

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W 331}	Continued From page 14 5. The RN Consultant (E3) will assess individuals promptly as based on their nursing needs. If the Consultant is not available, staff will call the alternate RN Consultant (E7), secured by the facility on 06/16/10; 6. The Physical Therapist Consultant (E8) was contacted on 06/15/10 and will assess R3 by 06/30/10; and 7. All direct care staff will be trained by nursing staff as to proper infection control techniques as of 06/16/10. While the Immediate Jeopardy was removed on 06/17/10, the facility remains out of compliance since the facility has not had the opportunity to fully implement and evaluate the effectiveness of their plan.	{W 331}			
{W9999}	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230d)1)2) 350.3240a) 350.3750 Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 15 operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1220 Physician Services</p> <p>j) The facility shall notify the resident's physician of any accident, injury, or 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.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <ol style="list-style-type: none"> 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>Section 350.3750 Consultation Services and Nursing Services</p> <p>Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 16</p> <p>facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that an effective health care system has been developed and implemented for 1 of 1 individual in the sample, who presently has open areas (R3), and who was diagnosed by her physician on 05/05/10 with cellulitis of the left foot and open wounds to the left foot, infected with gangrene. After this date, there is no documentation indicating that R3's open areas were ever assessed by nursing staff. R3 presently has two open areas on her left foot, with the area on her heel (of undetermined depth) still draining, and no individualized plan has been developed. This failure has the potential to affect 3 additional individuals (R1 who had an open area on 05/10/10 and R4 and R5 who require a wheelchair for mobility).</p> <p>The facility failed to:</p> <p>1. Develop and implement skin care policy and procedures;</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	Continued From page 17 2. Ensure that nursing staff assessed open areas including staging and measurements and documented these assessments; 3. Develop and implement an aggressive individualized decubitus prevention plan for maintaining skin integrity, inclusive of ongoing assessment, repositioning, proper hydration and adequate nutritional intake; 4. Ensure that nursing staff and direct care staff are aware of the physician's and specialist's orders and that these orders are implemented to prevent further breakdown and to promote healing; 5. Provide documentation of nursing monitoring of open area(s); 6. Make arrangements for licensed nursing services to care for the individual's health needs when the Registered Nurse/RN Consultant (E3) is not available; and 7. Ensure that staff have been trained and demonstrate proper infection control techniques during treatments to open areas. Findings include: E2 (Qualified Mental Retardation Professional/QMRP) was interviewed on 06/11/10 at 10:30 A.M. and stated that the facility did not have policies and procedures for skin care. a) The Physician's Order Sheet dated 05/01 - 05/31/10 states that R3 is a 39 year old female	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 18</p> <p>who functions at a moderate level of mental retardation with diagnoses of Spina Bifida and Peripheral Vascular Disease.</p> <p>R3's Physician's Office Visit report dated 05/05/10 states,</p> <p>History of Present Illness: Pt (patient/R3) is here for a f/u (follow up) visit after accident on 4/18/10. Pt was on wheelchair on the van lift pad when it got stuck and pt flipped back sustaining pain and swelling of shoulders and left foot and ankle. Went to ER (Emergency Room) on 04/19 had x-ray of foot showing calcaneal fx (fracture). Then pt developed large abrasion with blisters on top and heel of left foot...</p> <p>Skin: *Lesions: large open area to top of left foot and posterior left heel, began as blisters about two weeks ago. Dorsum of the foot lesion is raw open with redness around. The lesion in the heel measures 3 x 4 cm (centimeters) blackish with necrotic tissues, covered with loose skin from the blister. The surrounding tissue is red.</p> <p>Assessment * Cellulitis * Cellulitis of the left foot * Open wound * Open wound of the left foot - infected with gangrene</p> <p>Therapy: * Continue current medication * Shaving of a lesion Necrotic tissues were removed by piecemeal then dressed with Silvadene cream.</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 19</p> <p>Plan: *Oral fluids increase * Return to the clinic if conditions worsens or new symptoms arise * Follow up visit: 1 week Will start with antibiotics Silvadene dressing daily debridement done.</p> <p>In reviewing R3's record, no documentation is noted identifying that R3 was assessed by nursing staff after she was seen by E5 (Physician) on 05/05/10. R3's Nurse's Notes do not identify that nursing staff assessed R3's open areas after she was seen by E5, or prior to this visit. There is no documentation that R3's areas were staged and measured by nursing or that a plan of care was developed and implemented to address the infected, open areas on her left foot.