STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 10. In the event that a medication is not available, for the nurses consultation, there is a list on the top of the convenience box showing which medications are inside. A copy of this list will now be placed in the front of the MAR on each unit so that any nurse can immediately consult the list should a medication not available when needed. 11. All licensed nursing staff will be in-serviced on the following: - Foley Catheter Care - Assessing for signs and symptoms of urinary tract infection, especially in residents with Foley catheters. - Policy and procedures regarding labs and physician notification. - Checking antibiotic medication for sensitivity. All in- services will be performed by 06/07/07 Responsibility for above: DON, ADON, Restorative Nurse, Staff Development Nurse as overseen by Administrator. QA Plan to Monitor Facility Performance: See copy of Infection Control Log. All acquired infections are entered and tracked on this log from on-site date cleared. This insures that the treatment for each infection was effective. This data is included in our Quality Assurance data monthly. Responsibility for above: Administrator attends QA meeting monthly. Administrator will ensure that Infection Control log is reviewed and evidence of such review is entered into monthly minutes.	F 309		
F9999	FINAL OBSERVATIONS	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 16 LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)1) 300.1630d) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant 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. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 17 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on record review and staff interview, the facility failed to provide necessary care and services to one resident (R2) with a urinary tract infection who was inadequately monitored and treated as evidenced by: 1. Failure to notify physician and follow-up on a Urinary and Culture and Sensitivity lab result for R2 in a timely manner. This failure resulted in R2 being inadequately treated for the urinary tract infection with the wrong antibiotic. The facility also failed to administer the previously ordered antibiotic for 2 doses causing an interruption in necessary treatment. 2. Failure to monitor/assess R2's symptoms of UTI (Urinary Tract Infection).	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 18 These failures resulted in R2's hospitalization due to sepsis and complication of continued UTI. Because the facility failed to administer the proper antibiotic after they received the Culture and Sensitivity results on 4/11, R2 was on ineffective treatment for 7 more days of Augmentin given 4/6 through 4/17 which indicates failure to provide proper medical care and indicates several days of neglect for that time period. The facility also neglected R2 when they abruptly stopped antibiotic therapy for 2 doses on 4/7 without notifying physician for further orders. These actions contributed to R2's eventual fever and sepsis and need for hospitalization. Per nurse's notes, the urine in the catheter bag remained documented as symptomatic and cloudy throughout the antibiotic therapy with Augmentin, further indicating resident was not being monitored as required with antibiotic therapy and infection. On 4-11-07 the facility received the lab results indicating further Augmentin therapy was not effective for R2's UTI. There is evidence that facility nursing staff failed to inform the physician and get a more appropriate antibiotic. There is also evidence that physician was not notified that the facility stopped the previous Augmentin order for 2 doses when the drug was not available, also complicating the infection outcome for R2. Findings include: R2 has diagnoses including COPD (Chronic Obstructive Pulmonary Disease), Cerebro Vascular Accident, Left Above the knee Amputee, Right below the knee amputee, Peripheral Vascular Disease, and Diabetes Mellitus.