DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145765	A. BUILDING ______ B. WING ______	C **05/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHAB CENTER	**5888 NORTH RIDGE** **CHICAGO, IL 60660**

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F 000	INITIAL COMMENTS Complaint Investigation 1682492/IL85358 - F312, F314 1682503/IL85368 - F204	F 000		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the Discharge/Transfer of Resident policy and return personal medications purchased prior to admission for 1 of 3 residents (R1) reviewed for discharge and return of personal belongings in the sample of 12. Findings include: Closed record documents R1 was admitted to the facility on 4/22/16 after knee replacement surgery, and was discharged on 5/8/16. Against	F 204		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 204	Continued From page 1 Medical Advice (AMA) Discharge Form 5/8/16 documents R1 signed the form along with 2 witnesses. On 5/17/16 at 10:10am, in the presence of E2(Director of Nursing), a clear plastic bag containing 4 bottles of medications belonging to R1 were found in plain sight on the counter in the 1st floor medication room. E2 stated R1 left the facility against medical advice (AMA) on 5/8/16, and when a resident leaves AMA, they do not get written prescriptions to take home or orders from the physician, staff does not give them their home medications that were brought into the facility on admission. E2 stated she was not aware that R1's medications were not returned. R1's medications are the following: 1. Verapamil 360 mg (milligrams) 1 tablet daily, 90 pills filled on 1/2/16 at the local pharmacy. 39 pills remain in the bottle. 2. Benzonatate 200 mg 1 capsule every 6 hours as needed, 60 pills filled on 1/19/16 at the local pharmacy. 56 pills remain in the bottle. 3. Quetiapine fumarate (Seroquel) 25 mg 1 tablet daily, 90 pills filled on 1/6/16 at the local pharmacy. 110 pills remain in the bottle. 4. Sertraline (Zoloft) 50 mg 1 tablet daily, 90 pills filled on 3/5/16. 42 whole pills and 1 half of a pill remain in the bottle. On 5/17/16 at 9:50am, by phone, R1 stated she does not remember when the 90 day supply was filled, but the medications were purchased prior to admission into the facility. R1 stated the facility did not pay for those medications and they are her property, the facility has no right to keep them. R1 stated the facility kept Verapamil, losartan, Zoloft, spiriva, and tessalon pearls. R1 stated she had all of her belongings and clothes	F 204		

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in a backpack ready to leave, but the nurse would not give her the medications brought from home. R1 stated she called the next day and spoke to E3(Assistant Director of Nursing) and E3 told R1 that she could not get the medications back because R1 signed out AMA.

On 5/17/16 at 10:25am, E3 stated R1 called the facility on 5/9/16, the day after leaving AMA, saying she would pick up all belongings, including clothes and medications on 5/11/16. E3 stated he was not aware that R1 did not come to get her medications and the facility still had them in the medication room. E3 stated he did not follow up with R1.

On 5/17/16 at 10:45am, E2 stated patients have the right to their personal belongings, including home medications that they paid for, even if they leave the facility AMA; they facility should not keep medication a resident has paid for prior to admission. E2 stated E4(Social Service) will be following up to return the home medications to R1.

On 5/17/16 at 11am, E4 stated she did not know R1's home medications were still in the facility.

On 5/17/16 at 11:35am, E5(Nurse) stated R1 was admitted to the facility with home medications. When R1 was transferred to the first floor, E5 sent the medications with R1.

On 5/18/16 at 10:30am by phone, E8(Nurse) stated R1 signed out AMA on 5/8/16. R1 came to the nurse's station with a big backpack and stated she was going home. R1 was yelling and swearing about being late to an appointment the next day, 5/9/16. E8 stated R1 did not take her medications with her because when a patient signs out AMA, medications aren't given to them. E8 stated she worked on 5/9/16, but R1 never came back to the facility, did not call, and E8 was

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F 204	Continued From page 3 not aware that R1's medication were still in the medication room. Discharge/Transfer of Resident - 4. Should the resident's family or resident desire to leave without a physician's order, the resident or sponsor shall be required to sign a "Discharge Against Medical Advice" form. 5. Assist resident to dress and pack all personal belongings.	F 204		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their Incontinency Care policy and check for incontinent every 2 hours for 3 of 3 residents (R4,R6, R8) reviewed for incontinence care. This failure resulted in R4 sitting in the recliner for 3.5 hours without being checked for incontinence and the soiled incontinent brief cutting into R4's skin, causing an open wound on the left posterior inner thigh measuring 5.5 x 0.1 centimeters and requiring treatment. Findings include: Medical Record documents R4 was admitted to the facility on 7/31/15 with the diagnoses of dementia and Alzheimer's disease. R4 has a care	F 312		

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plan for functional incontinence resolved on discharge 4/15/16 and another one initiated on 5/16/16, the first day of the complaint survey. Interventions include "provide peri care after each incontinent episode". R4 has a care plan for pressure ulcer risk revised on 5/16/16 due to the new "opened area to left inner upper thigh from diaper use." Interventions include apply barrier cream to peri area after incontinence 12/3/14, and updates on 5/16/16 - apply treatment per physician order, ensure proper sized diaper and loose fitting, replace dressing as necessary when not in place, report any missing dressings from opened areas to nurse immediately. Discharge Minimum Data Set (MDS) 4/10/16 and MDS 4/28/6 both document R4 is always incontinent of bowel and bladder. Current Physician Orders (POS) 4/14/16 moisture barrier cream to buttocks and groin as needed. Braden Scale for Pressure Ulcer Risk 4/19/16 and 4/27/16 document R4 is very high risk for developing pressure ulcers, and R4's skin is "constantly moist". Bowel and Bladder Incontinence Screener 4/29/16 documents R4 never voids appropriately without incontinence, is never aware of the need to use the toilet, and R4 is not appropriate for the toileting program and continues with a "check and change" program/standard of care.

