### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** ManorCare of Highland Park  
**Street Address, City, State, Zip Code:** 2773 Skokie Valley Road, Highland Park, IL 60035  
**Provider's Identification Number:** 145923  
**Date Survey Completed:** 10/22/2012  
**Event ID:** CEUG11  
**Facility ID:** IL6014963  
**Event Code:** F9999  
**Form CMS-2567(02-99) Previous Versions Obsolete CEUG 11**

#### Summary Statement of Deficiencies

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**Summary Statement of Deficiencies:**

Continued From page 17  
On 10/15/12 at 10:15 AM several containers of outdated food were observed in the dry food storage room. A large plastic bin holding rice was labeled "Brown Rice 10/26/11"; 2-11 ounce cans of tomato pastes were labeled 10/26/11; 8-50 ounce cans of corned beef hash were labeled 10/26/11. E13 said that the items were not being used and should be discarded.

**Licensure Violations**

- 300.1210(b)  
- 300.1210(d)(5)  
- 300.3240(a)

Section 300.1210 General Requirements for Nursing and Personal Care

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:
A BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) 145923

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER MANORCARE OF HIGHLAND PARK

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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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 300.3240 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)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, the facility failed to implement appropriate interventions to prevent development of pressure ulcer caused by constant friction and pressure from splints. The facility also failed to ensure specific intervention was in placed to relieve pressure on both contracted knees. This applies to 1 of 6 (R11) residents reviewed for pressure ulcer in a sample of 24.

As a result of this failure, R11 developed an unstageable pressure ulcer on the lateral aspect of bilateral feet.

Findings include:

R11 is an 83-year-old resident with multiple...
diagnoses including CVA (Cerebral Vascular Accident) with right Hemiparesis, Lung Cancer and Dementia.

R11 requires extensive assistance of staff for transfers, mobility, hygiene, and toileting needs according to the Minimum Data Sets (MDS) dated 5/7/2012 and 7/23/2012. Review of the "Braden Scale " assessment dated 2/23/2012 and 10/17/2012 showed that R11 is at high risk for developing pressure ulcer.

Review of physician telephone order sheet showed that splints for R11’s contracted lower extremities were ordered on 6/9/2012. Review of "Skin Progress Notes" dated 9/7/2012 reflect the following:
- "Noted a dark purplish blood blister to (R11’s) left lateral outer aspect of foot, measured 2 cm (centimeters) in length and 1.6 cm in width. Skin intact with redness and swelling to surrounding skin and area tender to touch."

Review of "Skin Progress Notes" dated 9/10/2012 indicated that the splints had caused friction and pressure on both lateral aspect of R11’s feet. Review of "Wound Care Specialist Report" dated 9/11/2012 reflected the following initial wound consultation skin assessment:
- Unstageable DTI (Deep Tissue Injury) of the Left and Right lateral foot,
- Etiology: Pressure
- "(R11) recently placed on splints for the contracted lower extremities. (R11’s) wound sites appear to be on locations where the splints are causing pressure on the lateral aspects of her feet bilaterally."
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- Wound size of left lateral foot: 1.5-cm length, 1.6-cm width, and surface area  
- Wound size of right lateral foot: 0.3 cm in length, 0.2 cm, and surface area 0.06 cm

Review further of "Wound Care Specialist Report dated 9/18/2012, 9/25/2012, 10/2/2012 and 10/9/2012 showed that R11 developed unstageable pressure ulcer on the lateral aspect of both feet due to tissue injury caused by pressure from the splints. The 10/2/2012 report reflects that the unstageable deep tissue injury was noted with blister that was filled with fluid.

R11 was sitting in her motorized wheelchair on 10/16/2012 at 11:50 A.M., 1:10 P.M. and 2:20 P.M. R11’s lower extremities were contracted with knees rubbing together. There was no device in place to prevent both knees from rubbing together and prevent friction and pressure.

As documented on the nurse’s notes dated 7/30/2012 and 8/1/2012 indicated that R11 was noted with redness on the right knee.

On 10/17/2012 at 10:00 A.M., R11’s skin condition was checked in the presence of E3 (Registered Nurse, Wound Nurse), E8 (Licensed Practical Nurse, Wound Nurse) and E4 (CNA-Certified Nurse Assistant). E3 applied Betadine dressing on both lateral aspects of the feet. E3 stated that "these are unstageable pressure ulcers due to deep tissue injury caused from friction and pressure from the splints." E3 also added that she was not aware that R11 was placed on a splint for the contracted lower extremities. As E3 added, if she would have...
### Summary Statement of Deficiencies

**F9999 Continued From page 21**

Known, more padding could have been applied to the splints to avoid pressure.

E4 stated during the dressing change that the splints had caused R11’s tissue injury on the lateral aspect of both feet.

Review of R11’s care plan for the skin alteration shows that there were no interventions on how the splint was monitored to prevent skin breakdown. Further review of the current care plan showed that there was also no intervention to prevent pressure from the contracted knees.

E10 (Director Rehabilitation Services, Occupational Therapist) stated on 10/16/2012 at 2:00 P.M. that she would consider a “knee separator”. E10 also added that R11’s lower extremities appeared to be rotated to right side and thus rubbing the knees.

(B)