STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145700	A. BUILDING _____ B. WING _____	03/26/2008

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F 431	Continued From page 44 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure 2 medication refrigerators had a thermometer in the refrigerator to monitor and ensure appropriate environmental temperatures are maintained. Findings include: On 3/17/2008 at 2:25pm, the surveyor conducted an environmental tour accompanied by E1(administrator), E9(assistant administrator) and E13(housekeeper supervisor). The following observations were made during this tour: 3rd floor medication room- No thermometer in refrigerator/freezer 2nd floor medication room- No thermometer in refrigerator/freezer.	F 431		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)3) 300.1210b)5)	F9999		

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F9999	Continued From page 45 300.1220b)2) 300.3240a) 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. 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. 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 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin	F9999		

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F9999	Continued From page 46 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge ptoential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 observations, record reviews and interviews the facility neglected to provide adequate care for R4 and R12. The facility: 1. Failed to consistently monitor and assess a resident (R4) with a diagnosis of chronic constipation. The facility also failed to notify the physician of R4's bowel elimination pattern. R4 was assessed by the physician on 3/8/08 with	F9999		

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F9999	Continued From page 47 distended abdomen and absence of bowel sounds. R4 was sent to the hospital on 3/9/08 with admitting diagnosis of abdominal distension and fecal impaction. 2. Failed to identify new pressure ulcers in a timely manner, provide appropriate preventive measures for pressure ulcers, and provide appropriate nutritional interventions by dietary staff to aid in prevention of pressure ulcers (R12). This failure subsequently led to the decline of R12's wounds. 3. Failed to assess pain, and failed to obtain and administer pain medications to a resident (R12) who received multiple bedside debridement procedures due to multiple pressure ulcers. Findings include: 1. R4 has multiple diagnoses including Pulmonary embolism, Dementia, Alzheimer's and Parkinson's disease. Review of R4's most current MDS (minimum data set) dated 1/3/08 showed that the resident is moderately impaired with cognition, requires extensive assistance x two or more persons, and physical assist with bed mobility and transfers. The MDS also showed that R4 is non-ambulatory and requires extensive assistance x 1 person physical assist with eating. Review of R4's POS (physician order sheet) for the month of March 2008 showed an order from 8/7/07 to administer "Docusate Sodium Liquid 50mg/5ml, give 5 ml (50 mg) via gastrostomy tube once daily" and "Enulose Solution 10mg/15, give 15 ml (10gm) via gastrostomy tube once daily." Review of R4's MAR (medication	F9999		

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F9999	Continued From page 48 administration record) showed that R4 received the two ordered laxatives since it was ordered up to 3/8/08. Further review of the POS showed that R4's diets are mechanical soft with thin liquids and gastrostomy tube feeding of Jevity 1.5 at 60 ml/hour x 18 hours with gastrostomy tube flushing of 300 ml water every shift. Review of R4's intake & output record for the month of January and February 2008 showed inconsistent documentation of R4's fluid intake via oral and gastrostomy tube. These intake and output records do not reflect whether R4 received adequate fluid to help with her bowel elimination. Review of the C.N.A. tracker for the month of January 2008 showed that R4 had small bowel movements for at least 14 days (1/9, 10, 11, 13, 14, 15, 16, 18, 19, 20, 21, 24, 26, 29/08) and no bowel movement for at least 3 days (1/7, 22, 23/08). Review of the February 2008 C.N.A. tracker showed inconsistent documentation of R4's bowel elimination patterns for this month. The C.N.A tracker sheet from 2/1 - 2/8/08 showed that R4 had small bowel movements for at least 3 days (2/2, 5,7/08) and no bowel movements for at least 4 days (2/1, 3, 4, 6/08). Review of R4's nurses progress notes showed no evidence that the nurses were aware and/or have reviewed the C.N.A. tracker sheet (January and February 2008). Review of R4's records showed no documentation in the nurses progress notes indicating that the resident had problems with bowel movements even with the use of the two laxatives. Further review of the records showed no evidence that R4's physician was notified that the resident was having small or no bowel movements for the months of January and	F9999		

