STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145864	A. BUILDING _____ B. WING _____	C 03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDENTIAL PAVILION	**8001 SOUTH WESTERN AVENUE CHICAGO, IL 60620**

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F 314	Continued From page 18 shift on 5/27/11 shows R2 being out on pass. Nursing notes dated 5/27/11, 11pm to 7am states R2 out on pass; 5/28/11, 2:50pm, R2 out on pass. There is no documentation to support R2 ever returning from pass. Social service notes dated 5/26/11 shows documentation of R2's re-admission to the facility. There are no subsequent social service note, no discharge summary. Facility Pressure Risk Assessment Policy and Procedure For all Residents dated 2/29/12 indicates the facility is to do a systemic, ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities. Policy procedures also include presence of all wounds, ulcers and other skin abnormalities on admission and then weekly by a licensed nurse for all wounds, ulcers and impairments in skin integrity. Facility Pressure Ulcer Prevention Policy dated 2/29/12 indicates 'A nutritional evaluation should be completed on all residents in order to maintain skin integrity and prevent pressure ulcer development.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 19 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	F9999		

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F9999	Continued From page 20	F9999		

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. Restorative measures shall include, at a minimum, the following procedures:
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.
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 the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional

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F9999	Continued From page 21 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 evidence by: Based on observation, interview and record review facility failed to implement pressure sore prevention measures; failed to assess and treat pressure ulcer; failed to implement measures to promote healing of pressure ulcers that were already present for 2 residents (R2, R9). Findings include: 1) On 2/29/12 at 10:45 AM during initial tour observed R9 lying in bed with a strong odor of	F9999		

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F9999	Continued From page 22 urine present in the room. At that time E10 CNA Coordinator stated she didn't know why R9 was still in bed and didn't know if he had any wounds. E10 CNA Coordinator proceeded to pull back R9 sheet to assess skin and at that time observed R9 lying in urine soaked bed with dried darker area around outer edge of wet area. Total area of urine wetness and stain extended from R9 knees to axilla. At that time also observed soiled adhesive foam dressing on Left buttock, uncovered Right ischium deep Stage 3 wound and abdominal pad dressing on Right hip. On further observation noted R9 with multiple wounds on bilateral outer feet with large fluid filled blister on Left outer and inner heel; Right heel with partially fluid filled area and partial dry firm purple red wound. Two quilted heel protectors were present sitting on R9 bedside stand. R9 initially admitted to facility in 2002 with most recent readmission 2/3/12. Physician's Order Sheet (POS) dated 3/01/12 through 3/31/12 indicates R9 has diagnosis of Chronic Obstructive Pulmonary Disease, schizophrenia, gastritis, hypertension, Congestive Heart Failure, Major Depression, Glaucoma and CAD. On 2/29/12 at 11:05AM E11 Certified Nursing Assistant (CNA) and E12 Certified Nursing Assistant (CNA) stated that there is usually a turn schedule posted on the wall above the bed and stated that R9 should be turned and repositioned every hour. On 2/29/12 at 2:00PM E20 Wound Nurse stated "I started documenting wound assessments in the beginning of February 2012. I did assessments on every floor. The CNA does skin checks and I	F9999		

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F9999	Continued From page 23	F9999		

double back to check again. I do the Braden's."
On 2/29/12 at 2:20PM E13 Licensed Practical Nurse (LPN)/Treatment Nurse stated "Me and E20 (Wound Nurse) do treatments. I kind of took over after the weekend of February 4th or 5th. I didn't change R9 dressings today, I think E20 Wound Nurse did R9". E13 (LPN) further stated "E20 Wound Nurse told me R9 was done this morning. R9 has a Stage 3 wound on his left buttock. I did the treatment yesterday. I'm still learning. It depends on redness whether we document it or not or cover it or not".

On 2/29/12 at 2:55PM E21 Certified Nurse Assistant (CNA) stated "normally turn schedule is above the bed - it's not there now".

On 2/29/12 at 3:15 PM observed E13 (LPN) remove soiled foam dressing from R9 Left buttock. E13 (LPN) then stated this is a new open area - it's scabbed over - it's a healing pressure wound. I put foam dressing over it yesterday". E13 (LPN) further stated "left hip is red - not blanchable. Left outer heel is a fluid filled blister, that's a pressure wound".
On 2/29/12 at 3:25PM observed E13 (LPN) remove abdominal pad covering from R9 Right hip which revealed large palm-sized reddened area with dime-sized flat fluid filled center. E13 (LPN) went on to state that Right buttock/ischium wound was "unstageable" due to "dark tissue in wound". Observation of Right heel wound assessment by E13 (LPN) indicating wound measured 4 X 6 cm of eschar with deep red peri-wound area.
On 2/29/12 at 3:35 PM both E20 Wound Nurse and E2 Director of Nursing (DON) stated "We don't take measurements unless the skin is

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F9999	Continued From page 24	F9999		

broken. We're monitoring all of them - but we don't measure them". E20 Wound Nurse further stated "These marks on R9 's feet and legs could be from a lifetime. I haven't done treatments on R9 today".

