

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1010h) 300.1210a) 300.1210c) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of</p>	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 1 notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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)</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to implement measures to promote the healing of a pressure ulcer for one of three residents (R2) reviewed for pressure ulcer treatment in a sample of 4. This failure resulted in R2 developing a pressure ulcer that became infected, delayed healing and increased in size and depth from a Stage I to a Stage IV.</p> <p>Findings include:</p> <p>R2 is a 79 year old resident with diagnoses to include dementia, anxiety and pressure ulcer. The Braden Scale, 8/15/13 and 11/5/13, both place R2 at risk for the development of pressure ulcers.</p> <p>The facility Wound Assessment Details Report, 9/18/13, documents R2 developed a facility acquired Stage I area to the coccyx measuring 4.0 by 3.7 by 0.0 centimeters (cm) on 9/6/13.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>The facility Wound Assessment Details Report, 10/9/13, documents R2 developed an unstageable soft necrotic facility acquired pressure ulcer measuring 2.5 by 2.0 by unknown depth in centimeters.</p> <p>The facility Care Plan Report, 11/8/13, documents R2 has an unstageable pressure ulcer to the coccyx. Interventions include, labs, pressure reducing mattress and cushion when sitting, avoid friction, keep linen and clothes free of wrinkles, educate R2 as needed, treatment as ordered, report changes, encourage nutrition, encourage R2 to change position as often as possible, keep skin clean and dry, barrier cream, monitor skin daily, keep pressure off of affected area as much as possible, and treat pain. There is no care plan to limit sitting to sixty minutes or specific instructions for off- loading, including bedrest at any time between September 2013 through 1/3/14.</p> <p>The Physician Order Sheets, 10/23/13, starting continuously, document R2 as activity as tolerated. The Physician Orders 12/11/13 and 12/27/13 document orders for use of antibiotics for an infected ulcer.</p> <p>The Wound Care Specialist Initial Evaluation, completed by Z5, 10/9/13 documents R2 with a unstageable pressure ulcer to the medial coccyx measuring 2.5 by 2.0 by unmeasurable cm of depth. Debridement was completed. Recommendations were to limit sitting to 60 minutes, off-load wound and repositioning.</p> <p>The Wound Care Specialist Evaluations, all completed by Z5, after the initial evaluation are as follows:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>10/16/13- unstageable necrosis measuring 2.5 by 2.2 by unmeasurable cm of depth to the medial coccyx. Recommendation include limit sitting to 60 minutes and off-load.</p> <p>10/23/13- Unchanged measurements but wound progress deteriorated. Additional information documents R2 needs to limit sitting in a chair to 60 minutes. Now with additional tissue damage to surrounding skin. Debridement was completed. Other recommendations include a gel wheelchair cushion.</p> <p>10/30/13- unstageable necrosis to the medial coccyx area measuring 2.6 by 2.4 by unmeasurable area in cm. Additional information includes R2 is getting a new offloading cushion. Recommendation again include to limit sitting to 60 minutes. Debridement was completed.</p> <p>11/6/13- unstageable necrosis to the medial coccyx area measuring 3.0 by 2.5 by not measurable area in cm. Findings noted deterioration which was due to a generalized decline of R2 and non-compliance with wound care. Recommendations were for R2 to not sit in a chair for a week to aid in healing. "This was discussed with staff."</p> <p>11/13/13- unstageable necrosis to the medial coccyx measuring 3.5 by 2.5 by unmeasurable depth in cm. Additional information documents "still in chair prolonged periods. Needs offloading. Foul odor to tissue, increased necrosis. May need hospitalization for surgical debridement and infectious work up." Debridement completed. Recommendation again include to limit sitting to 60 minutes and off-load wound.</p> <p>11/20/13- unstageable necrosis to the medial coccyx measuring 3.5 by 3.0 by depth unmeasurable in cm. Additional information documents "debrided thin layers covering bone.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>Culture grew enterococcus. Antibiotics to be ordered by primary care physician." Procedure documents, "wound debrided via surgical incision and muscle removed along with infected tissue." Recommendation include to limit sitting to 60 minutes and off-load. Area not improved.</p> <p>11/27/13- Stage IV Pressure Ulcer to medial coccyx measuring 3.5 by 3.0 by 2.0 cm. Additional Information documents "Continued non-compliance with offloading, limit sitting. Patient up prolonged periods. MUST LIMIT SITTING/PRESSURE ON WOUND. Antibiotics end 11/30/13." Recommendations include to limit sitting to 60 minutes.</p> <p>12/4/13- Stage IV Pressure Ulcer to medial coccyx measuring 3.0 by 2.8 by 2.0 cm and wound progress as not improved. Additional information documents, "Facility finding balance between offloading and sitting in chair due to fall risk." Recommendations were to limit sitting to 60 minutes and off-load.</p> <p>12/11/13- Stage IV Pressure Ulcer to medial coccyx measuring 2.8 by 2.9 by 1.5 cm and wound progress as improved. Additional information documents R2 complying with offloading. Recommendation to limit sitting to 60 minutes to off-load wound.</p> <p>12/18/13- Stage IV Pressure Ulcer to medial coccyx measuring 2.2 by 2.4 by 1.1 cm and wound progress as improved.</p> <p>12/27/13- Stage IV Pressure Ulcer to medial coccyx measuring 2.0 by 1.9 by 1.0 cm and wound progress as improved. Recommendation is to off-load wound.</p> <p>On 1/3/14 at 10:00am, Wound Care was completed by E3 (Wound Nurse). R2 had a pressure area to the coccyx area which was measured by E3 as 2.0 by 2.2 by 1.0 cm. Tunneling was noted to the wound when E3</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>packed the pressure ulcer with dressing.