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F9999	Continued From page 49 February 2008. Review of R4's careplan showed that the facility will monitor the resident's abdomen every shift for distention. The documentation on the resident's abdomen was random and there is no evidence that it was assessed every shift. This intervention was under the tube feeding concerns. Further review of the care plan showed no evidence that the facility had any care plan in place to address R4's use of laxatives and problem with constipation. Review of R4's nurses' notes dated 3/8/08 (8:00 AM) showed in-part the following documentation: "abdomen soft BS (bowel sounds) + x 2 quadrant." During interviews held on 3/19/08 at 3:03 PM, E12 (nurse/nursing supervisor) stated that on 3/8/08 at around 9:00 AM, R4 was inside the third floor dining room, up in the wheelchair when she assessed R4's abdomen. Per E12 she palpated R4's upper abdomen only and noted that it was soft with positive bowel sounds. E12 stated that she did not assess R4's lower abdominal area because of the resident's position while sitting on the wheelchair. E12 stated that she was not aware of R4's bowel elimination problem since she was not the regular nurse in the unit. During interviews held on 3/19/08 at 12:25 PM, Z2 (physician) stated that he came in for the regular resident visit on 3/8/08 and examined R4. Z2 stated that when he examined R4's abdomen, he noticed that it was distended and R4 did not have any bowel sounds. Z2 told the surveyor that he believed R4 was fecally impacted. Z2 stated that he was not informed by the facility	F9999		

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F9999	Continued From page 50 regarding R4 having abdominal distention, absence of bowel sounds or any problem with regards to bowel elimination. Z2 further stated that he was not aware that R4 was having small bowel movements or no bowel movement for days. Z2 told the surveyor that the reason why R4 was on two laxatives was because of the resident's chronic constipation. Z2 stated that the laxatives should be able to help the resident with bowel elimination. Z2 stated that if R4 was having small bowel movements, resident could have a large amount of feces inside which was not totally evacuated that caused the fecal impaction. Review of R4's POS dated 3/8/08 showed in-part the following orders: "Fleet enema now & PRN (as needed), KUB (Kidney/Ureter/Bladder) and to monitor BM (bowel movement) daily for constipation & bowel impaction." Review of the KUB results dated 3/8/08 showed, in-part: "Large amount of feces in the colon. Possible fecal impaction." Review of R4's MAR (medication administration record) showed that on 3/8/08 at 3:00 PM, the resident received the ordered Fleet enema. However, review of the records including the MAR and the nurses notes showed no documentation to evaluate the effectiveness of the enema given. The C.N.A. tracker dated 3/8/08 (3-11) showed that R4 had a small bowel movement during this shift. Review of R4's nurses' notes dated 3/9/08 showed that the physician was notified of the KUB results. The nurses' notes also showed that the physician was notified of R4 having a small bowel movement, abdominal distention and hypoactive bowel sounds. R4 was sent to the hospital for evaluation and treatment on 3/9/08	F9999		

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F9999	Continued From page 51 and was admitted with diagnosis of fecal impaction and abdominal distention. 2. R12 has multiple diagnoses including DM (Diabetes Mellitus), old CVA (Cerebral vascular disease) with right Hemiplegia. Review of R12's quarterly MDS (minimum data set) dated 2/26/08 showed that the resident required extensive assistance x 2 person physical assist with bed mobility, extensive assistance x 1 person physical assist with transfers. R12 is non-ambulatory. On 3/17/08 surveyor observed R12 sitting at the table in the 2nd floor dining room with a tray consisting of the mechanical soft diet with thin liquids. R12 proceeded to leave the dining room only after eating 3/4 of a boiled potato with her left hand. There was no intervention by staff to encourage resident to eat or drink liquids. R12 then proceeded to leave the dining room with no intervention from staff. R12 is alert, responsive, but aphasiac. Record review reveals R12 was readmitted to facility from hospital on 1/24/08 after hospitalization for coffee ground emesis and abdominal pain. Review of facility readmission sheet dated 1/24/08 documents upon readmission was found to have pinkish areas to both buttocks. Review of facility pressure ulcer risk assessment reveals R12 was assessed a 15 (high risk) upon readmission and weekly after readmission times 4 weeks from 1/24/08 through 2/15/08. Review of monthly Physician Order Sheet reveals an order for skin integrity to check daily if high risk. Review of nurses notes dated 1/29/08 document R12 was found with a Stage II open sore to the	F9999		

