DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A							
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· · · ·	E SURVEY IPLETED	
						С	
145684			B. WING		05/17/2016		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORC	ARE OF HOMEWOOD			940 MAPLE AVENUE			
				HOMEWOOD, IL 60430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 00	0			
F 309 SS=D	INITIAL COMMENTS Complaint Investigation 1692444/IL85301 No deficiency 1692445/IL85302 No deficiency 1692511/IL85378 Refer to F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to leave a resident's incontinence brief open to air and failed to perform hourly incontinence checks as ordered for the treatment of a moisture associated skin dermatitis. This applies to one of one resident (R1) with dermatitis in a sample of 9. Findings Include: R1's face sheet diagnoses included bladder disorder. R1's Medical Practitioner Progress Note dated 4/26/16 indicated R1 had a moisture associated dermatitis due to incontinence and that R1 is incontinent of urine and stool. R1's		F 30	19			
	that R1 is incontinent nursing progress note	of urine and stool. R1's e dated 4/27/16 indicates I with moisture associated					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 05/18/2016

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/18/2016 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
145684		B. WING	_	C 05/17/2016				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-		
MANORCARE OF HOMEWOOD			940 MAPLE AVENUE HOMEWOOD, IL 60430					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 1         R1's Minimum Data Set dated 4/23/16 indicates that R1 requires extensive two person assistance for bed mobility and is always incontinent of bowel and bladder.         R1's alterations in skin integrity care plan revised 1/20/16 includes an intervention dated 4/23/16 to check resident frequently for incontinence and kept dry and repositioned as ordered.         R1's Physician Order Sheet (POS) included an order dated 2/26/16 for staff to check R1's incontinence brief hourly for soiling. Also, R1's POS included an order dated 4/27/16 to keep R1's incontinence brief open every shift and Triad wound paste to the right buttock.         On 5/12/16 at 3:20 pm, the surveyor observed R1 on a low air loss air mattress with a closed incontinence brief in place. E11 (CNA) was present at the time of the observation.         On 5/16/16 at 10:00 am , the surveyor observed R1 with a closed incontinence brief in place. E3 (wound nurse) was present at the time of the observation.         On 5/16/16 at 1:10 pm the surveyor , while with E3, observed R1 with a closed incontinence brief in place. R1 had a small open area to the upper right buttock where Triad cream was placed after wound cleansing. Following R1's wound observation R1's incontinence brief was replaced and closed by staff.         On 5/16/16 from 1:15 pm - 3:20 pm R1 was observed to receive no incontinence checks or care as ordered in R1's (POS) for hourly incontinence checks.		F 309					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/18/2016 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
145684		B. WING		-	C 05/17/2016			
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MANORC	ARE OF HOMEWOOD		940 MAPLE AVENUE HOMEWOOD, IL 60430					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page 2		F	309				
	Continued From page 2 On 5/17/16 at 8:42 am Z4 (Wound Nurse Consultant) stated the purpose of keeping R1's incontinence brief open is to wick the moisture away from R1's skin. Z4 stated when asked about the hourly incontinence checks for R1 that R1 needed more frequent incontinence checks and assessments due to the MASD. Z4 stated R1's intolerance to the removal of protective dressings due to pain required the interventions for hourly checks and open incontinence brief to but implemented. On 5/17/16 at 9:20 am with E3 Wound Nurse and Z4 Wound Nurse Consultant R1's right buttock MASD was observed with an open bleeding area measuring 1.0 centimeters (cm) x 0.9 cm.							

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