment nurse) confirmed that the wound had deteriorated. E17 also stated that the last time the wound care was done was March 31, 2007. E17 stated that the wound care needs to be done daily. The wound to the foot was also observed and E17 stated that this dressing should be done daily. The area around the wound was noted to have an indentation where the foam dressing was in place for three days.

A review of the POS (Physician's Order Sheet) indicates the following orders for R11's buttock treatment dated March 28, 2007: "Cleanse the wound to the left buttock extending to the Sacrum with Normal Saline, then apply Accuzyme daily until healed."

A review of the wound assessment record indicates that the wound to the left upper buttock was acquired in the facility on March 19, 2007. At this time the wound was noted to be a Stage II pressure ulcer measuring 2.0 by 2.6 by 0.2 centimeters. On March 28, 2007 the wound was noted to be "non stageable measuring 2.8 by 3.0 by undetermined depth to be coded on the MDS [Minimum Data Set] as a Stage IV". In nine days the wound went from a Stage II ulcer to a non stageable Stage IV ulcer needing a debridement treatment. A review of the Treatment Administration Record (TAR) indicates that the treatment was not documented as being done March 31, April 1 and April 2, 2007. The wound assessment record dated April 3, 2007 documents the wound as "Unstable Stage IV wound measuring 3.0 by 2.5 with an undetermined depth and 90% slough and undermining to the wound plus odor and unattached wound edges". Again on March 28, 2007 no slough (dead infected tissue) and no undermining was noted to the wound.

BELHAVEN NURSING & REHAB CENTER — 0048215

Facility Name — I.D. Number

CONT.

A review of the POS for the left heel wounds indicates the following the orders starting March 6, 2007, for R11: "cleanse wound to left heel with Normal Saline then apply Accuzyme and dry foam dressing daily until healed". The TAR indicates the wound was not documented as being done on the following days: March 9, 10, 11, 17, 18, 30 and April 1 and 2, 2007. The wound assessment record of October 27, 2006 reveals that this wound began as a blister identified on October 27, 2006 that was acquired in the facility. Documentation dated December 28, 2006, assess the left heel as now a "Non stageable Stage IV Ulcer measuring 2.0 by 2.4 with an undermining depth and Drainage and Eschar". On February 8, 2007 the wound was assessed to be closed and then re opened on February 21, 2007. On March 5, 2007 the wound was noted to be 80% eschar and 20% slough and measuring 2.5 by 2.8 by an undetermined depth. The wound was not provided treatment on April 1 and 2 and this was confirmed by E17. E17 measured the wound on April 3, 2007 and it measured: "3.0 by 3.7 by an undetermined depth and described as Non stageable, edges are loose".

Furthermore, additional noted during the observation that had not previously been identified by the facility. The following are the new wounds identified and measured on April 3, 2007:

1. Stage II to the peri wound of the Left Buttock measuring 0.5 by 0.5 by 0.1
2. Stage II to the left side of the peri wound of the Left Buttock measuring 2.3 by 1.6 by 0.2 with drainage.

The facility failed to provide necessary treatment to the pressure ulcers that developed in the facility, failed to identify new pressure sores and this failure resulted in R11 developing preventable, unstable infected pressure ulcers in the facility. The facility did not up date R11's plan of care when the pressure ulcer on the Buttock became worse and the facility did not provide preventative measures to prevent the heel sore from re opening.

2. R6 was readmitted to the facility on March 30, 2007 with the following diagnoses: Pneumonia, Dementia and Arterial Insufficiency. R6 was also placed on contact isolation for c-difficile infection. R6 has numerous pressure ulcers on the sacrum and coccyx which require daily treatments. On April 3, 2007, R6 was noted in her room to have a large, loose bowel movement that covered her entire backside. R6 was noted to have two soiled hydrocolloid dressing to the left trochanter and left buttocks. The right side wounds were noted to be without dressings and contaminated with loose stool. E10 (CNA) verified that no dressings were present to the wounds on the right side. E2 (DON) was also called to the room and observed the open wounds. The observation was at 10:00am and the wounds were left uncovered and exposed to fecal material until after 3:30pm when the treatment nurse was available. The staff nurse did not provide treatment to the wounds that were exposed nor did the facility provide the treatment when they were aware that R6 did not have dressings on her right side or sacrum. The wound to the sacrum was noted to be black in color and have an odor and is classified as a Non stageable Stage IV. E10 stated to surveyor that since the observation at 10:00am, R6

BELHAVEN NURSING & REHAB CENTER — 0048215

Facility Name — I.D. Number

CONT.

had two more episodes of loose stool. E10 also stated that no one had come into the room to change the dressing. E2 stated during the daily status meeting that the floor nurse should have covered the wounds to prevent infection.