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F9999	Continued From page 52 coccyx measuring 0.3cm. x 0.4 cm. A treatment order for DuoDerm to coccyx every three days was obtained. Documentation on 2/5/08 denotes R12's coccyx wound healed. Documentation in nurses notes dated 2/28/08 denotes R12 was found with open area on right lower posterior leg measuring 1.5 cm x 1.5 cm wound bed noted with 100% granulating tissue with scant serosanguinous drainage. An order for DuoDerm extra-thin on right posterior leg after normal saline cleanse every 3 days and as necessary was obtained on 2/28/08. Nurses notes from 2/28/08 through 3/4/08 lacked documentation regarding R12's wound to the right posterior leg. Documentation in nurses notes of 3/4/08 denote R12 was examined by the wound doctor and was found with a new open area right posterior leg proximal side measuring 0.9 cm x 0.8cm with 100 % granulating tissues: scant serosanguinous drainage with new orders. Review identified the wound doctor assessed both wounds on the right lower leg as Stage II. The description of the peri wound area revealed severe erythema and moderate localized edema to both wounds, with mild and serosanguineous drainage. Treatment ordered included clean wounds with normal saline, apply silver gel to right leg wound beds then cover with non-adherent dry dressing. Check both wound dressings daily. Keep wound clean and dry at all times. Ensure patient repositioning and avoid prolonged pressure to the wound site. Nurses notes of 3/5/08 at 2:00 PM document R12 was noted with Stage II ulcer on right ischium measuring 1 cm x 1.3 cm wound bed	F9999		

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F9999	Continued From page 53 noted 100% granulation with serosanguinous drainage with irregular wound edges. Treatment orders were obtained. Nurses notes of 3/10/08 note a fluid filled blister on the right 5th metatarsal brownish in color, noted with erythema on peri wound. Treatment orders obtained. Documentation in nurses notes of 3/11/08 denote R12 was seen again by the wound specialist physician. Review of nurses notes denote R12 was found with redness noted on right heel not open, measuring 6.0cm x 5.0 cm and also found to have a Sabel scab to right knee measuring 1.0 cm x 1. 4cm. On 3/18/08 documentation in the wound doctor's notes indicate R12 had debridement to the right ischium wounds and right 5th metatarsal joint. All necrotic and devitalized tissues were removed which included full thickness skin and subcutaneous tissues, healthy tissues exposed using sharp debridement tray. Wound cultures were obtained and R12 was placed on antibiotics for 10 days pending wound culture results. Review of R12's Physician Order sheet reveals no order for any preventive devices/measures to prevent the ulcers. R12 had only one elbow protector for the right elbow due to history of old healed ulcer to the right elbow. On 3/19/08 surveyor, observed R12 sitting in the wheelchair in the dining room at the noon meal. Surveyor asked R12 if she had any pain, R12 shook her head and said "yes." Surveyor asked R12 where the pain was and R12 pointed to her right hip and back area. R12 had one heel protector in place to the right heel along with the one elbow protector to the right elbow while sitting in the	F9999		

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F9999	Continued From page 54 wheelchair. Surveyor asked E17 (RN) if R12 receives any medication for pain, and E17 stated no. Surveyor informed E17 of R12's complaint of pain. An order was obtained by E17 that day for Darvocet N-100 one tablet every 6 hours. The last pain assessment completed on R12 was done upon readmission on 1/24/08 and scored R12 as not having any new pain and not requiring a comprehensive assessment. At 1:30 PM on 3/19/08, R12 was observed lying in bed in her room. Surveyor observed R12 lying on her right side with only a thin pillow halfway placed under R12. R12 was observed again only with one heel protector to the right heel. Surveyor prompted E7 (treatment nurse) that R12 was lying on her right side. E7 came to R12's room and stated "(R12) is always moving around and won't stay off her right side." Surveyor asked E7 if the facility has wedge pillows that can use that would support R12 off her right side and E7 stated no. Surveyor checked mattress on R12's bed which felt flat and hard. E7 stated the facility had pressure relief mattresses. Surveyor asked E7 why R12 did not qualify for a air loss mattress, E7 stated since R12's wounds are on the right ischium the mattress would not help the wounds. Surveyor pointed out to E7 that R12 had other wounds which would benefit the use of the air loss mattress, E7 stated again R12 turns to the right all the time. Surveyor asked E7 why R12 had only one heel protector on while R12 has been assessed as high risk. E7 responded, R12 can move, the left foot does not need it. On 3/20/08, E1 presented information regarding	F9999		

