

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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 14 night, and 2 nurses.  Review of employee counseling form dated 6/13 for E5 reflects that E5 was counseled for turning R3 without assistance.  During interview with E1 (Administrator) on 7/23, E1 stated that after this incident, she had facility staff do an audit of all beds, and they discovered that some of the beds, including R3's, moved even when locked, and she ordered new bed caster locks for those beds. In the meantime, she had staff apply non-skid material by the wheels on the beds involved. She stated that R3's bed has since been changed.	F 323			
F9999	FINAL OBSERVATIONS  LICENSURE VIOLATIONS  300.1210a)4)5) 300.1210b)2)3)5) 300.1220b)2)3)  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 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:	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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	<p>Continued From page 15</p> <p>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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 potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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	<p>Continued From page 16</p> <p>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.</p> <p>These Requirements were not met as evidenced by:</p> <p>Based on Observation, staff interview, and review of clinical record, it has been determined that the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Assess a resident (R3) at risk for the development for bedsores.</li> <li>2. Report a significant change in a resident's condition (R3).</li> <li>3. Obtain physician's order for treatment of a large fluid filled blister on right and left feet of a resident (R3).</li> <li>4. Follow their facility's Policy and Procedure for the Treatment and Prevention of skin Breakdown.</li> </ol> <p>-The staff initiated orders, evaluated and implemented treatment without the consultation of the treating physician. -Per speaker phone conversation with treating physician and nurse it was established the physician had not given orders for the treatment transcribed on the physician's order form for the resident. -Once the heels were opened on 7/13/08, by</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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	<p>Continued From page 17</p> <p>7/18/08 the right heel presented as a stage 3-4 opening, the left heel presented at a stage 2, and the area on left great toe also has opening along side documented as healed.</p> <p>Findings include:</p> <p>R3 is a 58 year old female with diagnoses including subarchnoid hemorrhage with a shunt implanted in the head, Diabetes, and CVA ( Paraplegia). R3 is assessed and found to be alert and oriented time 2-3 with some forgetfulness for events, and has limited movement to the upper and lower extremities. .</p> <p>Observed 7/22/08 1:00PM R3 to be up in special wheel chair in the dining room with 2-3 plus edema to bilateral feet with dressings to the right/left heels and left toes. R3's feet were resting on the metal portion of the wheel chair with no pillows or other provision to promote pressure relief.</p> <p>Observed R3 in room. Once nurse was questioned regarding edema to R3's feet the resident was wheeled to her room and put to bed. It was at this time E3 licensed Practical Nurse removed the brown stained soaked dressings from the feet of R3 and surveyor was able to observe the breakdown.</p> <p>Observation of right heel showed the entire heel to be without skin with the muscle showing the surrounding skin yellow. The left foot had the first layer of skin missing with the surrounding areas black and yellow. The left great toe was black at the tip and the lateral side of the toe was open with yellow drainage on the removed dressing.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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 18  Interveiw of E3 Licensed Practical Nurse (LPN) informed surveyor, quote, "I was not aware of the edema to the right and left feet. I did change the dressings this morning to the wounds but I did not see the swelling." E3 informed surveyor that R3 has a stage 3-4 wound on the right heel and a stage 2 on the left. The left foot also has some black necrotic tissue present. "When I opened the heels the skin left after the fluid was extracted turned black." The treatment for the wounds are Betadine and dry dressings to the areas.  Surveyor asked E3 LPN if she had received a physician's order for the opening of the areas on the feet of R3. (popping of blisters) E3 informed this surveyor that she had not obtained an order for the procedure which she had performed on Sunday 7/13/08. E3 further stated, "The family was in the room of R3. There were seven people present. The husband called me and asked why the feet of R3 were swollen and I told him I did not know and he took the sock off her feet and on the right heel there was a large blister with yellow fluid inside. The blister was very large and boggy on her heel. I then looked at her left heel and she also had a blister, a very large fluid filled blister there. I was going to wrap the blisters but the husband kept complaining stating quote, 'You people are doing nothing for my wife.' So I had a pointed metal small stick that we use at the facility for opening wounds. It had a pointed end. I stuck it in the blister. It was so full it squirted out on some of the adults in the room and they became angry with me. After I mashed all the yellow fluid out of the blisters, it was a large amount, I wrapped her feet with dry dressings. I opened the blister on the left heel and wrapped	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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	<p>Continued From page 19</p> <p>them in a dry dressing. It was at the time I opened the blisters that I saw her toe has reopened so I put the betadine on the area and wrapped them."