STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145237	A. BUILDING _____ B. WING _____	03/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

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F 514	Continued From page 41 3/9/12-3/14/12. On 3/6/12, the Medication Record documents at 4pm a glucose of 166 with no insulin administered. March, 2012 Medication Administration Record has an order for 2 units of regular insulin to be given for a glucose level of 166. These missing results are not documented in the computerized charting system. On 3/21/12, at 3:50pm, E4(Director of Nursing) stated that all blood sugar levels should be done according to the physician orders and documented on the Medication Flowsheet and in the computerized charting system. Medication Flowsheets and computerized charting for R14 and R15 were reviewed with E4. E4 verified the lack of documentation.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1210a) 300.1210b) 300.1210d)3)5) 300.1810b) 300.1810f)1) 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	F9999		

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F9999	Continued From page 42	F9999		

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.

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:
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.
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

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F9999	Continued From page 43 services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1810 Resident Record Requirements b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. 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 regulations are not met as evidenced by the following: Based on observation, interviews and record reviews, the facility failed to consistently and accurately assess, monitor, and prevent the development of recurring pressure ulcers for 1 resident (R29) out of the sample of 30 reviewed for pressures ulcers. This failure resulted in R29 becoming septic and required hospital admission for surgical debridement. Findings include:	F9999		

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F9999	Continued From page 44 R29 was an 85 year old who has multiple medical diagnoses including chronic decubitus ulcer. On 3/21/12 at at 4:10 PM, Z2 (Wound Care Doctor) stated he never had residents dying of a pressure wound, residents may have died with a pressure wounds, but not because of the pressure wounds. Z2 remembers R29 as having multiple pressure wounds but no sepsis. Z2 defined no sepsis as having no odor, no drainage and no redness. On 3/22/12 at 9:30 AM, Z6 (R29's son) stated over the phone, they were never notified regarding R29's multiple bedsores, especially the development of a Stage IV pressure sore on the hip, until R29 went to the hospital. Z6 added he and his siblings were told by the doctor from the hospital that R29 has sepsis related to the extremeness of the bed sore on her hip and that it was part of her decline. On 3/22/12 at 10:20 AM, E3 (wound care nurse) stated R29, as far as she recalled, the right and left ischial ulcer developed sometime in December. It was healing. R29 went to the hospital with a stageII ulcer on the right ischium (lower back/ back part of hip bone). Review of R 29's Treatment Administration Record indicated: Right Ischium; Cleanse with normal saline solution, apply Multidex to open wound only and cover with hydrocolloid dressing. Change dressing 2 times a week and as needed for soiled dressing.	F9999		

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F9999	Continued From page 45 Comprehensive skin assessments to right ischium was done only 3 times from 12/16/11 to 1/23/12. - 12/16/11 assessment indicated; a stage II ulcer, no exudates, no odor, and normal skin intact. The size (Length x Width x Dept) was 2.7 x 2.1 x .1 centimeter (cm). - 12/25/11 assessment indicated; a stage II ulcer, scant serosanguinous exudate, no odor, and skin macerated. The size was 2.7 x 2.1 x 0.1 cm. - 01/06/12 assessment indicated; a stage II ulcer, no exudate, no odor, and skin attached. No further comprehensive skin assessment was made after 1/6/12. E2 (Director of Nursing/ DON) stated on 3/23/12, comprehensive skin assessments should be done quarterly for residents with no wounds, and weekly for residents with wounds. Review of R29's progress notes indicated: -1/13/12 at 9:33 AM, E3 documented- Right Ischium is deteriorating, it is now unstageable and 100% slough. -1/16/12 at 12:02 PM, E3 documented (recorded as late entry on 2/13/12 at 12:06 PM). Right Ischium is healed. -1/18/12 at 1:37 PM, Z2 documented - Healed Ischium. There was no pressure wound care plan found in R29's list of care plan.	F9999		

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F9999	Continued From page 46 1/23/12 at 4:39 PM, E26 Nurse Practitioner, documented- chief complaint of R29: lethargic, very weak, decreased appetite. Necrotic wound right ischium. Fever, suspected septicemia. 1/23/12 at 5:15 PM, R29 sent to the hospital for further evaluation and treatment. Review of R29's hospital record indicated, R29 came in to the hospital on 1/23/12 with a stage IV pressure ulcer on the right buttock. Upon assessment of the right ischium wound was described with a measurement of 3 cm x 5.6 cm, 98% eschar, reddened surrounding tissue, blanchable and positive odor. R29 had sepsis related to this wound, was given anti- biotic therapy and had underwent surgical debridement on 1/26/12. The facility's wound care nurse's assessments were inconsistent with the hospital's assessment and treatment of the pressure sore. B	F9999		