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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	**5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644**

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F 000	INITIAL COMMENTS Complaint Investigation 1484022/IL71955 No deficiency cited 1484043/IL71977 No deficiency cited 1484211/IL72173 F314 cited 1484488/IL72469 F323 cited 1484252/IL72217 No deficiency cited	F 000		
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, record review, and interviews the facility failed to have evidence of monitoring, characteristics, current progress or the stages of pressure sores for 2 of 6 residents (R10 and R11) with a pressure sore in a sample of 17. Findings Include: 1. R10's wound records notes dated 8-21-14	F 314		

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

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notes; The picture states "Patient Refused Photo," but the nursing assessment is dated 8-14-14 for R10's pressure sores.

The documented assessments of 8-14-14 and 8-21-14 both said the same thing. Both documentation notes; exudates none, per wound criteria is normal, wound edges are distinct and attached. The size is 2.0cm x 1.50cm and there is no undermining.

Nursing notes dated 8-21-14 at 2:30PM by E16 (Treatment Nurse) notes R10 unavailable for wound photo, attempts made times 3. Off unit for therapy sessions and off unit for family visits. Wound care done by charge nurse,"dressing dry and intact. Preventative measures in place. Current plan of care to continue."

E16 (Treatment Nurse) explained on 10-21-14 at 11:00 AM, R10 was unavailable twice during the shift for a wound assessments because she was off the unit at therapy. The third time R10 had family members in her room and did not want the dressing change at that particular time. E16 have no comments as to why she did not return again after the visitors left or endorse to next shift or just return the following day to complete the pressure sore assessment. E16 stated she copied the general documentation from one week (8-14-14) to the next week, (8-21-14). E16 concur that she never saw R10's pressure sore on 8-21-14, but the floor nurse saw the dressing and documented that the dressing was intact.

Review of E16 employee personal files notes, E16 has disciplinary action related to documentation and for caring for wounds and pressure sores. On 5-7-13 a disciplinary

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counseling, notes E16 did not following the physician orders and did not ensure that a resident with a pressure sores received an air mattress bed for treatment and avoiding complications. On 7-25-14, (one day after the facility ' s documentation in-service on pressure sore) a written disciplinary counseling was done for no proper assessments and documentation with wounds and pressure sores.

2. On 10-22-14 at 11:00AM, R11's left heel pressure sore was extremely flaky with dry skin, no odor or drainage, it was open with redden shinny skin. R11 is unable to move his lower extremities but alert and oriented to person, place and thing.

Review of the wound records dated 3-23-14 of R11's left heel notes picture taken on 3-23-14 and the nursing wound assessment dated for 3-14-14. The general information notes are identical for both dates of 3-14-14 and 3-23-14. There are no current progress notes and assessments wound documentation from week 3-14-13 to 3-23-14.

R11' s wound records dated 3-14-14 of the left heel notes the exact same documentation on 3-23-14. The general information notes size 7.0cm x 7.50cm x 0.0, area 52.50cm exudates around per wound criteria normal and distinct and attach wound edges.

E16 stated on 10-22-14 at 11:00AM never gave confirmation of assessing R11's wound on 3-23-14.

E10 (Treatment Nurse) explained on 10-22-14 at 11:00AM in the conference room, that if there are no drastic changes in the wound than

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measurements and assessment do not need to be done along with the picture of the wound. E10 never gave any facility's policies related to the delay of time for documentation of an assessed wound or pressure sore.

Review of the facility's Employee Performance Improvement Action Plan (in-service) dated 7-24-14 notes the following; " Annotate on all wound assessments in wound rounds within 24 hours. Annotate on the assessments weekly. Monitor weekly assessment for completion". The target dates for completion and implementing according the facility's policy was 7-26-14 and go-going.

E10 also stated that the Wound Consultant gave an in-service on documentation and any time wounds (pressure sores) are re-assess documentation of the characteristics and care of the wound needs to be done and re-evaluated directly.