On 5/16/16 at 10:50am, upon arrival to the 2nd floor, no residents or staff were seen walking in the halls. A contractor was working in the hallway, spreading a thick dark gray liquid across the floor. This liquid was in various stages of drying based on the lighter shades of gray at the far end of the hall compared to the current area of work near the elevator and nurse's station.
On 5/16/16 from 10:55am to 1:45pm, in 10-15 minute intervals and periods of continuous

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F 312	Continued From page 5 observation, R4 remained in a reclining chair either in the 2nd floor dining room or in the resident room. R4 was not checked for incontinence or changed. On 5/16/16 at 10:55am, E10(Nurse Aide) stated all of the residents in the 2nd floor dining room were brought in there around 10am because the floors are being worked on. E10 stated no one can leave the dining room and walk on the hallway floor. On 5/16/16 at 11am, Z2(Contractor) stated he started working on the floor between 8:30-9am, since all of the residents were already in the dining room. Z2 stated everyone is "stuck" in the dining room until the floor is dry, about another 45 minutes. On 5/16/16 at 11:50am, E11(Nurse Aide) brought R4 back to the room. E11 did not check R4 for incontinence. R4 remained in the room until after all residents were done eating lunch, then moved back to the dining room. At 1:45pm, R4 was transferred back to bed using a mechanical lift. E11 and E14(Nurse Aide) changed R4's incontinent brief which was overflowing in the front and back with liquid brown stool. After R4's skin was cleaned, an open area was noted to the left gluteal fold, and white scars were noted to the left and right buttocks area. No dressings were present on R4's sacrum, coccyx, or buttocks. A new incontinent brief was place on R4, without any other skin care prevention interventions. On 5/16/16 at 1:15pm, E5(Nurse) stated E15(Nurse Aide) was pulled to the 1st floor around 10am and all of the residents had to stay in the dining room until the floor was finished, so no one could go out to their room to be changed. On 5/16/16 at 2:15pm, E14 stated R4 was last changed around 9-10am when she woke up. E14	F 312		

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stated E15(Nurse Aide) cleaned R4 this morning, but E15 was then pulled to the first floor (unknown time). E14 stated no one else changed R4 today because R4 and the other residents had to stay in the dining room all day while the contractor was here.
On 5/16/16/at 2:35pm, E2(Director of Nursing) stated incontinent residents are checked every 2 hours and toileted as needed. If a resident is unable to say if they need to go to the bathroom, the staff will do a visual check for incontinence every 2 hours.
On 5/17/16 at 11:35am, E5 neither E11 or E14 told him on 5/16/16 that R4 had any new open skin areas.
On 5/17/16 at 1:35pm, E6(Wound Care Nurse) stated incontinence residents are checked every 2 hours and changed if needed, moisture barrier is applied to prevent skin breakdown from the moisture of incontinence.
On 5/19/16 at 10:30am by phone, Z1(Physician) stated R4 cannot tell staff that she needs to go to the bathroom, so they should be checking her frequently and changing her right after an incontinent episode to prevent any type of skin breakdown. Z1 stated letting R4 sit in the soiled diaper and not get changed caused the incontinent brief to cut into the skin and cause an open wound.

On 5/16/16 at 2:20pm, R6 and R8 walked off the elevator on the second floor. No staff was present in the elevator. R6 self-propelled down the hall in a motorized wheelchair, and was noted with a large wet area to the crotch. R6 asked E11 for help. E11 replied "in about 30 minutes". R6 continued down the hall to the room without responding back to E11. On 5/16/16 at 2:30pm, R6 would not speak to the surveyor when

