STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A050	A. BUILDING _____ B. WING _____	C 02/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD MANOR, THE	**2444 WEST TOUHY AVENUE CHICAGO, IL 60645**

(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) COMPLETION DATE
F 323	Continued From page 21 During an individual interview with E4 on 10/24/06, E4 told surveyor that he believes the water temperature on 10/02/06 was too hot because of a faulty mixing valve that was recently installed on 9/27/06. E4 said that he was responsible for doing the water temperatures and showed surveyor the facility's water temperature log. The water temperature log included dates assessed between 9/04/06 and 10/24/06. The log did not include daily checks on 9/8 through 9/10, 9/13, 9/16 through 9/18, 9/20, 9/22 through 9/24, 9/30 through 10/02, 10/7 through 10/8, 10/14 through 10/15 and 10/21/06. The hot water temperatures logged 9/4 through 9/29/06 ranged between 106 to 110 degrees Fahrenheit, but the next documented hot water temperature after 9/29/06 was 120 degrees on 10/03/06. E4 said that he called the plumber on 10/03/06 about the hot water temperatures and the mixing valve was replaced on 10/04/06.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1220b)6) 300.3240a) Section 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 psychosocial	F9999		

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F9999	Continued From page 22 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 residents. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days a week basis: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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 were not met as evidenced by the following: Based on facility and hospital nursing staff and physician interviews, review of resident incident reports and medical records, review of facility water temperature log and maintenance records, and on observations made, the facility failed to: - provide timely medical evaluation and treatment	F9999		

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F9999	Continued From page 23 to one resident (R1) after sustaining 2nd and 3rd degree burns to bilateral lower extremities and feet as a result of being submerged in a tub of extremely hot water. R1 sustained the burns on 10/02/06 and the wounds were not evaluated by a physician until 10/19/06. R1's bilateral lower extremities burn wounds developed necrosis and yellow sloughing moist tissue. Physician consultation report from 10/19 - 10/21/06 initial hospitalization documented that R1 sustained "full thickness burns to dorsal and areas of medial and lateral aspects of legs" requiring a 10/21/06 hospital to hospital transfer to a specialized Burn Unit. The 10/20/06 hospital history and physical completed by a physician stated that R1 also sustained 2nd degree burns to her peri-anal area and buttock. R1 subsequently required several surgical interventions, including bilateral below the knee amputations as a direct result of the extent of the burn wounds. - to assure safe hot water temperatures before placing a dependent resident in the tub and leaving them submerged for 12 minutes in extremely hot water, resulting in full thickness burns to bilateral lower extremities and feet that required bilateral below the knee amputations. - to develop and initiate a plan of care to address the burn wounds and pain management of the aphasic resident with 2nd and 3rd degree burn wounds. Findings include: R1's medical record stated that R1 is an 81 year old resident, with a history of poor circulation to the lower extremities and diagnosis to include	F9999		

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F9999	Continued From page 24 Schizo-affective disorder, hypertension, arterial of sclerotic heart disease, recent (3/06) stroke (CVA) and osteoporosis. Since the 3/06 CVA, R1 has become aphasic (nonverbal), totally dependent on staff for all areas of activities of daily living, including bathing and transferring and is fed by a gastrostomy tube related to difficulty swallowing. E5 (nurse aide) told surveyor on 10/24/06 that R1 required at least 2 staff assist during transfer activities. R1's 9/16/06 Minimum Data Set Assessment (MDS) stated that R1 was severely cognitively impaired and has partial loss of range of motion to the lower extremities. R1 had physician orders for tub bath or shower with assist as needed. R1's 10/02/06 Incident report and 10/02/06 6:00PM nurses notes, and 10/24/06 interviews with E2 (Director of nurses), E1, E3 and E5 (nurse aides) and E6 (nurse) reflected that on 10/02/06 around 4:00PM, E1 transferred R1 into a tub of water where she remained submerged for 12 minutes. After the bath while being transferred to bed, E6 noticed "redness and skin peeling" on R1's right lower extremity below the knee and on the left ankle area. E1 told surveyor that on 10/02/06 she did not test the tub water with a thermometer, but that the water did not feel too hot to touch. During a 10/25/06 telephone interview, E6 told surveyor that on 10/02/06 R1's lower extremities were red but E6 just thought R1's skin was just sensitive to the water, not that R1 had sustained burns. E6 also said that on 10/02/06 she called Z1 (physician) for an ointment to protect the skin and Z1 ordered Silvadene Cream to the burn areas 3 times a day and as needed (PRN). E2	F9999		

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F9999	Continued From page 25 and E6 said that R1 was not sent out 10/02/06 to the hospital for an evaluation. R1's 10/03/06 9:30AM nurses note stated that R1 had redness with blisters on bilateral lower extremities and sores on 2nd right toe. The 10/04/06 8AM nurses note stated that R1 still had redness on right upper thigh and posterior knee, with blisters coming out at the back, peri-anal area, buttocks, groin and bilateral lower extremities. E2 and E4(Administrator) were notified and assessed R1. Z1 was called and notified of R1's condition and the spread of blisters to the areas. Z1 ordered neosporin ointment to "open blisters at right thigh, both lower legs, groin, buttocks, peri-anal area and back after a saline cleanse." Then at 10:00PM nurses notes states R1 still with multiple busted blisters and redness on abdomen, groin and thighs. On 10/5/06 R1 developed a temperature of 99 degrees Farenheit. The 10/16/06 8:00AM nurses note states that R1's blisters on her back, buttocks and thighs were drying up but there is blackish discoloration on toes and feet. The 10/17/06 12:10PM nurses note states that R1 had developed a non-productive cough. The 10/18/06 6AM nurses note stated that R1's toes with feet areas were with blackish discoloration. The 8:00AM nurses note stated that wound site not improving with non foul smelling, wet appearance and still with redness.	F9999		

