STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

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F 314	Continued From page 9 pressure sores wound care reporting (when to report changes to body and who to report changes to), how to properly complete and understand wound assessments and treatment policy and procedures. 3. All residents will identified pressures ulcers will be reassessed to ensure that risk assessments related to pressure ulcers are accurate and updated. 4. All residents in the building will be examined by nursing staff to ensure that all pressure ulcers are identified. 5. A QA tool will be developed and monitored weekly by DON or designee to ensure that pressure ulcers are being treated and charted in accordance with need of the pressure ulcer. 6. This plan will be monitored by the Director of Nurses and or designees on an ongoing basis, through the above mentioned QA tool, review of pressure ulcer documentation and direct observation of wound care. Pressure ulcers will further be addresses in the QA meetings to discuss IDT members problematic patients, review protocol and increase awareness of needs as they are identified relevant to this area. Completion Date: 08/29/2008	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4)5) 300.1220b)2)3)	F9999		

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F9999	Continued From page 10 300.3240a) 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 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis. 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of	F9999		

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F9999	Continued From page 11 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by: Based on observation, interview, record review and skin check protocol, the facility failed to Identify, comprehensively assess and notify the physician regarding newly developed pressure sores for two residents (R5 and R9); Treat newly developed pressure sores for R5 and R9; Treat existing pressure sore with the current treatment order for R3; Provide and implement	F9999		

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F9999	Continued From page 12 individualized interventions to prevent the development of new pressure sores for R5 and R9; Provide treatment as ordered and correct treatment of a pressure sore for R9; and Follow the facility skin check protocol for R5, R3 & R9. These failures resulted in the facility failing to identify, assess and treat the pressure ulcer in a timely manner and notify the physician of a resident's change in skin condition (R5). R5's pressure ulcers, Stage 3-4, were not identified, assessed and treated in a timely manner. This resulted in R5 requiring emergency surgery. R5 required two debridements at the hospital and was placed on contact isolation for Escherichia Coli and Enterococcus in the wound. The resident was admitted to the Intensive Care Unit (ICU). Findings include: 1. R5 was observed on 08/21/08 at 11:45 am in hospital ICU. R5 was in contact isolation with a right surgical leg dressing in place. R5 was on a cardiac monitor, oxygen, multi intravenous fluid and an indwelling catheter. Review of the hospital medical record for R5 indicated S/P Mastectomy, S/P Right Lower Extremities Debridement (08/13/08), S/P Redebridement (08/15/08), Hypertension, Depression, Diabetes Mellitus, Gastrointestinal Hemorrhage, Clostridium Difficile Colitis, Deep Vein Thrombosis, Aspiration, Pneumonia, Dyslipidemia and B12 Deficiency Anemia. Interview with Z2 (Physician) on 08/20/08 at 12:00 PM in the conference room stated, "She was transferred from the nursing home for	F9999		

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F9999	Continued From page 13 surgery, a simple mastectomy on 08/13/08. We were pre-operative for surgery. There was blood noted on right lower leg pant. Upon investigation their was a 5 cm circular pressure ulcer. It was a Stage 3 or 4 with necrosis edge of the pressure ulcer. It was a foul odor. There was no dressing in place. It was not a new pressure ulcer. It was approximately couple weeks old. On the surgical consent, debridement was added. We debrided on 08/13/08. There was a culture done on the wound. We did the debridement on the same day of the simple mastectomy. She had emergency surgery on 08/15/08 for redebridement of the pressures sores. It was infected." According to interview with Z3 (Social Worker) on 08/20/08 at 12:45 PM in the conference room she stated, "She was transferred from the nursing home on 08/13/08 for a simple mastectomy. It was noted on the lower right extremities a Stage 3 or 4 pressure sore. Necrosis around pressure sore and no dressing. Physician stated that it was there for awhile. Surgery debridement was done after the simple mastectomy on 08/13/08. The surgeons had to take her back on Friday night date 08/15/08 for emergency surgery. She had redebridement of the pressure sore." E3 (Certified Nurse Aide-CNA) was interviewed on 08/21/08 at 7:00 am in the hall and was asked if (E3) gave morning care to R5. E3 stated, "Yes, I took care of R5. Her right leg was swollen. She had a large scab and dark discoloration on the right leg. I told E4. It was August 08, 2008." According to interview with E5 (Nurse) on 08/21/08 at 7:10 am at the nurses station, E5 stated, "The CNA told me R5 had a sore on the right leg. R5 was evaluated of the pressure sore.	F9999		

