### Summary Statement of Deficiencies

1. **Environmental Services** stated that the resident bathrooms were in the hallways and that's why the odor was strong. However, the urine odor was also noticed in the lobby and resident's room as well.

2. Room 318 was noted with broken window blinds with missing slats on 11-7-12. On 11/7/12, E27 (Director of Environmental Services) submitted a work order for the broken blinds. E27 said, "The blinds should be coming soon."

3. The facility failed to monitor and ensure that resident recling chairs had working brakes and locks. On July 20, 2012, R5's recling chair was found to have nonfunctioning chair locks which resulted in R5 needing to be lowered to the ground during a transfer.

### License Violation

- 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...
## SUMMARY STATEMENT OF DEFICIENCIES

### F9999 Continued From page 6

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. 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:

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
**NAME OF PROVIDER OR SUPPLIER**

PALOS HILLS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

10426 SOUTH ROBERTS
PALOS HILLS, IL  60465

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td>Continued From page 7 not be limited to, the following:</td>
<td>F9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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 300.1810 Resident Record Requirements

c) Record entries shall meet the following requirements:

3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.

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)
Theses regulations are not met as evidenced by the following:

Based on observations, interviews and record reviews, the facility failed to accurately complete the Braden Skin Risk Assessment Tool, re-assess and complete the Braden Assessment after the development of a pressure ulcer, monitor and follow the care plan interventions for daily skin checks for one resident, R15, out of 4 residents reviewed for pressure ulcers from a total sample of 29. This failure resulted in R15 developing an unstagable necrotic pressure ulcer measuring 3.9 centimeters by 3 centimeters.

Findings include the following:

R15 is an 85 year old male resident who was admitted to the facility September 5, 2012 from an acute care hospital with the following diagnosis: Hypertension, Ischemic Heart Disease, and Diabetes Type II. According to the facility's "Clinical Assessment Report for Skin Wound Assessment" for September 6, 2012, R15 was noted with no pressure sore upon admission to the nursing facility. In addition, R15's Braden Assessment for pressure ulcers completed on September 6, 2012 indicates that R15 is low risk for pressure ulcers. The Braden assessment dated September 13, 2012 also indicates that R15 is a low risk for pressure ulcers.

R15's initial care plan dated September 5, 2012 from admission states the following: "resident at risk for skin complications r/t [related to] impaired mobility, incontinence of bowel and bladder,
Continued From page 9
disease process, and comorbidities. " The care plan also documents as an intervention the following: " Observe skin daily, with ADL [Activities of Daily Living] care for any changes such as redness, bruising in skin, tender areas and report to nurse."

The nursing progress notes of September 22, 2012 indicate that R15 was noted with an open area to the coccyx during morning care. Nursing notes state the following: " Resident was noted with a small open area to coccyx."

The Skin Wound Assessment dated for September 22, 2012 states the following under wound assessment: " Resident observed with Unstageable to sacrum pink/yellow/gray in color 20% pink and 80% necrotic tissue. " The wound was measured to be 3.9 centimeters by 3.0 centimeters.

As of October 23, 2012 skin-wound assessment, R15's wound has increased in size and continues to worsen. The wound was measured to be a Stage IV wound 5.0 centimeters by 4.0 centimeters by 3.5 centimeters.

On 11/1/12 at 9:50am, R15 was in bed, opened eyes to name called, but unable to participate in a conversation. E14 and E 13 (Treatment Nurses) performed wound care on R15's sacral pressure ulcer. E13 stated that R15 is incontinent of bowel and needs to be cleaned after each incontinent episode. E13 stated R15 should be turned, repositioned, and checked for incontinence every 2 hours. On 11/1/12 at 1pm, E13 stated the floor nurses really don't know how to do a Braden
### Summary Statement of Deficiencies

**F9999 Continued From page 10**

R15 is a higher risk for skin breakdown than assessed on the Braden Scales on 9/13/12 and 9/20/12.

On 11/1/12 at 4:30pm, Z10 (Physician) was interviewed and stated R15 is at risk for skin breakdown due to immobility and incontinence. Z10 stated that R15’s wound already had dead tissue on it when it was discovered, this could lead to infection. Z10 stated close monitoring of R15’s skin would have identified the breakdown earlier and before it was a necrotic unstageable pressure sore.

On 11/5/12 at 10am, E 14 stated Braden Scales are done with a change in condition which is the development of a new wound, change in an existing wound or change in functional status. E14 stated R15 should have had a Braden Scale on 9/22/12, upon discovery of the necrotic sacral pressure ulcer, but one was not completed.

On 11/5/12 at 12:30pm, E3 (Asst Director of Nursing) stated skin assessments are to be done daily and with skin care. Skin condition is documented daily on the Bath and Skin Report Sheet when residents are cleaned and with baths. E3 verified that R15’s Bath and Skin Report Sheet was not completed from 9/19/12, 9/20/12, and 9/21/12. There is no other documentation in the chart regarding the condition of R15’s skin on these three days, prior to the discovery of the necrotic sacral pressure ulcer.

**B**

---

**Form CMS-2567(02-99)** Previous Versions Obsolete  
Event ID: GMBG11  
Facility ID: IL6010086  
If continuation sheet Page 11 of 11