	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		146082	B. WING				C 09/2013
NAME OF P	ROVIDER OR SUPPLIER	14002			REET ADDRESS, CITY, STATE, ZIP CODE	05/0	09/2013
FRANKFORT HEALTHCARE & REHAB CENTER					500 EAST ST. LOUIS STREET VEST FRANKFORT, IL 62896		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	catheter in. I attem quickly stopped be patient most likely day, the patient wa where he was in fa bulbar urethral stric way this patient's c prior. Most likely, the	y and could not get another pted to place a catheter and cause I realized that the had a stricture. The following s taken to the operating room ct found to have a very dense cture, so therefore there is no atheter just removed the day he catheter was not in the weeks. I think the catheter operly".		315			
	LICENSURE VIOL 300.1010h) 300.1210b) 300.1210d)3)4)A)5 300.1220b)2) 300.3240a)  Section 300.1010 N h) The facility physician of any acchange in a resider health, safety or we but not limited to, the	ATIONS:					
	of five percent or m The facility shall ob plan of care for the	nore within a period of 30 days. Itain and record the physician's care or treatment of such change in condition at the time					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUIDENTIFICATION NUMBER: A. BUILDING (X3) DATE SUIDENTIFICATION NUMBER:					
		146082	B. WING				C <b>09/2013</b>
	PROVIDER OR SUPPLIER	REHAB CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST ST. LOUIS STREET VEST FRANKFORT, IL 62896	00/0	50/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 12	F99	99			
	Section 300.1210 G Nursing and Persor	Seneral Requirements for nal Care					
	care and services to practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the resident to the	shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident. Restorative ude, at a minimum, the					
	nursing care shall in	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:					
	resident's condition emotional changes, determining care re further medical eval	bservations of changes in a , including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the record.					
	24-hour, seven-day	re shall be provided on a -a-week basis. This shall limited to, the following:					
	personal attention, i	nt shall have proper daily including skin, nails, hair, and lition to treatment ordered by					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		146082	B. WING				09/ <b>2013</b>	
	ROVIDER OR SUPPLIER  ORT HEALTHCARE 8	REHAB CENTER		2	EET ADDRESS, CITY, STATE, ZIP CODE 500 EAST ST. LOUIS STREET //EST FRANKFORT, IL 62896	00/1	30/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F9999	Continued From pa	ge 13	F99	999				
	pressure sores, head breakdown shall be seven-day-a-week lenters the facility will develop pressure social condition desores were unavoid pressure sores shall services to promote	ogram to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who othout pressure sores does not pressure the individual's emonstrates that the pressure lable. A resident having a healing, prevent infection, essure sores from developing.						
	Services	Supervision of Nursing						
		hall supervise and oversee the the facility, including:						
	assessment of the include medically defunctional status, se impairments, nutrition psychosocial status condition, activities	g the comprehensive residents' needs, which efined conditions and medical ensory and physical onal status and requirements, discharge potential, dental potential, rehabilitation status, and drug therapy.						