</p> <p>In reviewing R3's Nurse's Notes it was noted that she was seen by E3 (RN Consultant) on 04/17/10. No further nursing entries were noted after this date (04/17/10).</p> <p>The Physician Referral Form identifies that R3 was seen by E5 (Physician) on 05/10/10 for a recheck of her left foot and questionable hospitalization. E5 (Physician) documented, "Abrasions with cellulitis and gangrene - better." At this visit, E5 continued R3's Augmentin medication for an additional five days and gave orders for her to return to his office on 05/17/10.</p> <p>There is no documentation that R3 was assessed by nursing staff after she was seen by E5 on 05/10/10.</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 20</p> <p>On 05/10/10 at 1:40 P.M., the facility's Log for Phone Calls to RN Consultant states that E4 (Direct Care Staff) called E3 (RN Consultant) regarding R3's foot and the new physician's orders for R3. It is documented by E4, "She (E3, Registered Nurse Consultant/RN) said she (R3) should be fine we are already doing everything the dr (Doctor) wanted. She (E3) can not make it tonight to come see her (R3) she (E3) has to much going on."</p> <p>The facility's Log for Phone Calls to RN Consultant form from 05/10/10 - 06/07/10 identifies there were no further phone calls documented on this log regarding nursing notification to E3 (RN Consultant) regarding R3's open areas.</p> <p>The Physician Referral Form identifies that R3 was seen by E5 (Physician) on 05/17/10 for a follow up appointment on her left foot. E5 documented that her wound was healing and that Silvadene cream should be continued.</p> <p>Another Physician Referral Form identifies that R3 was seen by Z1 (Orthopedic Surgeon) on 05/17/10. Z1 documented, "Decub Precautions" should be continued.</p> <p>R3's record does not identify any type of decub precautions were ever developed and or implemented.</p> <p>R3's Progress Notes for 05/17/10 identify that she was seen by the doctor (not specified) and that she (R3) was not to attend workshop for four weeks. There is no further documentation by direct care staff until 05/24/10. Documentation for 05/24/10 states, "R3's blisters on her feet are</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 21</p> <p>looking much better." After this entry, no further documentation is noted in the Progress Notes from 05/25/10 to 06/10/10 regarding R3's blisters by direct care staff.</p> <p>R3 was observed on 06/11/10 at 8:00 A.M. sitting in her wheelchair with the leg rests of her wheelchair positioned straight out in front of the wheelchair. A roll of towels were positioned under the lower portion of the left thigh, near her knee. Both heels were observed to be laying flat, in contact with the leg rests of the wheelchair.</p> <p>A Physician Referral Form dated 04/28/10 identifies that Z1 (Orthopedic Surgeon) ordered, "ABSOLUTELY NO Contact of heel on Bed. Place small bump under calf at all times. (MUST ADJUST Bump every hour to prevent calf ulcer.) As observed on 06/11/10, facility staff are not following Z1's orders by placing the towels under R3's calf and are not ensuring that her heel does not come in contact with the leg rest of her wheelchair.</p> <p>On 06/11/10, at 8:20 A.M., E4 (Direct Care Staff) was observed to change R3's dressing to her left foot. After E4 removing the sock, bandage and gauze from R3's left foot, the surveyor noted a healing abrasion measuring two to three inches in length by one half inch to three fourths of an inch across the top portion of R3's left foot. This area was covered with a light scab and the outer edges were red to pink in color. The surveyor also noted a circular open area, slightly larger than a quarter, measuring one half inch to three fourths of an inch in diameter on R3's heel. Bloody drainage was noted coming from this open area and the depth of this wound could not be visually determined. R3's guaze pad was</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 22</p> <p>soiled with bloody drainage, as was the bandage. E4 completed R3's treatment and was observed replacing the bandage which was soiled from the drainage from R3's open area on her heel. E4 removed the soiled bandage after being prompted by the surveyor that this is not an appropriate infection control technique.</p> <p>A Physician Referral Form dated 06/04/10 identifies that R3 was seen by E5 (Physician) for follow up on the blisters on her left foot. E5 ordered that R3's Silvadene Cream be continued daily. E5 also ordered, "May not hold leg when transferring. Avoid Trauma." (This entry was translated to the surveyor by E6 (E5's Nurse) on 06/16/10 at 9:30 A.M. by telephone after the surveyor had difficulty reading E5's handwriting. During this telephone interview, E6 informed the surveyor that E5 was on vacation and would not be available until 6/21/10.)</p> <p>During a telephone interview with E2 (QMRP) on 06/16/10 at 4:30 P.M., E2 stated that he was not aware that the physician had written orders not to hold R3's leg during transfers.