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REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

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F 314	Continued From page 16 All nursing staff was also in-serviced on the new standing order policies by the DON 1/15/08. All skin care plans have been reviewed and updated by the MDS coordinator 1/15/08. They will be reviewed as needed and quarterly by the MDS coordinator. Admission nurse will be completing the admitting Braden Scale. Thereafter the treatment nurse will check weekly for the first month for all new admissions, and then quarterly. This set of policies and procedures will be monitored by the administrator and the DON for effectiveness and reported to the QA committee every 30 days for the next 3 months. Based on the results, the QA committee may recommend adjustments to the policies and/or procedures.	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)2) 300.1210b)5) 300.1220b)7) 300.3220f) 300.3240a) 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,	F9999		

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F9999	Continued From page 17 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 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 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) 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.	F9999		

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F9999	Continued From page 18 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 7) Coordinating the care and services provided to residents in the nursing facility. 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 requirements are not met as evidenced by: Based on observation, record review and staff interview, the facility failed to: 1) Identify new and or recurrent pressure sores (R1, R3, R4) 2) Treat existing pressure ulcers with current treatment orders (R1, R2, R4, R5, R6, R7) 3) Provide appropriate preventive measures to prevent pressure ulcers (R6) 4) Accurately assess and care plan for residents identified with pressure ulcers and at risk for pressure ulcers (R1, R2, R3, R4, R5, R6, R7) 5) Notify the physician in a timely manner of	F9999		

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F9999	Continued From page 19 positive wound culture results (R2) This failure was a systematic failure. Three (R1, R3, R4) residents were noted with new and recurrent pressure sores unidentified by the facility. Seven residents (R1-R7) did not receive treatment to existing pressure ulcers according to current treatment orders. One resident (R6) did not have appropriate preventive measures in place to prevent ulcers. Seven residents (R1-R7) were not accurately assessed and care planned for pressure ulcers. The facility failed to notify the physician in a timely manner of positive wound culture results for one resident (R2). Findings include: 1) R1's diagnoses include Diabtes Mellitus and Encephalopathy, and R1 is ventilator dependent. R1 was readmitted to the facility on 1/2/08 after hospitalization for Fever and Congestive Heart Failure. Documentation in nurses notes by E6 (treatment nurse) titled wound assessment dated 1/3/08 assessed R1's wounds as the following: Right scapula skin tear 2 cm x 2 cm x 0.1 pink with serous drainage: Lower back sacral area Stage IV 8 cm x 10 cm x 2.0 with undermining at 2:00 PM with 95 % granualation, with 5% slough with serosanginous drainage noted from sacral area: Right lateral leg 6 cm x 3.5 cm x 0.1 cm slightly irregular: Right dorsal foot 1 cm x 2 cm: Right anterior ankle 3 cm x 6.0 cm Right leg 5 multiple skin tears no drainage noted: Left multiple skin tears no draingage.	F9999		

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F9999	Continued From page 20 Bilateral heels pink in color. Old decubti noted healed. Will obsereved closely for breakthrough. Review of R1's Treatment Administration Record dated 12/1/07-12/31/07 pulled from the treatment book by surveyor on 1/8/08 at 11:00 AM revealed the following treatments were being provided to R1: left posterior lower leg cleanse with normal saline apply tegaderm every three days; rt. anterior leg cleanse with normal saline apply tegaderm every three day and prn sacral area cleanse with normal saline apply algiste to sacrum daily. Surveyor observed E6 coming out of a resident room and surveyor asked E6 if treatment had been completed on R1. E6 stated no. Surveyor pointed out to E6 the treatment sheet had been signed out on the 3rd, 6th and pre-signed for the 9th. Surveyor asked why the 9th was already signed. E6 responded, I probably made a mistake on the date. On 1/3/08 the following treatment orders were obtained: Sacral area cleansed with wound cleanse and apply Maxsorb cover with dry dressing every 24 hours. Rt. anterior ankle cleanse with normal saline apply foam and dry dressing every other day. Left anterior ankle cleanse with normal saline and Tegaderm every other day. Bilateral heels cleanse with normal saline foam dresssing with rolled bandage every 3 days. Surveyor requested E2 (DON) make rounds with surveyor to observe R1's wounds. At 11:40 AM on 1/8/08 surveyor made the following	F9999		

