DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145939	A. BUILDING ______ B. WING ______	C 06/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

(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 314	Continued From page 6 and medications in a timely manner in accordance with physician's orders; 3) a review of the Facility's policies and procedures, as revised, on decubitus prevention and treatment; 4) a review of when reassessments are warranted. IV. How corrective actions will be monitored. - The Director of Nursing will monitor for overall compliance by her own rounds, general supervision, reports from nurses and documenting Weekly Wound Report. - The Facility will develop a QA program to monitor that daily and weekly skin checks are completed in a timely manner and that appropriate interventions are in place such as doctor's orders, preventative skin care, etc. - A QA program will be initiated where the Director of Nursing and/or her designee will monitor treatments and treatment nurses and review Weekly Wound Reports. Although the Immediate Jeopardy was removed on 6/13/07, based on completion of staff inservicing, the facility remains out of compliance at a severity level 2 to allow for implementation of all of the above responses and time for the facility to evaluate the efficacy of their interventions.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)5) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 7	F9999		

b)5) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Requirements were not met as evidenced by:

Based on record review and interview, it was determined the facility failed to ensure that R4, who developed a pressure sore, received the necessary care and treatment to promote healing and prevent infection. The infection ultimately resulted in R4's hospitalization and death.

Findings include:

R4 was admitted to the facility with diagnoses that included Hypertension, Osteoarthritis, Left Knee Contusion and Dementia on 11/16/06. She was hospitalized on 2/15/07 with bilateral Deep Vein Thrombosis and was readmitted to the facility on 2/26/07. At the time of readmission there was no nursing documentation/assessment to indicate that the resident had a pressure ulcer on her sacrum. The physician order sheet for readmission also did not contain any treatment orders. There was a physician's order for 2/27/07 which included treatments for the right inner heel

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F9999	Continued From page 8	F9999		

and left inner heel, and an over the counter ointment for the buttocks daily and PRN (as necessary). There was no order or identification for any treatment of a sacral wound.

The first mention of a sacral wound was in the nurses notes on 3/12/07 where it was documented as "2 openings to sacral and right upper buttocks." According to the nurses notes orders were received. The nurses notes document on 3/14/07 that the physician was notified that the wound reported on 3/12/07 as a Stage II wound was now a Stage IV.

On interview, E2 (Director of Nursing) stated that the facility does not keep a wound care log to baseline wounds; they only have the individual resident records. R4 developed the sacral decubitus ulcer in the facility.

Review of the "Pressure Sore and Skin Care Weekly Flow Sheet" for R4 documented that on 3/12/07 the resident had a Stage II sacral wound described as superficial and measuring 2.0 x 2.0. The next entry was dated 3/14/07 (2 days later) and the wound now measured 4.2 x 4.0 and was stated to be a Stage IV. There was no further documentation or description on this wound after 3/14/07 (3/15/07 to 3/29/07).

No evidence was found to show the facility implemented care to monitor and prevent further wound breakdown.

On 3/29/07 R4 was hospitalized with diagnoses including Septic Shock related to an infected sacral decubitus ulcer. The resident expired in the hospital on 4/1/07. The autopsy report stated the Immediate Cause of Death as, "Bacterial

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F9999	Continued From page 9 Septicemia secondary to infected stage IV sacral decubitus ulcer." On interview on 6/12/07 Z3 (physician of R4) stated that he visited the resident in the facility during her stay and that on occasion he found her laying in stool. He also stated that her treatments were not being done as they were ordered. (A)	F9999		