</p> <p>Further review of R3's record does not identify that a skin risk assessment has been completed. No individualized prevention plan has been developed to promote healing of R3's open areas. It is also noted, that physician's and specialist's orders are not being implemented and have not been addressed by the facility. As of 06/11/10, R3's record does not identify that the facility's consulting dietician has been contacted to address R3's nutritional needs and her need for increased oral fluid intake. It is also noted that as of 06/11/10, the facility's consulting physical therapist has not been contacted</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 23 regarding pressure relieving devices and/or R3's positioning needs.</p> <p>E3 (RN Consultant) was interviewed by telephone on 06/11/10 at 11:35 A.M. and stated, "I assessed R3's foot early on when it was purple and swollen. It might have been the next day." When E3 was asked where she would have documented this assessment, E3 stated, "In the Nurse's Notes or in the Consultant Book." The surveyor reviewed R3's Nurse's Notes and the facility's Consultant Report (Nursing) with E3 which both identify that her last visit to the facility was on 04/17/10. E3 stated, "I think I did, but I'm not sure." When E3 was asked if a skin risk assessment had been completed on R3, E3 stated, "No." E3 also stated, "No" when asked if skin risk assessments have been completed for R4 and R5 who both require a wheelchair for mobility. When E3 was asked whether R3's open areas on her left foot had been assessed and measurements taken, E3 stated, "No." E3 also stated, "No" when asked if an individualized plan had been developed to address R3's open areas on her left foot. During this telephone interview, E3 stated that she was not always available to come to the facility to assess the individuals when staff call.</p> <p>E2 (QMRP) was interviewed on 06/15/10 at 9:15 A.M. and stated, "We are looking into getting another nurse to cover for E3 when she is not available and the consulting dietician was in on 06/11/10 to assess R3." When E2 was asked if the facility had contacted the consulting physical therapist about pressure relieving devices and positioning needs for R3, E2 stated, "No."</p> <p>E3 (RN Consultant) was interviewed on 06/15/10</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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	
{W9999}	<p>Continued From page 24</p> <p>at 9:30 A.M. and stated, "Yes" when asked if she thought R3's diagnoses of "cellulitis and gangrene" were serious and posed immediate threat to R3's health.</p> <p>b) The Physician's Order Sheet dated 05/01 - 05/31/10 states that R1 is a 55 year old male who functions at a mild level of mental retardation.</p> <p>R1's Progress Notes dated 05/10/10 state, "R1's step mom called today and reported that R1 has skin breakdown on his legs. R1 states it is from having his legs propped on something wooden... The nurse was called and asked if she could come and take a look at them and she said she had to (too) much going on tonight but could come tomorrow and look at them and to put triple antibiotic cream on it and gauze bandage. We will also get him an apt (appointment) to see the Dr."</p> <p>Further review of R1's Progress Notes from 05/11 - 06/02/10 does not identify that any further entries were made in these notes regarding his skin breakdown.</p> <p>R1's Nurse's Notes were reviewed. No entries have been made by nursing since 04/12/10. R1's record does not identify that a skin risk assessment has been completed or that E3 (RN Consultant) assessed the skin breakdown on his legs after notification. No documentation is noted within R1's record identifying the specific location of R1's breakdown, nor was this area staged with measurements. R1's record does not reflect that an individualized plan was developed to address the breakdown on his legs.</p>	{W9999}			

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/17/2010
NAME OF PROVIDER OR SUPPLIER ROYAL LIVING CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH 9TH STREET NEW BADEN, IL 62265		
(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
{W9999}	<p>Continued From page 25</p> <p>In reviewing R1's Physician Referral Forms no documentation is noted identifying that R1 was seen by the physician for the skin breakdown on his legs.</p> <p>Further review of the Medication Administration Record does not identify that staff applied antibiotic cream and guaze bandage to R1's skin breakdown as recommended by E3 (RN Consultant).</p> <p>E3 (RN Consultant) was interviewed by telephone on 06/11/10 at 11:35 A.M. and stated, "I remember staff calling about R1's breakdown on the back of his leg. I told them to apply antibiotic cream. If I assessed R1 it would have been documented in his Nurse's Notes or on the facility's Consultant Report (Nursing)." At this time the surveyor reviewed R1's Nurse's Notes and the facility's Consultant Report (Nursing) with E3 which both identifies that her last visit to the facility was on 04/17/10. During this interview E3 confirmed that she had not assessed R1's skin breakdown, completed a skin risk assessment, nor developed an individualized plan to address R1's skin break down. E1 also stated that she was not aware that R1 had not been seen by the physician in regards to the breakdown to the back of his legs.</p> <p>(A)</p>	{W9999}		