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F9999	Continued From page 21 observations: left posterior lower leg with tegaderm dressing in place dated 1/3/08. Right lateral leg with a tegaderm dressing dated 1/3/08 with a pool of green drainage under the tegaderm. A dressing on right anterior foot. No dressing to the sacral area, right shoulder and upper back. On 1/4/08, E6 documented the following assessment in the nurses notes: left ankle, left big toe, right lateral leg, right dorsal foot, left foot and right ankle. All of these areas resolved. See per wound team. Resolved these areas. Will continue to monitor for breakthrough. Review of Z1(Wound Consultant notes) dated 1/4/08 denote the following assessments of the wounds with the recommended treatment: Lower back-Stage IV- 8.0 cm x 10.0 cm x 2.0 cm. with undermining at 1.7 cm at 2:00 PM. Cleanse wounds well with 0.9 Sodium Chloride. Pack wound #1 wound loosely with 0.5 % betadine /normal saline solution. Cover with sterile dressing change every 2 days and prn with soiled or 50% saturated. Do not allow packing to dry. Review of January 2008 treatment record lacked documentation that the treatment for the sacral wound was done. Review of previous wound assessment done on 12/18/07 indicates R1 did have the following wounds: Stage IV lower back 8.0 cm x 10.0 cm x 2.0 cm. Stage II-right lateral leg 6.0 cm x 3.5 cm. Stage II-right dorsal foot 1.0 cm x 2.0 cm. Stage II- right anterior ankle 3.0 cm x 6.0 cm.	F9999		

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F9999	Continued From page 22 The recommendations were to cleanse wounds well with 0.9 Sodium Chloride. Pack wound #1 loosely with 0.5 % betadine/Normal Saline solution, cover with a sterile dresing and change dressing every 2 days and as necessary (prn). Do not allow packing to dry. Apply duoderm or equivalent to each of the other wounds every 3 days and prn if soiled or 50% saturated. These recommend treatments were not documented on the December 2007 Treatment Administration Record. On 1/15/08 at 9:30 AM surveyor reviewed R1's treatment records with Z1 (wound consultant). Z1 stated he does not routinely see Stage II wounds and does not recommend Tegaderm on wounds. Z1 stated he does not recall seeing the wound on R1's right lateral leg even though an assessment by Z1 was completed on 1/4/08. Surveyor asked Z1 why he had left the facility on 1/8/08 after surveyor arrived in building. Z1 stated E6 had told Z1 to leave so "She can clean her cart and get ready to do rounds with the surveyor." Surveyor asked Z1 if R1 did not receive the appropriate ordered treatment would that affect the healing process. Z1 stated "It could delay the healing process." Review of R1's care plan dated 10/2/07 does not address the multiple wounds R1 has had or recommended treatments or changes in wounds. R1 was sent out to the hospital on 1/9/08 for abdominal distention and possible Gastrointestinal Bleed. R1 did not return to the facility during the investigation. 2) R2's diagnoses include Diabetes Mellitus, Cerebral Vascular Accident and Multiple	F9999		

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F9999	Continued From page 23 Decubitus Ulcers. R2 is vent dependent and needs total assistance with Activities of Daily Living. During tour with E2 (DON) on 1/8/08 at 11:40 AM surveyor observed R2 lying in bed. Surveyor observed dressings dated 1/4/08 on R2's bilateral ankles. Surveyor requested to check R2's sacral area. Upon observation, surveyor noted R2 lying in stool that had seeped through staining a lap pad and sheets. A sacral dressing was in place undated and soiled. Surveyor asked E8 (assigned CNA) if he was aware that R2 was lying in stool. E8 stated he did know, had not given R2 AM care yet and was just getting ready to clean him up. R2 is seen by Z1 for chronic wound care every week . Review of R2's wound assessments by Z1 dated 1/4/08 reveal the following: Stage IV-right lateral maleolus- 1.8cm x 3.0 cm x 0.3cm Stage II-right anterior ankle- 2.3cm x 4.1cm x 0.1cm Stage IV left heel-1.5 cm x 2.2 cm x 0.2 cm Stage IV left lateral maleolous- 4.0cm x 2.5 cm. x 0.2 cm with undermining 1.5 cm @ 4:00 Stage IV lower back-6.5 cm x 6.0 cm x 0.3.5 cm with central skin island of skin present -undermining 3.5 cm @ 3:00 Stage III-right lateral calf - 2.5 x 4.1 x 0.2 The following wound treatments were ordered by Z1 on 1/4/08: Cleanse all wounds well with 0.5% betadine/normal saline solution, loosely pack all wounds with sterile gauze soaked in 0.5% betadine solution and cover with a sterile	F9999		

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F9999	Continued From page 24	F9999		

dressing every other day (qod) and prn. Change any dressing that becomes soiled or 50% saturated. Do not allow the packing to become dry.

