STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ____ B. WING ____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 325	Continued From page 18 consume at least 50% of 2 meals. On 11/15/11 at 12:30 PM E2, Director of Nursing (DON) said, we should have followed through on the dietary recommendations. R4 was observed propelling his wheelchair with his feet in the hallway on 11/14/11. R4 appeared pale, thin, and frail.	F 325		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)3)4)A)5) 300.3240a) 300.7020a)1)2)F)4) 300.7020b)1)2)3)4)5)6)7) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

(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	F9999		

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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	F9999		

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) 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.
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment 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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

(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	F9999		

Section 300.7020 Assessment and Care Planning
a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission.
1) Assessments shall include at least a behavioral and a functional assessment, as well as direct observations of the resident. The facility shall attempt to interview the resident, the resident's family, the resident's representative, and recent and current direct care givers. This attempt shall be documented.
2) Assessments shall include at least the following:
F) adaptive equipment or activities that allow the resident to function at the highest practical level.
4) The assessment process shall be ongoing by direct care staff or other professionals, as needed, and shall include the assessment components in subsection (a)(2).

b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 1) The care plan shall be ability centered in focus (see Section 300.7030) and shall define how the identified abilities, strengths, interests, and preferences will be encouraged and used by addressing the resident's physical and mental well-being; dignity, choice, security, and safety; use of retained skills and abilities; use of adaptive equipment; socialization and interaction with others; communication, on whatever level possible (verbal and nonverbal); healthful rest; personal expression; ambulation and physical exercise; and meaningful work. 2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan. 3) The resident's care plan shall be reviewed by the unit director 30 and 60 days after the initial care plan's development and shall be modified, as needed, with the participation of the interdisciplinary team. 4) The care plan shall be reviewed at least quarterly. 5) All appropriate staff shall have access to and shall use the information in the care plan in order to integrate the care plan into the daily care of the resident. 6) The care plan shall be implemented and followed by staff who care for the resident. 7) Revisions may be made to the care plan at any time, with input from the resident, resident's family, and resident's representative, the care coordinator, and, if appropriate, the physician. These requirements were not met as evidence by: Based on observation, interview and record review the facility failed to identify and treat	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

(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 23	F9999		

pressure ulcers to resident's heels prior to the wounds becoming Unstageable. The facility failed to identify a pressure ulcer to a resident's coccyx prior to a Stage II. The facility failed to inspect the skin under a splint device and failed to identify specific risk factors and develop a prevention plan for R15. The facility failed to prevent pressure ulcers to the right calf and ankle under a splint device and failed to consistently off-load pressure to R15's heels. The facility failed to follow their wound management policy by not conducting quarterly skin risk assessments for R15.

These failures resulted in R14 developing an unstageable pressure ulcer to the left heel on 5/28/11. R18 developed an unstageable pressure ulcer to the left heel on 7/22/11. R15 developed pressure ulcers under the splint device on 8/10/11 and an unstageable pressure ulcer to the left lateral heel on 11/9/11.

This applies to 4 of 7 residents (R14, R15, R17, R18) reviewed for pressure ulcers in a sample of 19.

The findings include:
1. The Physician's Order Sheet dated 11/2011 shows that R14 has diagnoses including Osteoarthritis, Spinal Stenosis and Dementia.

The Minimum Data Set of 5/22/11 shows that R14 requires total assist of 2 staff for bed mobility.

The Nurse's Notes of 5/10/11 states, "(Nurse) in the ER reported that (R14) has a fracture of the left tibia/fibula." (R14 was involved in a motor vehicle accident while out of the facility with her husband and had been thrown out of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

(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 24	F9999		

wheelchair., causing the injury.) R14 returned to the facility on 5/10/11 with a soft cast in place.

The Nurse's Notes dated 5/27/11 states, "Bowel movement seeped down into splint and dressing. This writer entered (R14's) room to change dressing. After removal of splint and old dressing noted 18 x 18 cm dark brownish discoloration to left upper posterior thigh of unknown origin. Also noted a 4.0 x 2.5 x UTD (unable to determine)cm dark purple discoloration to left heel. Unstageable due to suspected deep tissue injury.....Resident is on complete bed rest at this time."

R14's Braden Scale for predicting pressure sore risk dated 5/23/11 shows that R14 scored a 12. (High Risk)

R14's care plan with a start date of 1/27/11 states, "Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences."

