STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	**1017 WEST GALENA BOULEVARD AURORA, IL 60506**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 9 changes in her mental status. The hospital 9/26/12 medical necessity determination noted R1 had to be hospitalized 'due to the need to treat acute delirium, as evidenced by abrupt change in mental status in the setting of high infectious risk due to an indwelling PICC line and hypoxia.' The hospital report also noted R1 to have a UTI, as well as her left arm PICC line blood culture was positive for gram-positive cocci bacteria. The Emergency Room notes indicated 'no known IV PICC line date,' at R1's left arm PICC line site. R1's physician (Z3) on 11/15/12 at 3:00 pm stated he was aware of her UTI and that is why he ordered IVPB medicine via PICC line, Z3 stated he was not aware of R1's PICC line being infected. Z3 also stated the UTI and PICC line infection can cause delirium and mental status can also change.	F 328		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)5 300.3240a) 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	**1017 WEST GALENA BOULEVARD AURORA, IL 60506**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 10 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: 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, record review and interview the facility failed to: - have an effective system to conduct pressure ulcer assessment; - develop and implement individualized interventions including use of pressure relieving mattress to prevent and / or to promote healing of pressure sores in the facility.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 11	F9999		

As a result:
R1 acquired in the facility on 9/20/12 (a) left heel 1.5 cm x 1.6 cm 100% necrotic deep tissue injury (DTI); (b) right heel 2.5 cm x 3.0 cm 100% necrotic DTI.
R1 also acquired a pressure ulcer in the facility on 9/21/12 to her sacrum. The facility did not document details to show size and stage of the sore.

R2 acquired a stage III pressure sore to his sacrum on 10/12/12. As of 11/16/12 the sore noted to have deteriorated.

This is for two of three residents (R1 and R2) who have facility acquired pressure sore in the sample.

Findings include:

R1 had no pressure sore upon her admission to the facility (11/5/11) as evidenced by her Minimum Data Set (MDS) from 11/18/11 through 8/18/12.

R1's 9/20/12 1:55 am Nurses Notes indicated R1 acquired in the facility:
(1) 3.5 cm x 1.5 cm pressure sore to lateral aspect of right heel;
(2) 1.5 cm x 3.0 cm pressure sore to lateral aspect of left heel. Facility 9/21/12 weekly wound care report indicated R1's both heel sores had 100% necrosis.
On 9/25/12 11:51 am R1's Nurses Notes indicated she acquired a pressure sore to her sacrum. No details of the pressure sore were documented, however a treatment order was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 12 noted in the nurses notes to indicate the pressure sore to be treated with 'no sting barrier wipe, aquacel bordered foam dressing, change every two to three days'. On 9/26/12 at 12:40 am R1's nurses notes indicated she was admitted to the local hospital for evaluation and treatment of changes in her mental status. On 9/26/12 at the hospital the wounds were described as bilateral heels decubitus ulcers which are blistered and are not open wounds, deep tissue injury (DTI). R1 also has sacral decubitus, two of them, which are about stage II. There was no documentation to show if the facility conducted a pressure sore assessment to indicate why R1 acquired the pressure sores in the facility. On 11/15/12 E1 at 4:30 pm the facility has a consultant who visits the facility once a week. E1 also stated the consultant does the weekly wound management. A review of consultant's weekly wound management reports for R1 indicated only date, location, size and status of the wounds, but has no explanation to show why R1 acquired pressure sore. The facility presented a form 'Risk Determination Instrument.' The form noted dates were 5/4, 5/18, 6/18, and 9/21/12. This form had check marks for low, moderate and high risk. The form noted Braden Scale score being '12' which included incontinence, immobility and neuropathy as risk factors and checked R1 to be at high risk for acquiring pressure sores. There was no further evaluation of these risk factors to show if the pressure sore were preventable or not; and to develop and implement individualized interventions.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 13	F9999		

R1's 11/9/11, 2/9/12 and 9/21/12 skin breakdown plan of care interventions are individualized or specific to address the risk factors. The interventions added after R1 acquired pressure sore to her bilateral heel were vague, for example 'wound care nurse saw, ordered treatment, wound nurse to follow along with physician and facility nurse.' The care plan had no interventions to address the use of specific pressure relieving devices and heel positioning as a measure to prevent and or to promote healing of the pressure sore.

On 11/16/12 at 3:30 pm via phone interview, the facility wound care consultant (Z2) stated she visits facility once a week or whenever she gets referral from the facility after a resident acquires a pressure sore. Z2 said until then she has no way of knowing which residents is at risk for acquiring pressure ulcers. Z2 stated R1's bilateral heel sores were of DTI nature, she was not aware of R1's sacral ulcer, because the sacral ulcer was not there when she saw R1 on 9/21/12. Z2 also stated it would have been 9/28/12 to evaluate R1's sacral ulcer. Z2 indicated R1 got DTI sores to bilateral heels due to her heels being in prolonged dependent position on her legs.

