

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

PRINTED: 05/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/03/2012
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9615 NORTH KNOX AVENUE SKOKIE, IL 60076		
(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 518	Continued From page 53 staff are in-serviced on emergency preparedness and each one of the staff are expected to know what to do.	F 518		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210d)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	F9999		

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F9999	<p>Continued From page 54 and shall be practiced on a 24-hour, seven-day-a-week basis:</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 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to assess and treat new pressure sores for 1 resident in the sample (R10), and failed to follow the manufacturer's directions for the use of a low air loss mattress and failed to reposition 1 resident in the sample (R1). This failure resulted in R1's pressure sore increasing in size.</p> <p>Findings Include</p> <p>1. On 12/27/11 at 10:15am during initial tour R10</p>	F9999			

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F9999	<p>Continued From page 55</p> <p>was transferred into a wheel chair. At 2:40pm, R10 was transferred back into bed. R10 was intermittently observed not able to reposition self to relieve pressure on the buttocks. The facility identified R10 has having pressure ulcer. R10 was also observed on 12/28 and 12/29 to be up in the wheelchair during the same time period and not repositioned to relieve pressure.</p> <p>E4 ADON (Assistant Director of Nursing) was questioned for clarification whether R10 has a pressure ulcer, and E4 replied that the pressure ulcers have healed.</p> <p>Upon observation on 12/27/11, R10 was noted to have two new open skin sites on the right buttocks. E4 (ADON) acknowledged that they are new and was asked to measure the site and stage them if applicable.</p> <p>E4 measured first site on the right buttocks as 2cm (centimeter) x 2.2cm and stage it as stage II ulcers. The second site on the right buttocks measured 0.4cm x 1cm and was staged as stage II pressure ulcer with reddened surrounding area of 8cm x 4.8cm staged as stage I .</p> <p>On the left buttocks an area of redness noted and measured 7.4cm x 6cm and was staged as stage I.</p> <p>At 3:30pm 12/27/11 the redness and open area on both buttocks remain the same, E4 stated the physician will be notified to get a new order for treatment.</p> <p>On 12/28/11 at about 9:15am, Z2 (Wound care Physician) acknowledged that the original site of pressure ulcer healed and these are new sites</p>	F9999			

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F9999	<p>Continued From page 56 that were just reported late last night</p> <p>12/27/11, Z1 noted in R10 's wound care assessment and progress note dated 12/7/11 that the right buttocks pressure ulcer size " remains closed. "</p> <p>On 12/27/11 R10 ' s care plan did not address the new site of pressure ulcer. R10 ' s MDS score for transfer is 3/3 and for bed mobility 3/2.</p> <p>2. Per observation and facility records, R1 has a stage II pressure sore on her right buttock. The resident was observed lying on a low air loss mattress on 12/27 (2:30pm), 12/28 (9:30am), 12/29/11 (2:25pm) and 1/3/11 (10:50am). R1 had a sheet on the mattress, 2 cloth pads under her, and a cloth diaper on during all of these observations. E4 and E31 (CNA's - Certified Nursing Assistants) performed incontinence care on the resident on 12/28 at 9:30am and placed the same amount of linen on the bed/resident as stated above.</p> <p>E22 was asked on 12/28/11 at 10am if there was any information available about the use of R1's bed, and she stated that all they had on the floor was the delivery receipt.</p> <p>A search of the Manufacturer's Specifications for this brand of bed documents the following regarding use of linens: "Limit to 1 bed sheet and only breathable incontinence pads. Waterproof cover is moisture vapor permeable."</p> <p>Observations on 12/28 at 12N and 2pm, 12/29 at 11am & 3pm, 12/29 at 2.23pm, and 1/3/12 at 1pm also showed that the resident was lying on her</p>	F9999			

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F9999	<p>Continued From page 57 back. No repositioning of R1 was observed.</p> <p>R1's pressure sore and wound records show that the area on the right buttock re-opened on 11/26/11 and measured 3.0cm x 2.0cm. The following measurements are documented weekly by the nursing staff or wound physician:</p> <ul style="list-style-type: none"> -11/30 - 2.0cm x 3.0cm -12/7/11 - 1.5cm x 2.4cm -12/14/11 - 1.5cm x 2.4cm -12/21/11 - 0.4cm x 0.7cm -12/28/11 - 0.8cm x 1.2cm -12/31/11 - 6.0cm x 1.5cm <p>The wound was remeasured by E22 (nurse) upon request on 1/3/12 at 12:30pm. It was measured at 5.4cm x 1.3cm. E22 stated that the wounds are measured every Friday by the nurses.</p> <p>According to these measurements, the wound increased dramatically from 12/28 to 1/3/12. No documentation was found to address the increase in size or the possible causes for it.</p> <p>A document titled "Skin Care Do's and Don't" was presented by the facility.</p> <p>Under "Do's"</p> <ul style="list-style-type: none"> - Do notify the treatment or the charge nurse of any redness or skin breakdown. -Do turn and reposition residents at least every 2 hours. <p>Under "Don'ts"</p> <ul style="list-style-type: none"> -Don't place multiple layers of sheets and underpads beneath residents. "Less is best" -Don't leave residents in a chair for more than one hour without repositioning them. 	F9999			