Review of the facility's Pressure Sore policy no dates notes the following;
Wound Care Documentation
A. Treatment of Pressure Ulcers Assessment and documentation's should be carried out at least weekly, unless there is evidence of deterioration, in which case both the pressure ulcer and the patient's overall management must be reassessed immediately. More often when indicated by wound complications or changes in wound characteristics.
B. Assessment Findings- Follow a systematic method of documenting your assessment
C. Acute Care and Long Term Care - all wounds should be monitored daily with documentation of findings.

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F 314	Continued From page 4 E1 (Director of Nursing) explained on 10-22-14 in the conference room, that E16 was given an employee action plan (disciplinary actions) again on 10-22-14 related to the lack of documentation related to wound care.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that fall prevention interventions were implemented for 1 resident (R5), of 3 residents , reviewed for falls. This failure resulted in R5 sustaining bi-lateral leg fractures. Findings Include: R5 is a 59 year old female admitted to the facility on 12-3-13 with the diagnoses which includes cerebral infarction and legal blindness. On 9-23-14 at 7:30PM, R5 was lying in a bariatric bed. R5 was alert and slow to respond verbally to simple questions. R5 had bilateral soft cast and	F 323		

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immobilizers on both legs and requires extensive assistance with bed mobility.

R5's Minimum Data Set (MDS) assessment dated 6-16-14 notes; bed mobility extensive assist and two person physical assist, transfer assessed ; total dependence with two person physical assist.

R5's care plan dated 12-15-13 notes;" potential for falls related to the diagnoses of blindness, cerebral vascular accident, (CVA) with left sided hemiplegic and impaired mobility. Incident on 2-8-14, witnessed by staff, R5 rolled to floor from bed no injury. Interventions to increase to a 2 person assist with transfers and bed mobility.

R5's Fall Risk assessment dated 12-15-13 is noted to be at a level of 13. The fall risk assessment notes any scores above ten puts the resident at high risk for fall.

Incident report dated 9-6-14 notes the following: " R5 rolled off the bed and onto the floor, full body assessment completed. Resident complaining of bilateral lower extremity pain. Medical Doctor (Z4) called and pain management provided. Order obtained to send to local hospital for medical evaluation. Resident was subsequently admitted with diagnoses of left tibia fracture and right femur fractures."

The facilities investigation of the incident concluded that on 9/6/14, E7 (Certified Nursing Assistant), while performing ADL (Activities Daily Living) care while R5 was in bed , E7 turned R5, which resulted in R5 rolling off the bed and landing on the floor. E7 was without staff assist.

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R5's hospital x-rays reports dated 9-7-14 notes the following, " An acute fracture is present at the distal aspect of the right femoral shaft. X-ray of left lower leg notes an acute transverse non-displaced fracture of the proximal shaft of the tibia is demonstrated."

On 10-17-13 E11 (Falls Coordinator) stated," R5 was assessed at a 13, high risk for falls. R5's high risk for falls was documented in the care plan for all to see."

On 9-23-14 at 5:30PM E6(Staff Nurse) stated," R5 is legally blind and has left sided hemi paresis, alert and oriented to self and place at times. Since R5's admission, R5 has always been a two person assist because of her weight (obese) and immobility. After the fall on 9/6/14, R5 returned from the hospital with bilateral soft cast on and splint immobilizers on both legs and very apprehensive and fearful with bed mobility and transfers. "

E1 (Director of Nursing) on 9-23-14 at 8:00PM stated," R5 was assessed as a two person assist based on the 6-16-14 MDS assessments with all activities of daily living. "

E4 (Administrator) on 9-23-14 at 8:30PM stated," E7 no longer works at the facility."

Z4 on 10-17-14 at 12:15 stated," The facility explained that they lost control of R5 while doing care and she rolled out of the bed onto the floor. This is how she sustained fractures of both legs. "

Facilities policy regarding transfers and fall prevention indicates that the individualized plan of care are to be followed.

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