Z1 stated per phone interview on 1/10/08 that after he does the wound assessments he gives a copy of the treatment orders to E6 (treatment nurse).

Review of R2's January 2008 Treatment Administration Record denotes R2 was receiving the following treatments: cleanse then apply silvadene with dressing two times daily, to the sacral area and bilateral ankles. There was no treatment documented for R2's left heel or right lateral calf. Further review of the treatment records lacked documentation that any treatments had been done since 1/4/08.

A wound assessment done by Z1 on 1/11/08 revealed R2's right lateral maleolus had in increased in size from 1.8 x 3.0 x 0.3 on 1/4/08 to 2.0 x 1.7 x 0.1 cm in size, and lower back (sacral) had increased in size from 6.5 cm x 6.0 cm x 0.35 cm on 1/4/08 to 7.5 cm x 7.0 cm x 3.0 cm.

Z1 stated in interview on 1/15/08 that he was unaware that R2 was not receiving the ordered treatments until prompting by surveyor. Z1 stated that the current treatments not being followed would cause a delay in healing of wound or worsening of wounds.

Review of R2's care plan identified the care plan was last updated 7/07 and did not address changes in R2's wounds or recommended treatments.

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F9999	Continued From page 25 Upon further record review, R2's physician was not notified of the results of a sacral wound culture which revealed a heavy growth of Escherichia coli until 1/4/08, four days after the facility received the positive culture results (12/31/07). R2's physician requested the results be reported to Z2 (wound specialist). An order for Clindamyicin 300mg four times day for 10 days was obtained on 1/4/08. 3) R3's diagnoses include Diabetes Mellitus, Arthritis and Clostridum Difficile. Review of R3's Mininum Data Set dated 10/16/07 reveals R3 required total assistance with activities of daily living and was also assessed as having no pressure ulcers. On 1/8/08 at 2:45 PM, surveyor requested to do wound check on R3 with E4 (LPN). Surveyor had copies of R3's treatment record from E2 (DON) and referred to those during the wound observation. During the observation R3 was observed to have a soiled dressing with foul smelling odor to the right hip area dated 1/4/08. Review of December 2007 MAR revealed a treatment ordered 12/22/07 to cleanse with normal saline and apply hydrocolloid every day was to be every 3 days. The treatment was not documented on 12/22/07 or 12/25/07. Review of wound description sheet done by Z1 revealed the following assessment on 1/4/08: right hip healed. Surveyor then had E6 do complete body check to see if any of the following treatments were in place according to MAR to the following areas: Right arm-left arm cleanse with normal saline and apply triple antibiotic ointment (TAO) wrapped (QOD) no treatment signed from 12/28/07-12/31/07. There was no dressing to the	F9999		

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F9999	Continued From page 26 right/left arm. There was no documentation on the December 2007 MAR that treatments to cleanse left 3rd toe with normal saline and apply 0.5 % betadine solution daily had been completed from 12/23/07-12/31/07. Right knee-apply TAO every other day with dry dressing. There was no dressing in place to the area. MAR lacked documentation this treatment was done from 12/28/07-12/31/07. The January 2008 MAR lacked documentation that the following treatments were completed: lower back, cleanse with wound cleanse apply 0.5% Betadine daily and prn. There was no signature 1/5, 1/6 and 1/7 until prompting by suveyor on 1/8/08. Right knee cleanse with normal saline paint knee with 0.5% Betadine every other day and prn. No signature on TAR that treatment was completed from 1/4/08 until prompted by surveyor on 1/8/08. Left hip cleanse with normal saline dry dressing border gauze every other day and prn. No documentation treatment was done 1/4/08 through 1/8/08 upon prompting by surveyor. On 1/15/08, the surveyor requested Z1 do a wound asssessment on R3. E2 was present during the observation. Z1 removed a dressing from the right hip and stated the wound had reopened measuring 7.0 cm x 5.3 cm, 30% eschar and 20% slough with 50% granulation. Z1 stated he was unaware of the wound reopening. Z1 also stated that a satellite lesion measuring 1cm x 2.5 cm opened at 5 o'clock. Z1 denoted the right hip and left hip wound had a malodor and stated he would start an antibiotic. There was no documentation that R3's physician	F9999		