		ee, administrator, employee or nall not abuse or neglect a						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		146082	B. WING				C 09/ <b>2013</b>
	PROVIDER OR SUPPLIER	REHAB CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST ST. LOUIS STREET VEST FRANKFORT, IL 62896		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	by:  Based on interview failed to identify, as necessary treatmer pressure ulcers fror (R2) reviewed for p changes with the us catheter for 1 reside indwelling urinary cin R2 being admitte Retention, Hematur	were not met as evidenced  and record review the facility sess, monitor, and provide at and services to prevent new medeveloping for 1 resident ressure ulcers, and condition se of an indwelling urinary ent (R2) reviewed for atheter. This failure resulted at to the hospital with Urinary ria, and Balanitis requiring a of Direct Vision Internal	F99	999	DEFICIENCY)		
	diagnoses including Acute Pain, Demen and Chronic Kidney to the Physician Ord The Norton Pressur document dated 4/3 8 that R2 is high ris review on 5/8/2013 (Physician's Prelimi R2 was admitted to diagnoses of Urina Balantitis. A review documentation in the that R2 was sent to indwelling urinary care.	this facility on 7/27/2012 with g Pressure Ulcer Stage II, tia with Behavior Disturbances Disease Stage III, according der Sheet dated 5/1/2013. The Ulcer Assessment 15/2013 notes with a score of k for pressure sores. Per of the hospital clinical record finary Report dated 5/5/2013), the hospital on 5/5/2013 with any Retention, Hematuria, and of R2's record noted the nurse's note on 5/5/2013 the hospital after his atheter was out and facility are real times was unable to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		146082	B. WING				C <b>09/2013</b>
	ROVIDER OR SUPPLIER  ORT HEALTHCARE 8	REHAB CENTER		250	EET ADDRESS, CITY, STATE, ZIP CODE 00 EAST ST. LOUIS STREET EST FRANKFORT, IL 62896		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 15	F99	99			
	Z5 (Emergency Rodupon arrival at the hastage IV pressure complained of inabipubic area, R2 did uplace at time of adristated that upon extesting R2 was four cc of residual urine that R2 was incontinuing an interview with Z2 (Registered Nurse at the hospitareferral for wound culcer to the coccyx. On 5/6/2013 at 11:17 record "area bruise attempts to insert Fopinion if the ulcers ulcers Z2 states "ye location, and appearance is a pression of 5/8/2013 at 1:30 Nurse/LPN) was int 5/5/2013 at 7:50 A.I. after it was reported he complained of precision in the pression of the pression of the pression of the complained of precision is a pression of the complained of precision is a pression of the complained of precision is a pression of the complained of precision of the pression of the complained of precision of the pression of t	on 5/8/2013 at 10:00 A.M. I Nurse/RN) Wound Care al, Z2 stated she received a are to R2's stage IV pressure and ulcerations to his penis. I8 A.M. Z2 wrote in the clinical d from multiple tried and failed oley". When asked in her to R2's penis were pressure es, looking at size, depth, arance, the area on the top of ure sore".  In P.M., E7 (Licensed Practical erviewed and stated on M. she went to assess R2 If he had not voided and that ain in his penis. E7 stated ollen and scant bloody In the top of the top of the had not voided and that ain in his penis. E7 stated ollen and scant bloody I to reinsert it.					
	Nurse's note writter	by E7 (Licensed Practical					

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		146082	B. WING				ට <b>09/2013</b>
	PROVIDER OR SUPPLIER	REHAB CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST ST. LOUIS STREET VEST FRANKFORT, IL 62896	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Nurse/LPN) on 5/5/examined d/t not voswollen, sl bloody dvoided since 6 A.M res c/o hurting bad pressure there, the did not attempt to resolve the did not see ulcertied to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013. When foreskin to the peni he attempted to reinsert R2's on 5/5/2013.	2013 at 9:45 A.M. "res bided at this time, penis very lischarge, resident has not, f/c removed from prior shift, in penis and unable to void, Foley catheter was out and I einsert it".  2 P.M., E8 (Registered erviewed about R2's Foley I have not seen his catheter inserted on 4/15/2013. E8 ered Nurse at the facility from	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		146082	B. WING				C 09/ <b>2013</b>		
	PROVIDER OR SUPPLIER	& REHAB CENTER		25	EET ADDRESS, CITY, STATE, ZIP CODE 500 EAST ST. LOUIS STREET /EST FRANKFORT, IL 62896				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F9999	On 5/8/2013 at 11:0 (Physician/MD/Urol the ulcers to R2's p concern was that the probably due to the bladder or that it was of time from the stream there were ulceratic if R2 was receiving urinary catheter wo visible, Z4 stated "yneed for the Circunto help with the heat areas that had devended by the catheter placement hematuria which was got down to the midleads me to believe previous catheter the balloon being blown also has Balanitis as foreskin". Z4 wrote admitted the patien diagnosis of urinary ulcerations of his form the bed opposite bag was located and foreskin causing so there is no excuse		F99	999					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		146082	B. WING			C <b>09/2013</b>
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896	1 00/1	33/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFILITION  DEFICIENCY)	) BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 18	F9999			