</p> <p>On 1/3/14 at 10:15am found R2 in a wheelchair in the hallway of the dementia unit. On 1/3/14 at 11:05am, 11:15am, 11:30am, 11:40am, 11:45am, 11:55am and 12:12pm found R2 in the activity/dining room area in the wheelchair asleep. On 1/3/14 at 12:50pm, R2 remained at the dining room table asleep after lunch was served.</p> <p>On 1/3/14 at 11:35am, E8 (Nursing Assistant) stated R2 was placed in the wheelchair before breakfast, placed in bed for wound care then gotten back up. E8 stated R2 had been up in the wheelchair since approximately 10:15am. E8 stated the protocol for R2 is to lay down after lunch and get up at approximately 3-4pm. E8 stated all residents with wounds are encouraged to go to bed after lunch.</p> <p>On 1/3/14 at 11:25am, E7 (Nursing Assistant), state she was familiar with R2 and is a regular caregiver for R2 for the last several months. R2's protocol is to be turned and repositioned every 2 hours. E7 stated R2 currently is compliant with care but approximately 4 months ago didn't like to go to bed and would try to get up without assistance. E7 stated R2 is a one person assist to transfer and would be going to bed again after lunch and get back up at approximately 2 pm. E7 was unaware of any other pressure ulcer interventions for R2.</p> <p>On 1/3/14 at 11:22am, E6 (Nurse) stated R2 has a pressure ulcer to the coccyx. R2 is to use a cushion in the wheelchair and lay down after meals. E6 stated R2 on occasion has issues laying down and will want to get up</p> <p>On 1/3/14 at 11:05am, E3 (Wound Care Nurse)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>stated E2 (Director of Nurses) manages the wound care and there is a weekly conference to discuss residents wounds at the facility. E3 stated Z5 recommended sitting up for no more than 60 minutes in a chair as an intervention to heal the pressure ulcer to R2's coccyx. E3 stated if a resident is non-compliant the facility talks to the family and resident or asks the physician to talk with the family. IF still non-compliant education is completed. A Care Plan is also initiated. E3 stated there is no documentation in the care plan for R2 to limit sitting or be placed on bedrest for a week. E3 stated the staff would be aware of R2's interventions by physician order. E3 stated there is no physician order in the clinical record to limit sitting.</p> <p>On 1/3/14 at 12:52pm, E2 stated R2 has a protruding sacral bone. IT started as redness and a cushion was placed in R2's wheelchair. E2 was aware the wound has declined and was being seen by Z5. E2 stated R2 wasn't always complaint with laying down. E2 stated back in September R2 would only remain in bed for short periods of time. R2 is positioned per standard of care which is every 2 hours. IF a resident is non-complaint with care a care plan is initiated and wounds are discussed weekly. The facility protocol for pressure ulcers is the wound care nurse will evaluate and the physician, E2, unit manager and family is notified. Problem solving is completed an interventions are initiated as appropriate. A care plan is initiated if there is a new or special order for care. The Nursing Assistants are aware of care needs via a Caregiver Alert Card placed in each residents closet. IF a resident is to be up one hour at a time it would be on the Caregiver Alert Card. On 1/3/14 at 12:58pm, E2 accompanied the surveyor to R2's room. The Caregiver Alert Card was</p>	S9999		



Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>present in R2's closet but no repositioning needs or instructions other than use of a wheelchair cushion were presents. E2 stated E9 (Unit Manager/Nurse) would be able to provide specific care needs for R2 and would be aware if R2 had a sitting restriction of 60 minutes.</p> <p>On 1/3/14 at 1:00pm, E9 stated a weekly meeting is held and all wounds are discussed. R2's interventions include antibiotics, gel cushion in the wheelchair, lay down after meals and walking with Restorative Therapy. R2 is to reposition herself in her wheelchair every hour. E9 stated she was unaware of the recommendation to restrict R2's sitting to 60 minutes.</p> <p>On 1/3/14 at 2:00pm, E12 (Medical Director) stated all pressure ulcers are to be followed every day, repositioning is to occur and follow facility protocol is to be followed to promote healing. E12 was not aware R2 had a wound that was not healing, not aware of Z5's recommendations or that R2 was not complaint with care causing the pressure ulcer to worsen. The facility "should follow the recommendations of Z5. (R2's) behavior should be addressed and the recommendations should be followed. The facility should take advantage of the behavioral improvement and take care of the wound (R2) has."</p> <p>On 1/3/14 at 3:00pm, E1(Administrator) and E2 were asked to provide documentation the facility reviewed the recommendations of Z5 and made implemented measures to assist with the healing of the pressure ulcer to R2's coccyx, including management of non-compliance behaviors. No documentation was provided.</p> <p>The facility policy, Skin Management, 8/10,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LEXINGTON OF ORLAND PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462</b>
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>documents the facility is committed to the prevention of pressure ulcers through the identification of at risk residents and the specific factors that place them at risk. The initiation of intervention based on these factors will be designed to decrease the risks.</p> <p>There is no documentation in the clinical record of the facility implementing interventions or creating a plan of care to address the risk factors R2 exhibited which caused the wound to worsen, including limited sitting or individualized repositioning measures and behavioral interventions to address non-compliance.</p> <p>Z5 was unable to be reached on 1/3/14 for an interview.</p> <p style="text-align: center;">(B)</p>	S9999		