STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145718	A. BUILDING ______ B. WING ______	C **09/07/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD CARE CENTRE	**14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445**

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F 325	Continued From page 16	F 325		

notification of R4's physician regarding R4's lack of dietary and fluid intake from 7-17-05 until 7-20-05 and no notification of R4's continued poor intake from 7-21-05-7-25-05.

Review of the facilities weight assessment sheet denotes that on 7-7-05 R4's weight was 160 lbs. Review of the nutrition note (done by a Registered Dietician) dated 7-27-05 upon admission to the acute care facility denotes that R4 weighed 134 lbs. Further documentation denotes patient is at a level one nutrition risk, patient is only 75% of his ideal body weight.

The facility was unable to provide any documentation of monitoring of R4's actual nutritional intake neither was the facility able to provide any documentation of the monitoring of R 4's bowel and bladder.

Per interview via phone on 8-25-05 Z1 stated "if the facility would have called me regarding R4's difficulty swallowing and decreased intake I would have sent him to the hospital".

Per interview on 9-1-05 via phone Z3 (Dietician) stated that she had not be informed by the facility of R4's difficulty swallowing, weight loss or poor nutritional intake.

F9999 FINAL OBSERVATIONS F9999

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LICENSING VIOLATIONS

300.1010 h) Facility staff shall notify the resident ' s physician of any accident, injury, or significant

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F9999	Continued From page 17 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 notification. 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident ' s comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.1210 b) 3) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: Objective observations of changes in a resident ' s condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident ' s medical record. 300.3240 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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F9999	Continued From page 18	F9999		

Based on record review and interview the facility failed to ensure that 1 resident (R4) was free from neglect as evidenced by:

1. Failure to notify R4's physician regarding his continued inability to swallow and lack of adequate nutrition and hydration for 4 days.

2. Failure to notify R4's physician and family regarding the development of a stage II pressure sore on 7-20-05 when it was initially discovered, and failure to notify the family with a change of condition regarding R4's inability to walk and decline in nutritional intake.

3. Failure to promptly assess/reassess, monitor and notify R4's physician when he developed an acute change in his respiratory condition on 8-2-05 (after the placement of a nasogastric tube).

Findings Include:

1. R4 is an 83 year old male with diagnoses that include CVA, Dementia, Gastritis and Osteoporosis. Documentation in R4's clinical record denotes that days and weeks prior to 7-7-05, R4 was alert, responding to verbal stimuli, ambulatory with a slow gait and eating well.

Further documentation (nurses notes dated 7-7-05) denotes that after the fall on 7-07-05 R4 complained of pain to the left lower extremity at weight bearing. Further documentation denotes that Z1 (physician) was notified and x-rays of R4 's left ankle and foot were done and found to be negative for fracture. Further documentation denotes the following:

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F9999	Continued From page 19 7-09-05- 6 a.m. R4 needs assistance to walk. 7-09-05- 12 noon R4 stood up complained of pain when standing. 7-09-05-3-11 p.m.. resident resistant to walking very apprehensive, wheel chair needed to assist back to bed. 7-11-05- 10:30 a.m. resident seems cautious about getting up and ambulating. CNA reports that resident will stand but will not walk, requires a wheelchair to move. 7-11-05- 1:30 p.m. complains of pain both legs refuses to stand and ambulate. States that legs hurt all over. 7-12-05- Unable to put weight or stand on legs complained of pain when attempting to stand. Documentation denotes that R4 was sent to the hospital on 7-25-05 due to a decline in his condition. X-rays were taken and denotes a fracture to the left femoral neck. 2. Review of 24 Hour Nursing Reports dated 7-20-05 denotes that R4 developed difficulty swallowing and was referred for an swallowing evaluation. Further documentation denotes that on 7-21,7-23-,7,24, and 7-25-05 R4 continued to have difficulty swallowing consuming very little/50 %. There was no documentation of any reassessment done by the facility or notification of the dietician for additional nutritional assessment measures (calorie count, nutritional supplements..) to ensure adequate dietary and fluid intake. There was no documentation of notification of R4's physician (until 7-25-05) or family (until 7-23-05) regarding R4's lack of nutritional and hydration intake. R4 was transferred to an acute care facility on 7-25-05 were he was admitted and diagnosed with	F9999		

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F9999	Continued From page 20	F9999		

Profound Dehydration, Fecal Impaction and Left Femoral Neck Fracture.

Review of the facilities last documented weight dated 7-7-05 denotes that R4's weight was 160 pounds. Review of the acute care facilities nutritional note dated 7-27-05 (at time of admission) denotes that R4's weight was 134 pounds, 75% of his ideal body weight.