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F9999	Continued From page 14 I told the treatment nurse. It was a few weeks ago. E7 (Nurse) was the treatment nurse. I don't know what happened." Surveyor ask for the pressure sore documentation. E5 stated, "I don't remember writing anything." Interview with E2 on 08/21/08 at 12:30 PM, E2 stated, "E7 was the treatment nurse. She left around the last week of July, 2008 or beginning of August, 08. The floor nurses are doing the pressure sore treatment. The nurses should assess, care plan and call the physician for treatment orders." An attempt was made to contact E7 by telephone for an interview, but E7 did not return the call. Review of the hospital pre-operative record dated 08/13/08 indicated that R5 was sent to the hospital on 08/13/08 for a simple mastectomy. During pre-operative surgery, a Stage 3 or 4 pressure ulcer was discovered on the right posterior lateral of the leg in which surgical debrided was needed. R5 had debridement of the right lower leg. The wound was somewhat necrotic, but did not appear infected with no erythema of the surrounding tissue. Culture was done of the right leg wound. Review of the Discharge Summary/Operative record for R5 dated 08/13/08 indicated that she was admitted in the nursing facility and had a right breast mass. On the day of surgery (08/13/08) the patient was taken to the preoperative area and was noted to have a wound on her right lower leg on the posterior laterals aspect of her calf. This had not been noted by patient or her family member and previously and had no dressing on it. The wound was somewhat necrotic, but did not appear	F9999		

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F9999	Continued From page 15 infected with no erythema of the surrounding tissue. Culture done of the right leg wound. 08/15/08 states preoperative diagnosis Necrotizing postoperative soft tissue infection of the right leg. Operative Performed-Radical debridement of right leg including skin, subcutaneous tissue, muscle and biopsy of left leg. This is a complication of the patient's complications prior operation on 08/13/08. Operative Finding on 08/15/08 a 5 x 6 cm full thickness defect was present on the posterior aspect of the right leg. The muscle was black with foul smelling odor at the base of the wound. Biopsy of the left leg lesions did not reveal necrotic tissue." Review of the culture of the wound from the hospital laboratory dated 08/13/08 indicated Isolated Escherichia Coli and Enterococcus. Review of the facility medical record of R5 confirmed that there was no documentation of the right lower leg pressure ulcer. Further review of the wound assessment flow sheet, weekly documentation, skin surveillance report and other skin problem sheet confirm their was no documentation of the left lower leg pressure sore. The facility did not present any documentation of the left lower leg pressure sores. Review of the Skin Check Protocol indicated that: Skin checks will also be done on all residents that are assisted with bathing (shower, tub or bed bath). CNA is to mark on skin sheet, anything found-red mark, pen area, bruise, scratch or rash. CNA will sign it, and give it to the nurse.	F9999		

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F9999	Continued From page 16 The nurse will assess each area. The nurse will notify the Physician, if appropriate and carry out any further orders. The skin sheet will then be given to the DON. The DON will then assess any pressure ulcers for nursing intervention. DON will document interventions and findings to determine if it was avoidable or unavoidable. 2. During pressure sore treatment observation with E5, E6 and E8 (Treatment Nurses) on 08/21/08 at 8:15 am, R9 was observed with no dressing on the sacral pressure sores. Surveyor observed three pin point pressures ulcer on the right buttock approximately 0.2 x .4 cm, 0.3 x 0.4 cm and 0.4 x 0.4 cm, Stage 2. E5 stated, "There was no dressing on the sacral pressure sores. Those are new pressure sores on the buttock. They are Stage 2. There are no assessments, treatments or care plan. I am going to call the physician." According to interview with E9 (CNA) on 08/21/08 at 8:35 am in the hall, E9 stated, "I have not done morning care on R9. E9 was asked what time did you check resident and was there a dressing on the sacral. E9 stated, "I checked her at 7:20 am. There was no dressing on the sacral pressure sore. I did not check for any other open areas on the sacral or buttock." 3. E6 was observed during pressure sore treatment on 08/21/08 at 7:10 am. R3 was observed with a sacral ulcer dressing in place. E6 proceeded to remove the dressing from the sacral area. E6 cleansed the areas with normal saline, applied Xeroderma ointment and a dry dressing.	F9999		

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F9999	Continued From page 17 E6 was asked what was the wound care. E6 stated, "Cleanse with normal saline, apply Xeroderma ointment and a dry dressing." Review the medical record for R3 indicated that R3 acquired the sacral pressure on 07/24/08. Family notified of breakdown on ischium. There was no documentation identifying the pressure sore, treatment, care plan or that the physician was notified in the change of condition until 08/20/08. Review of the nurses notes dated 08/20/08 at 6:20 am indicated: Upon daily skin assessment, noted Stage 2 to sacrum pink small drainage. Medical Doctor aware of areas and measure of wound 5.0 x 3.5 x 0.1 cm. Review of the physician order sheet (POS) dated 08/20/08 indicated, Sited-Applied Xeroderma, cleanse with warm water and mild soap. Leave open to air. Further review of the physician order indicated that the wrong treatment was done. Review of the Skin Check Protocol indicates that skin checks will also be done on all residents that are assisted with bathing (shower, tub or bed bath). CNA is to mark on skin sheet, anything found-red mark, pen area, bruise, scratch or rash. CNA will sign it and give it to the nurse. The nurse will asses each area. The nurse will notify the Physician, if appropriates, and carry out any further order. The skin sheet will them be given to the DON. The DON will then asses any pressure ulcers for nursing intervention. DON will document interventions and findings to determine if it was avoidable or unavoidable. (A)	F9999		