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F9999	Continued From page 27 had been notified of the right hip wound re-opening. Review of the MAR's for January reveal the ordered treatments were not followed. Review of facility wound care sheet did not identify R3 on the pressure ulcer report with pressure ulcers, only as a laceration to scalp. There was no care plan interventions implemented for R3's wounds. 4) R4's diagnoses include Cerebral Vascular Accident (CVA), Diabetes Mellitus and Psoriasis. R4 is totally dependent upon staff for activities of daily living. On 1/8/08 surveyor reviewed R4's TAR. An order for Mystatin cream to rash was noted twice daily. There was no documenation the treatment was done on 1/5/08 and 1/6/08. Surveyor requested E2 and E6 to do a skin check on R4. Surveyor observed R4 lying in bed. Upon staff turning R4, surveyor observed blood on R4's sheets. Surveyor observed an open area to left hip/buttock area, and right hip area. E6 identified these areas as Stage II wounds. E6 stated she was unaware of the openings of these wounds. Record review revealed R4 had history of previous wounds and was at risk due to excoriation over buttock and history of exema. On 1/14/08, E2 provided documentation "nurses concern sheet" dated 1/2/08 that staff observed R4's buttocks pink and extremely dry. Staff was instructed to apply barrier creme until treatment nurse comes. There was documentation the physician was called for an order for skin cream but facility was awaiting a call back. There was no further documentation the physician was notified or the treatment nurse was notified of	F9999		

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F9999	Continued From page 28 R4's skin breakdown on 1/2/08. Documentation dated 1/6/08 on the nurse concern form denoted staff was informed of R4's skin breakdown to the left buttocks and coccyx area. Staff documented a wet to dry dressing was applied to the coccyx area and Mystatin was applied to area. There was no documentation R4's physician was notified of the skin breakdown and there was no order for the wet to dry dressing applied to R4's coccyx. There was no assessment of R4's wounds. Documentation dated 1/7/08 denoted staff (E6) was made aware of R4's skin breakdown. There was no documentation R4's physician was notifed. E6 also stated on 1/8/08 that she had not worked on 1/7/08 and was not aware of R4's skin breakdown. Treatment orders were obtained on 1/8/08 for the following wounds: left buttock, right trochanter, and left ischium. A wound assessment done by Z1 on 1/11/08 revealed the sizes of R4's wounds: excoriation to buttocks closed at present Stage 2-right buttock- 5.0 cm x 0.5 cm x 0.1cm Stage 2-left buttock -3.5 cm x 4.0 cm x 0.1 cm Stage 2- left medial leg 1.5 cm x 1.0 cm. Scant serosanguinous drainage noted from wounds 3, 4, 5. 5) R5's diagnoses include Hypertension and Cerebral Vascular Accident, and R5 is ventilator dependent. Review of R5's MDS of 10/10/07 assessed R5 as totally dependent upon staff for activities of daily living.	F9999		

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(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 29 On 1/8/08 at 11:35 AM surveyor with E2 in attendance observed R5 in bed with dressing to left foot dated 1/4/08. Review of R5's January TAR revealed an order to cleanse left lateral foot with normal saline, apply Betadine with dry dressing every three days. Documentation on the TAR denotes treatments were done on 1/3/08 and 1/6/08. The dates are inconsistent with the dated dressing on R5's left foot. A wound assessment by Z1 done on 1/4/08 revealed the left lateral foot wound is unstageable measuring 0.7 cm x 1.0 cm and the left 5th metatarsal wound is unstageable measuring 4.0 cm. x 1.5 cm. The treatment ordered was to cleanse wounds with 0.9 Sodium Chloride and paint daily with Betadine. Leave open to air. There was no change of a treatment order on the Treatment records as recommended on 1/4/08. The treatment record indicated the same treatment was given on 1/9/08, four days after the recommendation. There was no care plan intervention for R5's wounds. 6) R6's diagnoses include Hemiplegia and Cerebral Palsy. On 1/8/08 R6 was identified by E4 as having a pressure ulcer. R6 was observed lying in bed watching TV. R6 was asked by surveyor if a wound check could be done by E4 and R6 agreed. An open wound was noted to left ischium. There was no dressing on the wound. Surveyor asked R6 how the wound felt and R6 stated it "hurts like hell." R6 stated it has been a couple of days since he has had a dressing in place. Review of nurses notes dated 1/2/08 document a wound assessment done by E6 assessing a wound to the right ischium 3.7 cm x 2.6 cm x 0.2	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2008