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F9999	Continued From page 26 The 5:00PM nurses note stated the wound site remains with redness, non-foul smelling and wet appearance. The 10/19/06 8:00AM nurses note stated that R1 had increasing discharge with formation of yellowish tissue slough. R1's medical record and Z1's 10/25/06 telephone interview validated that the first time R1 was medically evaluated by a physician after the 10/02/06 thermal burn incident was on 10/19/06 by Z1 at his office. Z1 documented in 10/19/06 progress note that R1 had 2nd degree burns to bilateral legs. Z1 also noted that R1 continues to rub wounds and prevent healing. Z1 ordered R1 to be immediately evaluated at the hospital wound center. On 10/19/06 at 1:50PM, R1 was evaluated at the hospital wound center and the burn wounds were debrided of the yellowish tissue slough on both feet. Then at 2:30PM R1was admitted to the hospital with diagnosis to include "Full thickness burns to bilateral lower extremities." As of 10/24/06, R1's current care plan noted that R1 had poor circulation to the lower extremities, but nothing about the burn wounds and pain management. R1's 10/19/06 to 10/21/06 initial hospitalization record included a plastic surgeon consultation report that documented: R1 sustained "Bilateral lower extremity full thickness burns to dorsal and areas of medial and lateral aspects of distal legs." This consult report and a 10/21/06 hospital physician progress note stated that due to R1's age and the severity of the burns, R1 required	F9999		

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F9999	Continued From page 27 immediate transfer to a Burn center at another hospital, which was done on 10/21/06. R1's Burn Unit hospital record (starting 10/21/06), stated that R1 had developed infected necrosis to both feet. R1 required a surgical debridement of the burn wounds on 10/24/06. This record also documents morphine Intravenous push and Versed for pain as needed, being administered prior to dressing changes. R1's nursing home medical record revealed that R1 was not receiving any pain medications prior to the dressing changes at the nursing home 10/02/06 through 10/19/06. On 10/25/06 R1 was observed by surveyor at the hospital on the Burn unit, in bed with wound dressings on bilateral feet and legs up to the knee and audible gurgling respirations without auscultation. On 10/25/06 Z5 (Burn Unit nurse), told surveyor that R1 has had hyperglycemia since 10/21/06 admission probably due to the burns and infection and is receiving Insulin by Intravenous drip. R1 was observed to have bilateral lower extremity contractures and to be non responsive to verbal stimuli. Z5 also told surveyor that R1's hemoglobin was only 8.3, hematocrit 24.3 and red blood cell count was 2.71 today and is awaiting blood transfusion to be administered. Z5 also said that R1 is scheduled for another surgical intervention to burn wounds on 10/26/06. On 10/27/06 during a telephone interview, Z6 (burn unit nurse) told surveyor that on 10/26/06, R1 had a surgical debridement of the burn wounds and skin grafting and received 2 units of packed blood cell transfusion.	F9999		

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F9999	Continued From page 28 On 02/07/07 during a telephone interview, Z3 (plastic surgeon) told surveyor that R1 sustained full thickness burn wounds to bilateral ankles and anterior feet, that extended up the distal aspects of her legs. R1 had tendons exposed and necrosis on the tips of her toes. R1 had poor circulation and poor healing and had very bad burn wounds. R1 underwent multiple wound debridements and a temporary skin grafting to the burn wounds but the grafts did not take. R1 required and received bilateral below the knee amputations as a direct result of the extent of the burn wounds. E3 told surveyor that facility was having difficulty regulating the water temperatures for some time and that is why E4 (Administrator) had the mixing valve changed on the boiler on 9/27/06. E3 stated that the faucet handle on the tub in the tub room that R1 was injured in just keeps turning around and around, does not stop when its at the extreme of either hot or cold and it is difficult to gauge the temperature. E3 also said that ever since R1's 10/02/06 incident, facility keeps a thermometer in the tub room for staff to check water temperatures prior to placing a resident in the tub. R9 told surveyor during the tour that sometimes the bath water temperature gets too hot. During 10/4/06 tour of the facility and water temperature assessment, surveyor observed the faucet handle in the tub room by the nurses station to turn and turn around and not stop at the highest hot or coldest cold level. This is the tub room in which R1 was bathed on 10/02/06.	F9999		

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F9999	Continued From page 29 During an individual interview with E4 on 10/24/06, E4 told surveyor that he believes the water temperature on 10/02/06 was too hot because of a faulty mixing valve that was recently installed on 9/27/06. E4 said that he was responsible for doing the water temperatures and showed surveyor facility's water temperature log. The water temperature log included dates assessed between 9/04/06 and 10/24/06. The log did not include daily checks on 9/8 through 9/10, 9/13, 9/16 through 9/18, 9/20, 9/22 through 9/24, 9/30 through 10/02, 10/7 through 10/8, 10/14 through 10/15 and 10/21/06. The hot water temperatures logged 9/4 through 9/29/06 ranged between 106 to 110 degrees Fahrenheit, but the next documented hot water temperature after 9/29/06 was 120 degrees on 10/03/06. E4 said that he called the plumber on 10/03/06 about the hot water temperatures and the mixing valve was replaced on 10/04/06. (A)	F9999		