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F9999	Continued From page 55 the mattress provided to R12. The mattress R12 had was a pressure reduction mattress not a pressure relieving mattress. Review of R12's dietary notes revealed the last assessment by the registered dietician in August 2007 and it noted R12 had a significant weight decrease of 6.9 percent in 1 month, and 10.9% in 6 months. R12 's weight was documented at 151 lbs. Appetite 50-75 %, and resident has stage 2 to right elbow. R12 was seen by the nutritional support coordinator (E10) on November 2007. R12's weight was documented at 144.8 lb, and R12 had been placed on multivitamins, zinc sulfate, beneproteins and juven for wound healing. R12 had not been assessed again by the registered dietician (E11) until 3/18/08. Surveyor interviewed E11 at 2nd floor nurses station. Surveyor informed E11 of the observation made during the noon meal on 3/17/08 when R12 received no assistance in her meal. E11 stated R12 should be 1:1 assistance. Surveyor informed E11 that R12 had multiple new pressure ulcers to her right lower extremity and right ischium area. Surveyor asked E11 if the registered dietician should have been notified of pressure ulcer. E11 stated not necessarily. Surveyor asked E11 if R12 had a significant weight loss since January 2008 at 145 lbs., February 2008 at 140 lbs, and March 2008 at 138.4. E11 stated it was a gradual weight loss. Surveyor asked why R12 needs supervision at meals. E11 stated because she does not eat that much and will refuse food and staff assistance. Review of record revealed no calorie count initiated, andno reweigh or notification of R12's	F9999		

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F9999	Continued From page 56 decrease in appetite and refusal of food. On 3/19/08, surveyor requested reweigh of R12 prior to discharge to hospital. The weight obtained and documented on Z1's progress note was 122 lbs., a decrease of 16 lbs since the beginning of March 2008 when the weights were obtained. E1 and E17 stated in interview that R12 refuses assistance with meals and refuses food. Care plan dated 2/2/08 denotes R12 needs supervision and encouragement with meals due to related chewing, swallowing difficulty. Review of R12's care plan dated 1/28/08 revealed the following interventions for pressure ulcers: -confer with Registered Dietician regarding nutritional intake options/encourage protein consumption -assist with eating -check for redness, swelling and report to nurse -encourage hydration -pressure relieving mattress -assist with turning and repositioning -monitor for changes in cognition, mood, and behavior On 3/19/08 R12 was seen by Z1 (attending physician). Z1 stated he was shocked when he saw R12 due to her weight loss and complaints of pain to right hip area for several days. Z1 made arrangements for R12 to be a direct admit to hospital on 3/19/08 for wound care and pain management. Review of hospital record from admission and phone interview with Z1 revealed R12's admitting diagnoses included: 1) pressure sore stage 3 at right lower gluteal	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF CHICAGO RIDGE	**10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415**

(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
F9999	Continued From page 57 area 2) pressure sore stage 3 at right lateral external border of the right foot 3) old ischemic cerebral infarction with right hemiplegia 4) protein-calorie malnutrition (advanced) 5) peg tube insertion 6) possible osteomyelitis of right foot 7) peripheral arterial insufficiency 8) Methicillin Resistant Staph Aureus (MRSA) to right gluteal region Z1 stated in phone interview on 3/24/08 a bone scan revealed R12 was positive for osteomyelitis to the right foot and MRSA to the right ischial wound. Z1 further stated though R12 has history of peripheral arterial insufficiency, R12 's wounds were due to weight loss, protein depletion and R12's frequent lying on her right side. Z1 stated R12 was placed on Vicodin for pain while hospitalized. Z1 stated R12's wounds were preventable. (A)	F9999		