The undated facility policy entitled Pressure Ulcer Risk Assessment Policy and Procedure states, "Based on the results of the Pressure Ulcer Risk Assessment, all residents AT HIGH RISK for pressure ulcer development will receive a documented daily visual inspection of their skin by the RN/LPN or CNA delivering care. All other residents will have a documented weekly review of skin condition utilizing the CNA Skin Attention Form.."

2. R15's November, 2011 Physician's Order Sheet documents that R15's diagnoses includes Dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

(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 25 R15's Minimum Data Set (MDS) assessment of 9/14/11 shows that R15's cognitive summary score is 05. (00 - 07 = Severe Impairment) R15 is totally dependent on one person for bed mobility. R15 is dependent on two or more persons for transfer .R15 has functional limitation in range of motion of both lower extremities. R15 is incontinent of urine and bowel. The same assessment shows that R15 has a fracture. R15's Braden Scale Assessment of 4/1/11 documents a score of 12. (12 or less = high risk) (Last documented skin risk assessment) R15's Nursing Notes for 8/7/11 documents that R15's knee was extremely swollen and painful, with an area of redness to the medial aspect of the right knee. An occurrence report dated 8/8/11 documents that R15 had an x-ray of the right knee which showed a moderately displaced fracture of the distal femur. The same report shows that R15 returned to the facility from the hospital with a leg brace on. R15's Nursing Notes for 8/10/11 at 10:00 AM documents that R15 had a 1 cm x 1 cm (centimeter) red area on the posterior ankle that was under a right leg brace. The same note documents that R15's right leg brace did not fit properly because it was too big. R15's Nursing Notes for 8/17/11 at 8:00 PM, documents that R15 had an open area on the left lateral ankle. R15's Nursing Notes for 8/19/11 documents that	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 26	F9999		

R15 has 2 open areas on the right lower calf. One open area is described as 1 cm with a 6.5 cm open center. (This note describes the center wound opening as larger than the total wound surface)
The other area is described as 0.10 cm x 6.10 cm area of redness with a 0.4 cm x 0.4 cm open area.
On 9/28/11 at 9:00 PM the notes show : splint removed due to observed sores on posterior ankle and pedal edema on the top of the right foot. The splint had slid down till around the ankle and while up foot hanging over edge of splint caused rubbing to the posterior calf and impeded circulation. Dents running on the proximal to distal on the posterior leg matches the metal stays on the splint.

On 10/19/11 at 6:00 AM R15's Nursing notes shows that R15 has a 2.0 cc x 2.0 cm red area on her mid back.

On 11/9/11 Nursing Notes at 5:00 AM documents that R15 has unstageable necrosis (devitalized tissue) to the left lateral heel.

R15's current care plan for pressure ulcer dated 9/21/11 through 12/19/11 does not identify the use of a splint device or approaches for monitoring the skin under the splint. The care plan does not document off loading pressure to R15's heels.

On 11/16/11 at 7:55 AM, R15 was observed in a high back wheel chair with her feet resting on the foot rests, wearing quilted type boots to her feet. (Heels were not off-loaded.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ________ B. WING ________	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	811 WEST 2ND, PO BOX 585 BYRON, IL 61010

(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 27 According to the facility Wound Management Policy; At risk residents will be reassessed at least quarterly and additionally in the event that there is a significant change in physical condition. The policy does not include inspection of skin under splint/brace devices. 3. The Nurses Notes dated 7/14/11 for R18 showed, "R18 admitted to facility.... Right groin has new incision site with 4 staples, well approximated without signs and symptoms of infection noted at this time. Left groin has small bruise noted. Right inner knee area has 9 staples on new incision without signs and symptoms of infection noted; well approximated. Top of right foot at ankle area, R18 has new incision area with 6 sutures noted. Site well approximated also without signs and symptoms of infection noted at this time. Right great toe amputated with open wound dressing changed to area so wound vacuum was started earlier. 3rd toe - right, has open area to tip of toe, right side. Area cleansed with new dressing applied. Slight yellow drainage noted to toe wound. Buttocks and coccyx area slightly red." The Physician Progress Notes dated 7/20/11 for R18 showed, "R18 is here for rehabilitation. He had a traumatic amputation of his great toe for gangrene. He currently has a wound vacuum. During his hospitalization he had a right popliteal to dorsalis pedis bypass to hopefully resolve some of the circulatory problems to his foot. R18's Nurses Notes dated 7/22/11 showed, "Physical Therapist brought to this nurses attention that resident had a small amount of drainage on sheet under his left heel. Upon	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 28 — F9999

further examination, noted 2cm by 2cm open area to left heel. Border of wound is irregular in shape and has a grayish/white center. Heel protectors initiated. Attempted to call nurse practitioner to report unstageable pressure ulcer to left heel."