The admission notes classify all wounds as Stage II, however, E17 noted the Left Buttock to be a Stage III, the Sacrum an Non stageable IV, and the right hip an Non stageable IV.

The facility failed to provide nursing care to R6 to prevent a decline in condition and prevent the contamination of the wounds.

3. R13 was readmitted to the facility from the hospital on April 2, 2007 from the hospital. R13 was readmitted with numerous pressure ulcers. The pressure ulcer on the sacrum was noted to be 7 by 9.5 by 3.2 with 10% slough and several open areas in the peri area of the wound. R13 was observed on April 3, 2007 in the room with no dressing in place on the sacral wound. The observation was done at 10:00am and still no dressing was placed until after 3:30pm. R13 was also placed on isolation for c-difficile infection. The facility failed to obtain and perform a treatment on R13 when the wounds were noted to be without dressings.

4. R4 has multiple diagnoses to include DM (Diabetes Mellitus), severe DJD (Degenerative joint disease) and Dementia.

During observations made on 4/3/07 at 9:45 AM, R4 was observed sitting on the wheelchair near the 2nd floor nursing station. Surveyor requested E14 (Licensed practical nurse) to bring R4 to her room to see if the pain medication patch of the resident was applied. While E14 and E16 (restorative nurse) were assisting R4 to bed, surveyor noticed that the resident's pants from the right buttock to the right upper posterior leg area was soaking wet. After E14 and E16 removed R4's wet pants, surveyor observed that the resident was wearing a disposable incontinent brief that was wet with dark yellow urine. R4 was observed with 2 blisters and 2 Stage II pressure sores on the right posterior leg/thigh area. R4 was also observed with 3 blisters and 1 Stage II pressure sore on the left posterior leg/thigh area. There were no treatments in place noted on the open sores during these observations.

During interviews held on 4/3/07 at 10:05 AM, E15 (CNA) stated that she is the CNA taking care of R4 on 4/3/07 and also told the surveyor that she took care of R4 on 4/2/07. E15 stated that R4's blisters and pressure sores were not present, when she took care of the resident on 4/2/07. E15 stated that when she started her shift on 4/3/07 at 6:00 AM, the previous shift (10 PM - 6 AM) had R4 already dressed and up on the wheelchair. E15 told the surveyor that since she started her shift on 4/3/07 she had not changed R4's incontinent brief. Based on this interview, R4's incontinent brief was not changed for at least 3 hours and 45 minutes.

During interviews held on 4/3/07 at 10:20 AM, E17 stated that she was just informed of R4's newly developed pressure sores (this was after surveyor observation). E17 stated

BELHAVEN NURSING & REHAB CENTER — 0048215
Facility Name — I.D. Number

CONT.

that she will assess the pressure sore and will provide documentation. E17 stated that prior to April 3, 2007 R4 does not have any pressure sore.

Review of R4's records showed that the resident does not have any skin breakdown documented prior to the above observations made on 4/3/07. R4 was assessed by the facility on 2/4/07 at moderate risk for development of pressure sore per Braden scale. Review of R4's current MDS (minimum data set) dated 2/24/07 showed that the resident is moderately impaired with decision making, requires extensive assistance x 1 person physical assist with transfers, requires total assistance x 1 person physical assist with toilet use and personal hygiene.

Review of R4's 4/3/07 wound assessment record which was documented by E17 showed the following documentation:

1) right posterior outer thigh - Stage II (open blister) measuring 3.2x4.3x0.1cm,
2) right outer posterior thigh (inferior) - Stage II (open blister) measuring 1.4x3.3x0.1cm,
3) right posterior thigh (superior) - Stage II (blister) measuring 2x5cm,
4) right posterior thigh (inferior) - Stage II (blister) measuring 1.0x2.8cm,
5) left posterior thigh - Stage II (open blister) measuring 1x2.3x0.1cm,
6) left posterior thigh (superior) - Stage II (blister) measuring 1.0x8 cm,
7) left posterior thigh (inferior) - Stage II (blister) measuring 2x7.8cm and
8) left medial thigh - Stage II (blister) measuring 1.2 x 0.8 cm.

Based on these wound assessments all the above mentioned pressure sore were acquired in the facility.

5. R8 was admitted to the facility on March 15, 2007. Upon review of the medical record on April 4, 2007 the pressure sore risk assessment had not been completed. The Braden Scale was not completed by the facility. After prompt the facility finally completed the assessment 20 days after admission.

(A)