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 19 Review of POS (Physician Order Sheet) on 04/05/07 reflects that R2 has an order for "CBC in AM, CMP and Pre-albumin." Lab result reported 04/6/07 indicated that R2's WBC (White Blood Count) was 26.9 C (Critical) (4.8- 10.8 reference range) and was called to E4 (Nurse) on 04/06/07 at 11:25 AM. Nurses notes dated 04/06/07 at 6:30 PM reflect "CBC result was reported to Z2 (Physician covering for Z1, the attending physician of R2) N.O. (New order) noted and carried out. (pls. see POS)." Review of POS dated 04/06/07 reflects that Z2 gave an order for UA (urinalysis) / C & S (Culture and Sensitivity) and started the Augmentin 875 mg. / G- tube BID x 10 days as a direct response to the CBC results. MAR (Medication Assessment Record) reflects that Augmentin was started on 04/06/07 at 4:00 PM. 04/07/07 8AM and 4PM was circled - NA (not available) so it was not given. There is no evidence physician was notified. Then the facility resumed giving the antibiotic Augmentin on 04/08/07 to 04/17/07. Review of UA (urinalysis) report dated 04/06/07 reflects: Appearance: cloudy (Reference range - clear). Protein: greater that 300 (Reference range - negative). WBC: greater than 50 (Reference range - 0-5) /hpf. Bacteria: moderate (Reference range - none seen).	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 20 When interviewed on 05/31/07, E3 ADON (Assistant Director of Nursing) stated that the facility received above UA result on 04/07/07. Facility received the urine culture result on 04/11/07 which reflects: Colony count greater than 100,000 col/ml ESCHERICHIA COLI. Colony count greater than 100,000 col/ml ACINETOBACTER BAUMANNII. Urine susceptibility result reflects: Organism---COLONY COUNT: greater than 100,000 COL/ML ESCHERICHIA COLI. AMPICILLIN/ SULBACTAM - Resistant. The facility did not notify Z1 of the lab result that reflected the organism being treated is resistive to Ampicillin which is the same type of antibiotic as was being used on R2. As a result, the urine culture done on 04/20/07 continued to have the same type of organism with the same resistance showing treatment ineffective for this resident's infection. Review of lab report dated 04/20/07 for urine culture reflects: Colony count greater than 100,000 col/ml ESCHERICHIA COLI. Colony count greater than 100,000 col/ml ACINETOBACTER BAUMANNII. Urine susceptibility result reflect: Organism---COLONY COUNT: greater than 100,000 COL/ML ESCHERICHIA COLI. AMPICILLIN/ SULBACTAM - Resistant. Review of nurses notes reflect the following:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 21 -On 04/15/07 2 PM - ABT (Antibiotic) in progress for WBC. Awaiting call back from MD (Physician) re: recent U/A C &S. -04/16/07 2AM- T- 99.6 ABT in progress with no adverse reaction noted. Indwelling catheter with cloudy urine to gravity drainage bag. -04/18/07 10:15 AM- nurses notes reflect "Z1 (Attending Physician) here & visited with resident. MD made aware of 04/06/07 & 04/13/07 lab results. New order to push oral fluids & urine C&S S/P ABT. Rx. Last dose of ABT 04/17/07." -04/20/07 2AM- Urine C/S S/P ABT for UTI collected from indwelling catheter port via aspiration. -04/25/07 12 AM - T 99.2. Indwelling catheter patent to gravity drainage bag with cloudy yellow urine noted. -04/27/07 2:15 AM - Temp. 102. Tylenol 650mg given via G-tube. Will recheck temp. 6 AM - T 99.2 10:30 AM- V/S taken. Resident noted with 103.6 (A) temp. Pulse 116 - R18 B/P 170/80. Resident easily aroused when named called. POA (Z3) called voiced concerns of high temp.. Informed Tylenol 650mg via G-tube given and MD will be contacted. 12:15 PM- Contacted Z4 (physician covering for Z1). Informed on resident status received order to send to hospital for eval. R2's admitting diagnoses were Renal Insufficiency and Urosepsis. When interviewed, E3 ADON (Assistant Director of Nursing) stated that they received the 04/20/07	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 06/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 22 culture result on 04/23/07. Review of nurses notes does not reflect that physician was notified of the lab result for 04/20/07. When interviewed on 05/31/07 at 2:50 PM, E4 (Nurse) stated that Z1 is aware that R2 is resistant to the antibiotic. E4 further stated that on 04/18/07 the lab results dated 04/06/07 and 04/13/07 were shown to Z1 who ordered to push fluids and to re-culture R2's urine. On 05/31/07 at 3:10 PM surveyor asked Z1 if the facility made him aware of lab results and R2's resistance to Augmentin. Z1 stated "No, and if I was made aware, Why not change it or discontinue the order. I'm not stupid." The result of non-notification of physician and lack of timely assessment resulted in R2 having a urinary tract infection identified from 04/11/07 until 04/27/07 when R2 was sent to the hospital with a diagnosis of Renal insufficiency and Urosepsis. (A)	F9999		