On 11/15/12 at 3:00 pm R1's physician (Z3) stated he does not treat pressure sores, however based on Z2's recommendations the pressure sore treatments are ordered. Z3 stated any one should not acquire pressure sore given adequate staff availability; and in case of R1's pressure sores, she was not eating well, repeated infections, incontinence, immobility, positioning, transferring to prevent friction and shearing may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 14	F9999		

be some of the issues. Z3 stated he was aware of R1's bilateral heel sores, but not aware of her sacral sore.

II. On 11/15/12 at 1:38 pm R2 was in his bed, his both feet were curled in blanket, his knees were contracted and his heel were pressing against his mattress. R2 was alert when called his name, responded to questions with short response, but was appropriate. On 11/16/12 at 12:30 pm was in his in supine position, again his both feet were pressing against the mattress. There was a sign posted at the head of his bed to indicate 'TED HOSE on at all times to his both legs,' but he had no TED hose on to his legs.' E2 the Director of Nurses confirmed this observation. E2 stated she will check with the Certified Nurse Aide (CNA). Both days R2 had regular mattress on his bed similar to the one other residents have. There were no positioning devices such as pillow or heel boots to float his heels.

The facility 9/21/12 weekly wound surveillance report noted R2 acquired a stage III pressure sore on 10/12/12 measuring 1.0 cm x 0.1 cm. This pressure sore as of 11/16/12 weekly wound management tool noted deteriorated, size noted noted to be 1.5 cm x 0.6 cm x 0.6 cm with exudate and serosangious drainage.

R2's 10/11/12 Braden Scale scored '19' which indicates he is less than mild risk for acquiring pressure ulcer. There was no assessment to show why R2 acquired a stage III pressure sore to his sacrum.

R2's pressure sore care plan dated 4/15, 4/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	**1017 WEST GALENA BOULEVARD AURORA, IL 60506**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 15 6/18, 9/21 and 10/5/12 interventions included (a) special ordered mattress with air on bed when resident in bed, (b) apply heel protectors to relieve pressure on heels, place pillows under calf to raise the heel off the bed, (c) use positional devices (pillows, foam wedges) to keep bone prominence from direct contact with one another. The facility did not implement these interventions 11/15/12 and 11/16/12. On 11/16/12 at 12:45 pm E1 stated R2 used to have special ordered mattress with air on bed, and mattress changed to a regular one when his pressure sore got better. Now that R2's sore is deteriorating, E1 stated she will order a special mattress. The facility policy and procedure titled 'pressure ulcers / skin breakdown - clinical protocol' is specific as to how the staff should conduct assessment, develop and implement interventions for the prevention and treatment of pressure ulcers. (B) 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 16	F9999		

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

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.

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 record review and interview the facility failed to have a protocol for insertion and care for the management of peripherally inserted central catheter (PICC) and maintain PICC line free from infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	1017 WEST GALENA BOULEVARD AURORA, IL 60506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 17	F9999		

As a result R1 acquired a gram-positive cocci infection to the PICC line site.

This is for one of one residents (R1) in the sample of three residents who had PICC line.

Findings include:

On 9/15/12 R1 had a physician order to administer Meropenem 500 mg Intravenously via Piggy Bag (IVPB) for the treatment of Urinary Tract Infection (UTI).

On 9/16/12 pharmacy clinical infusion progress note indicated a PICC was inserted to R1's left upper arm for the administration of medication via IVPB. The progress notes did not indicate the size of the catheter, length of the catheter, or the circumference of the arm at PICC line site. The PICC line insertion infusion progress note at the time of the PICC line insertion was signed, but there is no name or the title of the person who inserted the PICC line. E1 the Administrator stated it was a Nurse from the pharmacy consultant.

There was no plan of care on record for the management of R1's PICC line, and maintain the line and site patent and keep the site free from infection.

On 11/16/12 at 12:45 E1 stated that the facility has no policy or procedure for the management of the PICC line and they just follow physician orders. R1's 9/16/12 treatment record indicated 'PICC line dressing to left arm, change every 72 hours' and signed off as done on 9/19 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145663	A. BUILDING _____ B. WING _____	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD TERRACE HEALTHCARE CTR	**1017 WEST GALENA BOULEVARD AURORA, IL 60506**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 18 9/23/12. There is no documentation to indicate if the site was patent and describe the site (swelling, redness, pain and infiltration). On 9/26/12 the facility sent R1 to the local hospital for the evaluation and treatment of changes in her mental status. The hospital 9/26/12 medical necessity determination noted R1 had to be hospitalized 'due to the need to treat acute delirium, as evidenced by abrupt change in mental status in the setting of high infectious risk due to an indwelling PICC line and hypoxia.' The hospital report also noted R1 to have a UTI, as well as her left arm PICC line blood culture was positive for gram-positive cocci bacteria. The Emergency Room notes indicated 'no known IV PICC line date,' at R1's left arm PICC line site. R1's physician (Z3) on 11/15/12 at 3:00 pm stated he was aware of her UTI and that is why he ordered IVPB medicine via PICC line, Z3 stated he was not aware of R1's PICC line being infected. Z3 also stated the UTI and PICC line infection can cause delirium and mental status can also change. (B)	F9999		