STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. BUILDING _____ B. WING _____	12/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SHORE HLTHCARE &REHAB CTR	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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F 441	Continued From page 16 disposable gloves underneath the clean linen. The substances and spills were removable with a wet paper towel. The carts were in the halls outside of resident rooms of 416, 418, 435, the 4th floor South Common Bathroom, the 3rd floor South Pantry, 335, three linen carts outside of rooms 314/313, 235 and 2 linen carts outside the 2nd floor South Common Bathroom, 204, 210, and 216. There were no clean linen carts on 1st floor. Some of the linen cart covers were tattered, frayed and soiled with dried white substances. On 12/21/11 at 10:45 AM, E26 (Housekeeper Director) stated he has no set schedule to clean the linen carts. He stated the carts are cleaned 1 to 2 times a week and as needed. E26 stated he does not keep a log on the cleaning of the carts. E26 concurred the clean linen carts were dirty and needed cleaning. E26 obtained a wet cloth which he stated he had chemical sprayed on it and was using it to clean the substances off the carts while the linen remained on the carts.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210b)4) 300.1210c) 300.1210d)2) 300.1210d)3) 300.1210d)4)A) 300.1210d)5) 300.3240a) 300.3240b) 300.3240c)	F9999		

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F9999	Continued From page 17 300.3240d) 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) b) The facility shall 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 resident care plan. 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition	F9999		

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demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.
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.
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:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
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

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F9999	Continued From page 19 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 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) Based on observation, interview and record review, the facility failed to monitor for and implement preventive measures to prevent the development of new pressure ulcers for one resident (R2) in six residents at high risk for skin breakdown in the sample of 27 residents. Findings include: R2 is a 79 year old whose diagnoses included	F9999		

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Metastatic Pancreatic Cancer, Abdominal Pain, Cellulitis of Both Legs, and Hospice. R2 is alert and oriented to person, place and time. R2 was admitted to the facility on 12/01/11 with infection to open wounds to both legs and otherwise intact skin. R2's care plan for 12/14/11 noted R2 to be at risk for skin breakdown on buttocks and other bony prominences. Interventions to prevent skin breakdown included:

1.) Apply moisture barrier to buttocks or moisturizer to dry skin.
2.) Apply lotion or moisturizer to dry skin.
3.) Inspect skin for early signs and symptoms of skin breakdown and report to nurses any redness, cracks, bruise, change in colors and temperature of skin areas.

During the initial tour on 12/ 20/11 at 10:00 AM, R2 was awake in an oversized bed . R2's red and edematous legs were exposed to air as R2 lay on his back. R2 remained in the prone position when he was visited after lunch at 1:30 PM. Also, throughout the next two days, R2 was observed lying on his back only. Review of thePOS (Physician Order Sheet) upon admission stated "Skin check by licensed nurse daily and PRN (as needed).

The nurse's note for 12/07/11 at 12:07 notes open wounds on the buttocks area. The clinical record did not show follow up to this observation. On 12/21/11 at 2:00 PM, E5 (Nurse) was questioned about the wounds on the buttocks which she had noted. E5 stated that it was only excoriation and the area was being treated with a house stock skin barrier cream. When the area was viewed with E5and E6, CNA (Certified

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Nurses Aide) at 2:45 PM, the sacrum wound covered the whole sacrum with the middle area being black with necrotic tissue. Smaller wounds were noted on the lower left buttock, the upper left buttock and one to the right posterior thigh. E5, nurse stated, "That is fresh. It did not look like that when I saw it 2 days ago. I told the wound care nurse (E8) about the open areas on 12/07/11 and I got a doctor's order for the colloid dressing and asked E8 to follow up." E6, CNA stated that the area did not look that bad that morning. At 2:50 PM, E4, ADON (Acting Director of Nursing) viewed the wounds for the first time and stated that he would get the wound care nurse.

At 3:00 PM on 12/21/11, E7, Wound Care Nurse came to observe R2's wounds. E7 stated that he was not the regular wound care nurse for R2. E7 said that the regular wound care nurse (E8) was busy. After viewing the wounds, E7 spoke with E8 on the phone then stated, "She said that site is new." When asked for the treatment orders for the wounds, E7 checked the treatment record and did not find a prescribed treatment for the wounds. E7 also checked the computer with the same results.

E8, wound Care Nurse arrived at 3:15 PM and stated that she did not report the wounds or document on them because the area was just shearing and excoriation. E8 stated, "I apply a skin barrier." E8 stated that she saw the area two days prior but did not notify the wound care doctor because R2 is a Hospice resident and, "Hospice has to give their approval for any referrals." E8 did a wound assessment and described the wounds as :

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1.) Sacrum unsalable 9.4 x 15.0 cm
2.) Lower left buttock 1.8 x 3.1 cm
3.) Upper left buttock 1.7 x 2.3 cm
4.) Right posterior thigh 1.0 x 0.6 cm

When E5, Nurse was asked for Hospice notes, they could not be found. R2 was admitted to Hospice on 12/02/11. On 12/22/11, E5 presented a Hospice note dated 12/21/11 which said the sacral sore had been pointed out to Hospice on 12/21/11. E5 also showed that wound treatment had been ordered for the four new wounds on 12/21/11.

On 12/22/11 at 11:45 AM, Z4 MD stated that she was made aware of the wounds on 12/21/11 by the nurse and ordered a referral for R2 to the wound care specialist. The doctor mentioned that R2 was admitted with encrusted wounds to the legs. The doctor was reminded that there were four new wounds observed. The doctor repeated that R2 was being referred to the wound care specialist.

On 12/23/11 at 10:10 AM, E15 stated that she had worked with R2 for about 10 days. E15 said that she bathes R2 every other day. E15 said that she has never seen the sacral wound because it was always covered with a large dressing. E15 said that the wound care nurse always provided the creams to apply to the other three wounds.

At 10:40 AM, E8, wound care nurse arrived to change the dressings. After removing the dressings, E8 confirmed that the sacral wound and the left lower buttock wound had eschar

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F9999	Continued From page 23 caps. E8 stated that the treatment being applied now would loosen the cap in about one week and the wounds would then start healing better. E8 said that the wound care doctor would see R2 in six days. (B)	F9999		