Care Plan dated 2/3/12 indicated impaired skin integrity due to "Buttock", no other skin impairments or wounds were identified on care plan. No interventions or treatments were in place to address multiple wounds on feet, heels or hips.

Comprehensive Care Plan for Nutrition with goal date of 3/15/12 did not address nutrition interventions for wounds or skin impairment. Most recent Nutritional Assessment by a Registered Dietician was dated 6/1/10. Most recent Nutritional Assessment and Progress Note by a Diet Technician was dated 12/08/11. No Nutrition Assessments were available after most recent readmission of 2/3/12.
On 3/2/12 at 1:05PM Z5(RD) Registered Dietician stated "I don't recall whether I was notified when R9 was readmitted on February 3rd. I talked to the facility yesterday, I don't have my records with me. I couldn't say when I was notified about R9 status".

POS dated 2/3/12 to 2/29/12 indicated to Apply Zinc Oxide to buttock and cover with dressing after cleansing with Saline. No other skin/wound treatment orders were present prior to 2/29/12.

Discharge wound assessments from hospital dated 2/2/12 indicated excoriation with patches of breakdown Left buttock: non-pressure ulcer and bilateral heels dry, peeling and cracked:

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F9999	Continued From page 25 non-pressure ulcer. On 3/2/12 at 2:40PM E20 stated "R9 was transferred to the hospital last night due to shortness of breath. He's no longer in the facility". 2) Closed record review states R2 is a 42 year old male resident admitted to the facility on 5/6/11 with diagnoses which include Paraplegia, Depression, Urinary Tract Infection. Minimum Data Set (MDS) dated 5/27/11 shows lower extremities impairment, non-weight bearing, impaired mobility and indwelling urinary catheter. R2 is scored having no pressure sores. Nursing Admission Skin Assessment dated 5/6/11 shows a total of 7 pressure sores to Sacrum, Buttocks, both heels and left foot: three Stage III, one Stage II, three unstageable. Braden Scale dated 5/6/11 and 5/13/11 shows R2 at 'moderate risk' for skin breakdown, however, R2 was scored as no impairment in sensory perception despite lower extremities paralysis. Pressure ulcer prevention measures include inspection of skin every shift, pressure reduction mattress, weekly wound assessment. Wound assessment and treatment were rendered on 5/6/11 and 5/13/11 with documentation showing no change in wounds status. Nursing notes dated 5/17/11 states R2's Sacral wounds (2) were noted with dark colored, brown and green drainage, with distinct foul odor. R2 was sent out to hospital and admitted. R2 returned to the facility on 5/26/11 on intravenous antibiotics administered via a peripherally inserted central catheter (PICC line). Nursing psychosocial assessment states R2 was in an anxious mood. There was no evidence to support a comprehensive skin assessment being	F9999		

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F9999	Continued From page 26 done. Braden scale was scored at '23', signifying no risk for skin breakdown. The Braden scale was inaccurately done. R2 was scored as having no impairment in sensory perception, rarely moist, walks frequently, no limitations in mobility and no apparent problem with friction and shearing. Nursing 72 hour admission charting 3pm to 11pm shift on 5/27/11 shows R2 being out on pass. Nursing notes dated 5/27/11, 11pm to 7am states R2 out on pass; 5/28/11, 2:50pm, R2 out on pass. There is no documentation to support R2 ever returning from pass. Social service notes dated 5/26/11 shows documentation of R2's re-admission to the facility. There are no subsequent social service note, no discharge summary. Facility Pressure Risk Assessment Policy and Procedure For all Residents dated 2/29/12 indicates the facility is to do a systemic, ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities. Policy procedures also include presence of all wounds, ulcers and other skin abnormalities on admission and then weekly by a licensed nurse for all wounds, ulcers and impairments in skin integrity. Facility Pressure Ulcer Prevention Policy dated 2/29/12 indicates 'A nutritional evaluation should be completed on all residents in order to maintain skin integrity and prevent pressure ulcer development. (B)	F9999		