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F 312	Continued From page 7 approached inside her room. Minimum Data Set (MDS) 4/7/16 documents R6 is always incontinent of bladder. Bowel and Bladder Incontinence Screener 4/7/16 documents R6 is never aware of the need to use the toilet and remains incontinent of bowel and/or bladder and is not appropriate for a toileting program; continue with a "check and change" program/standard of care. Braden Scale for Pressure Ulcer Risk 4/7/16 documents R6's skin is very moist. Weekly Skin Alteration Report 4/12/16 documents R6 has a healed pressure ulcer to the coccyx. Alteration in skin integrity care plan 1/17/15 documents the intervention of "good peri care". R6 does not have a care plan to address incontinence care. From the front, R8's pink pants were noted with a large wet stain in the crotch to the knees, and the whole back of the pants down the thighs. R8 shuffled down the long hall from the elevator without any staff intervening until E5(Nurse) followed R8 into the room near the end of the hall. E5 stated R8 does not wear incontinent briefs. MDS 3/31/16 documents R8 is frequently incontinent of urine. R8's incontinence care plan was initiated on 5/16/16, the first day of the complaint survey, and includes interventions of toilet at regular intervals, remind the resident to use the toilet at regular intervals, administer appropriate cleansing after incontinent episodes, and teach the resident to ask for toileting assistance, all initiated on 5/16/16. Incontinency Care policy - Incontinent residents will be checked periodically every 2 hours and provided perineal and genital care after each episode. Care Plans will identify residents to be monitored. Purpose: to prevent excoriation and skin breakdown, discomfort and maintain dignity. Assist resident to comfortable position after	F 312		

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F 312	Continued From page 8 applying moisture barrier.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the plan of care and implement wound preventive interventions to reduce the risk of developing a pressure ulcer for 1 of 3 residents (R4) reviewed for pressure ulcers. Findings include: Medical Record documents R4 was admitted to the facility on 7/31/15 with the diagnoses of dementia and Alzheimer's disease. R4 has a care plan for pressure ulcer risk initiated on 3/26/14 and revised on 5/16/16 due to the new "opened area to left inner upper thigh from diaper use." Interventions include apply barrier cream to peri area after incontinence 12/3/14, and updates on 5/16/16 - apply treatment per physician order, ensure proper sized diaper and loose fitting, replace dressing as necessary when not in place, report any missing dressings from opened areas	F 314		

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to nurse immediately. Initial Skin Alteration Assessment 4/15/16 documents R4 was readmitted to the facility on 4/14/16 with an open area to the right buttocks. R4 does not have a care plan with interventions and treatment for the right buttocks pressure ulcer identified on readmission to the facility on 4/14/16. Weekly Skin Alteration Report 4/26/16 documents the right buttocks pressure ulcer is healed and current treatment orders are hydrocolloid. Current Physician Orders (POS) 4/14/16 moisture barrier cream to buttocks and groin as needed, and 4/26/16 right buttock: cleanse with saline, pat dry, apply hydrocolloid every 7 days and as needed for wound care preventive measures. Braden Scale for Pressure Ulcer Risk 4/19/16 and 4/27/16 document R4 is very high risk for developing pressure ulcers, and R4's skin is "constantly moist". Bowel and Bladder Incontinence Screener 4/29/16 documents R4 never voids appropriately without incontinence, is never aware of the need to use the toilet, and R4 is not appropriate for the toileting program and continues with a "check and change" program/standard of care. Treatment Administration Record May 2016 documents hydrocolloid every 7 days was last applied to R4's right buttocks on 5/10/16.

On 5/16/16 from 10:55am to 1:45pm, in 10-15 minute intervals and periods of continuous observation, R4 remained in a reclining chair either in the 2nd floor dining room and in the resident room. R4 was not checked for incontinence or changed.
On 5/16/16 at 11:50am, E11(Nurse Aide) brought R4 back to the room. E11 did not check R4 for incontinence. R4 remained in the room until after all residents were done eating lunch, then moved

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back to the dining room. At 1:45pm, R4 was transferred back to bed using a mechanical lift. E11 and E14 changed R4's incontinent brief which was overflowing in the front and back with liquid brown stool. After R4's skin was cleaned, an open area was noted to the left gluteal fold, and white scars were noted to the left and right buttocks area. No dressings were present on R4's sacrum, coccyx, or buttocks, or present in the soiled incontinent brief. A new incontinent brief was place on R4, without any other skin care prevention interventions or moisture barrier cream applied.

On 5/16/16 at 1:15pm, E5(Nurse) stated E15(Nurse Aide) was pulled to the 1st floor around 10am and all of the residents had to stay in the dining room until the floor was finished, so no one could go out to their room to be changed.
On 5/16/16 at 2:15pm, E14(Nurse Aide) stated R4 was last changed around 9-10am. E14 stated E15(Nurse Aide) cleaned R4 this morning, but E15 was then pulled to the first floor (unknown time). E14 stated no one else changed R4 today because R4 and the other residents had to stay in the dining room all day while the contractor was working on the floor.
On 5/17/16 at 11:35am, E5 stated no dressing changes were completed 5/16/16 for R4, it was not due. E5 stated R4 gets hydrocolloid every 3 days for a reddened sacrum for protection and prevention of wounds. E5 stated neither E11 or E14 told him R4 did not have a dressing on her sacrum or that R4 had any new open skin areas.

Incontinency Care policy - Incontinent residents will be checked periodically every 2 hours and provided perineal and genital care after each episode. Purpose: to prevent excoriation and skin

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F 314	Continued From page 11 breakdown, discomfort and maintain dignity. Assist resident to comfortable position after applying moisture barrier. Skin Care Do's and Don'ts - Do use moisture barrier ointment to protect skin from incontinence. Pressure Ulcer and Skin Condition Assessment Policy - Dressing will be checked daily for placement, cleanliness, and signs and symptoms of infection. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care.	F 314		