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F9999	Continued From page 30 cm with wound base 85% slough with redness with periwound redden. New treatment orders in place. Review of Physician Telephone Orders reveal an order to cleanse right ischium with normal saline apply hydrocolloid every 3 days. Review of R6's wound assessment done by Z1 on 1/4/08 assessed the left ischium wound as a Stage 3 measuring 6.0 cm x 3.5 cm x 0.1 cm. Treatment orders were to cleanse wound well with 0.9 Sodium Chloride, pack wound loosely with 0.5% betadine/normal saline solution cover with a sterile dressing and change every 2 days and prn when soiled or 50% saturated. Do not allow packing to dry. Review of R6's TAR documents a treatment was done on 1/4/08. The treatment was to be done every 2 days or prn. There was no documentation the treatment was done on 1/6/8 or 1/8/08 as ordered. R6's MDS did not identify R6 as having wounds and there was no current care plan addressing R6's wounds. Review of R6's Braden Scale of 5/5/07 assessed R6 as a mild risk for pressure ulcers and on 8/23/07 and 1/2/08 R6 was reassessed as severe risk (6). There were no interventions care planned with R6's change in skin condition until after prompting by surveyor. R6 had not been assessed for a pressure relief mattress. 7) R7 was identified by E4 as having a pressure ulcer on 1/8/08. R7 was admitted to facility on 11/23/07 with diagnoses including below the knee amputation right lower extremity and Organic Brain Syndrome. Review of transfer sheet from acute care hospital denotes R7 as having a Stage I pressure ulcer on right midbuttock with flat redness. Allevyn dressing	F9999		

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F9999	Continued From page 31	F9999		

applied. Review of facility record lacks documentation of an initial Braden Scale done on R7. R7's initial MDS assessed R7 as a zero for pressure ulcers.

R7 was identified by E4 as having a pressure ulcer. E4 stated the wounds are done by E6 (treatment nurse). Surveyor requested to do a wound check on R7 on 1/8/08 at 2:55 PM. Surveyor observed an open area to right inner buttock and reddness to left buttock. There was no dressing in place to right inner buttock.

Nurses notes dated 12/28/07 document an assessment by E6 of a wound to right inner groin area measuring 3.5 cm x 2.1 cm x 0.1 cm Eschar 25% noted. Treatment orders in place. Review of R7's TAR for January 2008 obtained on 1/8/08 reveal a treatment order to cleanse with normal saline apply Hydrocolloid every 3 days. The only documented date on the January TAR was signed off on 1/1/08, with no further documentation that treatments were done.

A second copy of the R7's TAR obtained on 1/9/08 indicated a treatment was signed off on 1/4/08 and 1/9/08 after the surveyor obtained the 1st copy of the TAR. Surveyor reviewed findings with E1 and E2 during daily status and no further information was obtained regarding the signed treatment of 1/4/08.

There was no reassessment of R7's wound after the observation made by the surveyor. Surveyor still had not received reassessment of R7's wounds as of 1/15/08.

E2 stated in interview on 1/8/08, the dressings were removed in preparation for the wound

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F9999	Continued From page 32 consultants rounds. Surveyor informed E2 again that multiple old dated dressings were observed on residents, there was lack of documentation of treatments, and lack of assessments for wounds. Review of facility pressure ulcer list requested upon entrance on 1/8/08, was not current and updated as far as identified residents in the facility with pressure ulcers. The pressure ulcer list was dated 12/14/07. On 1/9/08 the surveyor was informed by E1 the treatment nurse (E6) had notified her on 1/9/08 that she resigned from her position as the treatment nurse. (A)	F9999		