STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. BUILDING _____ B. WING _____	C 01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQUARE N & REHAB CTR	**5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644**

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F 000	INITIAL COMMENTS Complaint Investigations: 1282586/IL58781- No deficiency 1282803/IL59021- Refer to F314 1283314/IL59582- Refer to F314 1283712/IL60001- Refer to F314 1283902/IL60201- Refer to F314 1284014/IL60315- No deficiency 1284082/IL60401- Refer to F314 1284131/IL60447- No deficiency 1380101/IL61052- No deficiency	F 000		
F 314 SS=G	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 pressure ulcer policy for monitoring skin condition and	F 314		

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 314	Continued From page 1 implement pressure relieving methods, completing accurate measurement for pressure ulcer and provide pressure ulcer treatments as ordered for two of seven residents (R3 and R5), in the sample of fourteen residents reviewed for pressure ulcers. As a result of these failures R3 developed stage II, III and IV pressure ulcers, resulting in the need for debridement of the stage IV ulcer at a hospital. R5 development a stage III pressure ulcer that had increased in size just seven days after being admitted to the facility. Findings Include: 1. R3 was readmitted into the facility on 8/27/12. R3's admission records for bodily assessment indicate that R3 had no open pressure areas. R3's risk assessment scale for skin breakdown indicated that R3 was scored 14 which is moderate risk. Review of the facilities policy for pressure ulcer prevention state that all residents assessed and treated. The facility's wound care notes indicate that on 9/16/12, R3 had developed four new pressure ulcer areas. The wound summary sheets with date of 9/16/2012 indicated a stage three pressure ulcer to the right buttock, stage three pressure ulcer to the coccyx, stage two pressure ulcer to the left buttock and stage two pressure ulcer to the anal area. The comprehensive assessment of the pressure ulcers did not include measurement for the depth for any of the stage three pressure ulcers identified at this time. Further review of the wound care notes indicated R3's had a sacrum ulcer stage IV in which was not assessed until 10/29/2012 after treatment was started 10/27/12. There was no documentation when this pressure ulcer was developed. The facility's wound assessment details report date 10/30/12 denotes 5.5 cm X 3.5	F 314		

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F 314	Continued From page 2 cm X 2.0 cm with exudates and moderate amount serosanguineous drainage on the sacrum area. The hospital physician progress notes date 10/01/12 indicated that the sacrum ulcer was infected and Stage IV. The hospital physician progress notes indicated that the pressure ulcer was debrided. The facility's pressure ulcer prevention policy and procedures included but not limited: "All residents assessed to be at risk for breakdown should be placed on a pressure reducing bed or mattress. Based on the results of the pressure risk assessment, all residents at-risk for pressure ulcer development will receive a documented daily visual inspection of their skin by the RN/LPN (register/licensed nurse) or CNA (certified nurse aide)delivering care." This policy also denotes: "a Stage 3 pressure ulcer has a full thickness tissue loss and the depth varies and Stage 4 pressure ulcer has full thickness tissue loss with exposed bone, tendon, or muscle and the depth varies. " R3's physician's order sheet reflected no use of a pressure relief mattress until 9/16/12, when facility staff acknowledged R3 developed new pressure ulcers. In addition, the wound assessment notes does not include measurements of depth for the identified stage 3 pressure ulcers during the period of 9/16 to 9/27/12. E2 (Director of Nursing) on 11/7/12 at 10:45 A.M. stated, " the certified nurse's aides are to do daily skin checks on all residents during bath or shower days, note any unusual observations on the skin assessment sheets and inform the nurse in charge". E2 was unable to supply documentation of the skin assessment sheets for	F 314		

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F 314	Continued From page 3 R3 from 9/12 to 9/16/12. E2 continued to state that the treatment nurse is to check the skin assessment sheets on a daily basis for follow up on any concerns regarding resident's skin issues. E4 (treatment nurse) stated on 11/5/12 at 11:50 A.M., "She was not notified of R3's pressure ulcer until 9/16/12." R3 was observed on 01/10/13 at 10:05 A.M. in bed. R3 was observed with sacrum pressure ulcer length 3.0 cm X 2.5 cm, pink tissue, scanty amount sangerious drainage and no odor. E5 (nurse-wound care coordinator) on 01/28/13 at 10:28 A.M. stated, "It was the right buttock but it extended to the sacrum. I didn't assess the sacrum ulcer or treat the sacrum." E5 was unable to show where this change in R3's skin condition was documented by any of the wound care staff. 01/28/13 at 2:30 P.M. E12 (nurse consultant) in the presence of E5, acknowledged it was true that a stage 3 and stage 4 would have a depth measurement included in the assessment. 2. R5 closed record documented R5 as total care resident admitted to facility on 7/20/12. R5's skin assessment dated 7/20/12 indicated that R5 had only small scratches and a skin tear, both to the sacrum upon admission. R5's wound care notes dated 7/20/12 and initial minimum data set (MDS) assessment dated 7/27/12 both documented R5 having a pressure ulcer on admission. The wound care notes stated, R5 had a previous pressure ulcer noted to right ischium/ sacrum noted with stage 2 with measurement of 2.5 cm (long) X 1.8 cm (wide) X 0.2 cm (depth). On the MDS the same measurement was recorded but it was indicated as a stage 3 pressure ulcer. In addition, it indicated R5 was incontinent of bowel and bladder.	F 314		

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F 314	Continued From page 4 -R5's nurses notes dated 7/24/12 at A.M. stated, R5's indwelling catheter was removed this AM (morning). R5's comprehensive care plan dated 7/20/12 for the pressure ulcer indicated R5 was to be kept clean and dry as possible to minimize skin expose to moisture. The care plan had no details how the staff members would accomplish this take. The care plan also identified the use of a low air loss mattress (pressure relief mattress). -On 1/28/13 at 2:30 P.M. E5 (wound care coordinator) and E12 (nurse consultant) were asked what was the plan for reducing the moisture or keeping R5 as dry as possible to decrease the risk for development for further pressure. E12 initially reported it was documented on the wound care notes 7/20/12, R5 had a indwelling catheter. The surveyor asked for a physician order for the use of the catheter and it was not found. R5's physician's order did not have any orders for the use of a pressure relief mattress and indwelling catheter. R5 had order dated 7/20/12 for treatment of the sacrum area to be done on Monday, Wednesday and Friday and as needed. Also, treatment orders dated 7/27/12 for the right buttock on Monday, Wednesday and Friday and as needed and sacrum everyday and as needed. R5's treatment administration records (TAR) were reviewed to confirm the treatments were done as ordered. R5's TAR between 7/20 and 7/27/12 denoted one treatment (7/20/12) for R5's sacrum area. The treatment that should have been scheduled for 7/23 and 7/25/12 were not documented as being done. Next, R5's TAR between 7/27 and 8/09/12 had undocumented treatments for R5's sacrum area for 8 of 14 days before being transferred out. The treatments that should have been scheduled for 7/30, 8/3 and	F 314		

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F 314	Continued From page 5 8/06/12 were not document as being done. R5's wound care notes dated 7/27/12 documented upon dressing change R5 had an open area to the right buttock measuring 2.5 cm X 3.5 cm, and sacrum wound 5.0 cm X 6.0 cm X 0.2 cm. This was a newly developed pressure ulcer and an increase of the pressure ulcer identified on admission. R5's medication administration record (MAR) had the administration of pain medication on 8/08/12 for pain located in R5's buttock area.	F 314		