</p> <p>E3 was asked if she had an order from a physician to open the blister? E3 stated, "I had no order to open the blisters. There was a large amount of yellowish fluid inside the blisters. I was not aware the blisters were there until the husband called me to the room to look at the swelling."</p> <p>Surveyor asked E3 what the treatment was for the wound as from the date the blisters were opened on 7/13/08 to this date of observation 7/18/08; currently, the areas on the heels are no longer blisters but open wounds. E3 informed surveyor, "R3 had an ingrown toe nail- it healed but now it had reopened. I am applying Betadine soaked dressings to that area also." E3 further stated, "the physician was not aware of the blisters on the feet of R3 prior to the opening. I am familiar with the orders that Z1 (physician for R3) writes so I opened the blisters, wrote the order and signed the physician's name, Z1 who is covering for the regular physician who was on vacation."</p> <p>E3 informed surveyor I am supposed to document on all wounds weekly in the nurses note and daily on the Treatment Record.</p> <p>Review of clinical documentation:</p> <p>7/13/08 10:30 PM was the only documentation for any areas on R3 which stated blister on left outer heel area approximate size of a nickel. This is the only documentation for the wounds on R3.</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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 20  -Treatment Record: this is the sheet wound care nurse documents on: May 27,2008 area on left great toe healed and treatment has stopped - Treatment Record shows treatment for right heel on 7/13/08: apply dry dressing to right heel daily and PRN till healed. Apply Betadine to the left heal every day and as needed until healed. Apply Betadine to the left great toe daily and as needed until healed..  Interview with Z1 per telephone placed for listening of surveyor and E3, Z 1 stated, "Now E3, you know I have never seen R3. I was in the facility on 7/17/08 seeing residents and no one there told me there was a problem with R3. I am very angry because I had no knowledge of R3's condition until the State lady (Surveyor) called me. I have never, E3, and you know it- I have never given you permission to open any blisters and never would. If there was fluid there a culture of the wound should have been done. I would never order Betadine wraps for an open wound. Care is tailored for each resident individually. This lady is a diabetic and now she has open areas on her feet and you wrote orders for care that I never gave you. The only call I ever received from this facility was on 7/18/08 about 7:00 PM asking for some lasix- I spoke with E2 (Acting Director of Nursing) and I asked her what the measurement of the edema was and I was told by her she had not seen R3- some one was there and complained So I told her to go and see the resident and call me back. When she called back, E2 said there was no edema. You can look at the physicians order and you should see the only orders I ever gave were for 7/18/08 for Depakote level, Tramadol, ASA These are my only orders, E3. Now with this	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET</b> <b>CHICAGO, IL 60621</b>		
(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	<p>Continued From page 21 information I have to have R3 transferred to the hospital for emergency care."</p> <p>See Physicians order dated 7/18/08 to verify order. Physicians order for 7/22/08 was obtained due surveyors call to Z1 on 7/21/08 to obtain update as to why the heels were being treated with Betadine and was asked by the physician to go to floor and obtain the record and call her back with the nurse who had written an order and put her name on it without her permission.</p> <p>Careplan: R3 5/17/08 updated and is at risk for skin breakdown and approach is to report any signs of skin breakdown, sore, tender or red areas. Care plan was later updated on 7/13/08 by E3 to state History of Pressure Ulcers healed 5/30/08 left great toe with no mention of stage 2-3 on left heel or stage 3-4 on right heel.</p> <p>The Facility's Policy and Procedure for the Treatment and Prevention of Skin Breakdown: Policy:1. complete Braden Scale on admission and weekly for the first 4 weeks post admission and quarterly and with a significant change in status. Skin should be inspected with each risk assessment. -Page 3 The careplan is to be evaluated and revised based on response, outcomes, and needs of the resident. III. page 4----Initiation of a weekly assessment of skin alteration form with the onset of skin condition which will include: Type of wound, Location, date, stage, length, width, and depth; based description, wound edge description and if present drainage odor undermining, tunneling and or pain. There should only one wound per form. This was not done in the case of R3.</p>	F9999			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C 07/25/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN WENTWORTH REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 WEST 69TH STREET CHICAGO, IL 60621</b>		
(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 22  <p style="text-align: center;">(A)</p>	F9999		