Per interview via phone on 8-25-05 Z1 stated "if the facility would have called me regarding R4's difficulty swallowing and decreased intake I would have sent him to the hospital".

3. Nurses notes dated 7-20-05 (7 a.m.) denotes that E4 (Licensed Practical Nurse) assessed R4 to have a stage II pressure sore to the buttocks. Review of R4's clinical record denotes no documentation regarding R4's pressure sore on 7-20-05,7-21-05 or 7-22-05 and no documentation of the notification of R4's physician regarding the development of R4's pressure sore. Nurses notes dated 7-22-05 denotes that R4 developed a stage I and stage II pressure sore to the left and right foot, with eschar to the right heel. Review of R4's clinical record denotes no skin assessment of R4's additional facility acquired pressure sore, no care plan or notification of the physician, treatment nurse or dietician.

Review of the facilities skin care policy, denotes that upon a change in condition:
1. a full assessment will be completed....
2. the physician will be notified for treatment orders..
3. the resident will be referred to the skin care coordinator/team.

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F9999	Continued From page 21	F9999		

Further documentation denotes Never delay getting a treatment order.

Per interview on 9-1-05 via phone E4(LPN) stated that on 7-20-05 she noted an open area on R4's buttocks. E4 stated that the top layer of skin was off and that there was a little drainage. E4 stated that she did not call the physician to inform him or obtain orders. E4 stated that she started a treatment plan using the facility protocol . E4 stated that she endorsed to the morning shift to notify the physician and the treatment nurse. E 4 further stated "I observed the area on R4's buttocks , I don't recall doing a full body assessment.

Per interview via phone on 9-2-05 E8 (Licensed Practical Nurse) stated that it was brought to her attention by the Certified nurses assistant that R4 had sores on his feet during the 3-11 p.m. shift. E 8 stated that she looked at the areas and noted a stage I to the left heel and a stage II to the right heel with eschar. E8 stated that she used the facilities protocol and started treatment. E8 stated that she does not recall informing R4's physician or doing a full body assessment to determine if R 4 had any other pressure sores. E8 stated that she was not aware of R4's pressure sore to the coccyx area or of R4's poor intake.

Per interview on 9-1-05 at 1:25 p.m. E9 (Assistant Director of Nursing) stated that the nurse who identifies the pressure sore should initiate a full body assessment, obtain the initial orders from the physician and refer the resident to the treatment nurse. E9 further stated that the treatment nurse will then follow the care and

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F9999	Continued From page 22	F9999		

treatment of the pressure sore. E9 stated that the orders for the care and treatment of the residents pressure sore should be obtained from the physician. E9 further stated that the facilities protocol is a guideline and should not be substituted as physician's orders unless the physician actually orders them.

Per interview via phone on 9-1-05 Z3 (dietician) stated that she was not informed by the facility of the development of R4's pressure sores or poor nutritional intake.

Review of R4's Physicians's order sheet denotes that after notification of the physician on 7-23-05, orders that were written by E4 and E8 using the facilities protocol were discontinued and a different treatment plan was ordered for all of R4 's pressure sores.

The facility was unable to provide any documentation or assessments of R4's pressure sores to determine any progression or deterioration in condition.

4. Nurses notes dated 8-1-05 denotes that R4 was readmitted into the facility from an acute care facility, with a nasogastric tube intact, to be used for feeding and medication administration. Nurses notes dated 8-2-05 4 p.m. denotes (NGT feeding infusing... resident with lots of congestion in throat and chest, attempted to suction no success). Documentation dated 8-3-05 3:00 a.m. denotes, (very congested, suctioned copious amounts of mucous secretions, oxygen saturation 78-89%).

Review of R4's clinical record and medication

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F9999	Continued From page 23	F9999		

administration record denotes no documentation regarding the checking of the nasogastric tube placement by staff during the p.m. shift on 8-2-05 .

Per interview on 8-25-05 via phone E7 (License practical nurse) stated that it was not reported to him by the outgoing shift on 8-2-05 that R4 was having difficulty breathing and copious amounts of secretions. E7 further stated that he received R4 from the outing shift with his nasogastric feeding infusing. E7 stated that when he made rounds he noted R4 to be very congested with a lot of secretions. E7 stated that they appeared to be the tube feeding solution. E7 stated "I suctioned so much stuff out of him it was ridiculous". E7 further stated, "he was having trouble breathing, I placed him on oxygen and alerted the supervisor, and got as much of the fluid that I could suctioned out of him". E7 stated that Z1 (physician) was notified and R4 was transferred to an acute care facility for evaluation, where he was admitted to the Intensive care unit.

Per interview Z2 (R4's relative) stated that upon admission to the hospital R4 was placed on life support, were he remained for three days.