The Physician's Orders dated 7/22/11 for R18 showed, "Heel protectors on at all times. Left heel - Betadine twice a day."

The Wound Care Center Note for R18 dated 8/4/11 showed, "Use/wear when in bed: Pressure relief boot when in bed."

On 11/16/11 at 10:55am, E10 (Wound Care Nurse) stated, "I am here for 8 hours per week to do treatments. I rely on everyone to make sure interventions are in place and effective."

The facility's Skin Assessment Policy showed, "Upon admission to the facility the following will be assessed: Risk for developing pressure ulcers using valid assessment of pressure ulcer risk. General skin condition. History of ulcers and skin condition. Current ulcers.; On admission, a head to toe assessment of the resident's skin will be completed by a licensed nurse along with the admission nursing history. Residents' who are determined "At High Risk" for the development of pressure ulcers will have a head-to-toe skin assessment done by a licensed nurse or CNA (Certified Nursing Assistant) daily and documented on the Daily Skin Assessment record or the Treatment Administration Record (TAR).; All residents, regardless of risk, will have a documented weekly review of skin condition utilizing the CNA Skin Attention Form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 The Skin Assessment Sheet dated 7/21/11 for R18 showed, "No new issues. See treatment record." The Pressure Sore Risk Score for R18 on 7/15/11 was documented on the form as a 19. A total score of 12 or less represents high risk. The Care Plan dated 7/14/11 for R18 showed, "Right groin has 4 staples; Left groin has bruises; Right upper calf (just below knee area) has 9 staples.; Right top of foot by ankle area has 6 sutures. Right great toe amputated with wound vacuum dressing.; Right third toe has open wound with puss.; Coccyx and buttock slightly red.; Approach: 7/22/11 - Betadine to left heel twice a day.; 7/23/11 - Wound treatment to wound bed on left heel. Apply Betadine around wound bed. Cover with dry dressing twice a day. Bactrim DS, 1 by mouth every 12 hours for ten days - wound infection." 4. On 11/16/11 at 10:45am, R17's gel cushion was observed to be flattened out. E10 (Wound Care Nurse) was present and confirmed the observation. R17's Nurses Notes dated 7/8/11 showed, "Noted abrasion to R17's coccyx measures 2.0 by 1.0 by 0.05cm with epithelial tissue noted. Scant serous drainage noted. Gel cushion in wheelchair." The Weekly Pressure Ulcer Report dated 7/17/11 for R17 showed, "Date Acquired: 7/8/11.; Facility acquired. Ulcer site: Coccyx.; Stage III.; Minimum Data Set (MDS) Stage: III.; Size: 4.0 x 1.5 x 0.1cm; &5% devitalized & 25% granulation.;	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 30 Serous exudate.; Slight odor." The Weekly Pressure Ulcer Report for R17 showed on 7/24/11 the coccyx wound was "unstageable." R17 continues to have the pressure ulcer to her coccyx and the Weekly Pressure Ulcer Report dated 11/13/11 showed, "Date acquired: 7/8/11.; Facility acquired.; Ulcer site: Coccyx.; Healing unstageable.; MDS Stage: Unstageable.; Size 0.6 x 0.2 by 0.2cm.; 100% granulation tissue." On 11/16/11 at 10:55am, E10 (Wound Care Nurse) stated, "I am here for 8 hours per week to do treatments. I rely on everyone to make sure interventions are in place and effective." The facility's Management of Wounds Policy showed, "Pressure Ulcers - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Pressure ulcers are staged to determine the extent of tissue damage. Treatment of the ulcer, dietary management, management of tissue loads and interventions to improve tissue tolerance to pressure, friction, and shearing forces are critical components.; Managing tissue load: It is the policy of this facility to manage tissue load and improve tissue tolerance to pressure, friction, and shearing forces. This will be accomplished through the use of appropriate positioning practices, positioning devices, and support services." R17's Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/12/11 showed short term memory impairment, long term memory impairment and cognitive impairment.; Extensive assistance required for bed mobility, transfer, dressing, toilet use,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145440	A. BUILDING ______ B. WING ______	**11/17/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEIGHBORS REHABILITATION CENTER, LLC	**811 WEST 2ND, PO BOX 585 BYRON, IL 61010**

(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 31 personal hygiene and bathing. (B)	F9999		