PRINTED: 05/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145975	B. WIN	IG		02/0	2/2012
NAME OF PROVIDER OR SUPPLIER  ROCHELLE REHAB & HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH 3RD STREET ROCHELLE, IL 61068			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F9999	FINAL OBSERVATI	ONS	F99	999			
	LICENSURE VIOL	ATION					
	300.1210d)5) 300.3240a)						
	Nursing and Persor d) Pursuant to substant to substant shall include, and shall be practic seven-day-a-week so head own shall be seven-day-a-week enters the facility we develop pressure sores were unavoid pressure sores shall services to promote and prevent new procession sources shall be serviced to promote and prevent new procession sources shall be serviced to promote and prevent new procession sources are procession sources and prevent new procession sources and prevent new procession sources are processed and prevent new procession sources are procession sources and prevent new procession sources are p	section (a), general nursing at a minimum, the following sed on a 24-hour, basis: In to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who sithout pressure sores does not ores unless the individual's emonstrates that the pressure lable. A resident having II receive treatment and e healing, prevent infection, essure sores from developing.					
	review the facility fa from occurring and promote healing. Tone unstagable pre pressure ulcers. The	on, interview, and record tiled to prevent pressure sores failed to provide treatment to his resulted in R18 developing ssure ulcer and eight stage II is applies to 2 of 8 residents and for pressure sores in the					

Facility ID: IL6008106

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING		<u> </u>		
		145975	B. WI	NG		02/02	2/2012
NAME OF PROVIDER OR SUPPLIER  ROCHELLE REHAB & HEALTH CARE CENTER				90	EET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH 3RD STREET OCHELLE, IL 61068		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F9999	Ulcers Risk form da and 11/11 show R1: developing pressure. The quarterly asses R18 is assessed as in bed mobility, hav pressure relieving and being on a turn R18's weight history. Monthly Weight show October 2011125. November 2011125. November 2011120. Tebruary 2012120. February 2, 2012120. Total protein/serum Albumin 3.1 (normal CBC with Differential Hemoglobin 10.8 (Hematocrit 36.1 (not The Respiratory/Cirshows R18 entire bedorders dated 1/12/Start Azithromycim tab PO QD times 5. Thick Duoderm on hours. Tylenol #3.1 tab PC.	cale For Preventing Pressure ated 6/08/11, 6/15/11, 9/11, 8 is at moderate risk for e sores. Sament dated 11/2011 shows a needing extensive assistance ing mild pain, having a devices in the chair and bed, ing /repositioning program. y as shown on the Report of the base a 7.6 pound loss: lbs. 23 lbs. lbs. lbs. lbs. ltr.4 lbs. results of metabolic panel5.4 (normal 6.0-8.0) al 3.5-5.0) al normal12.0-15.0) ormal 37.0-47.0) reculatory form dated 6/1/2011 auttocks were red. (12, 11:54 AM: 250 mg. 2 tabs today then 1	F99	999			

PRINTED: 05/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145975	B. WIN	IG		02/0	2/2012
NAME OF PROVIDER OR SUPPLIER  ROCHELLE REHAB & HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH 3RD STREET ROCHELLE, IL 61068			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	"1400-Resident has superficial open are Anatomy Assessme The Nursing Admis 1/25/2012 identifies superficial, ranging measurement.  The 2/2012 Physici mechanical soft dis supplement, 60ml.  The food tray card oz of whole milk, su and toast for break meal. Likes are list chops.  Dislikes are identified broccoli, carrots, monions, peas, spinated on 1/31/2012 at the bread, 1/4 of the 2 serving, none of the none of the oven brown of the oven brown of the super cereal on and results are consumed only bits super cereal) and results are results and results of the drank sips of the none of the 4 oz. serving her buttered by the super butter	es redness with several ea on coccyx area. See ent Sheet. " sion Assessment Sheet dated is 4 pressure sores, labeled from 2 cm. to 1.5cm. in  an Order Sheet shows regular et, whole milk, and 2 cal 3 times daily with meals.  identified foods to be served: 8 uper cereal, eggs, 1/2 banana, fast. Coffee and juice every ted as meat loaf and pork ed on the card as: beans, chili, ixed vegetables, spicy foods, ach, and lettuce. e noon meal, R18 ate bites of cal drink, none of 4 oz. milk e broccoli (on dislike list) rown potatoes or Italian melt. s of water and 1/2 cup of ute for broccoli was mixed	F99	999			

Facility ID: IL6008106

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  NG	(X3) DATE SU COMPLE	
		145975	B. WIN	NG _		02/02	2/2012
NAME OF PROVIDER OR SUPPLIER  ROCHELLE REHAB & HEALTH CARE CENTER				,	REET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH 3RD STREET ROCHELLE, IL 61068		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
F9999	cal. supplement.  2/2/2012 at the breat toast, bites of her sit cal. supplement. Regg, banana, or 4 or R18 was not served ordered per the tray. The January 2012 Moreon consumed: less than 25% of he between 25% and 5 out of the 93 meals.  R18 was observed AM, 9:30 AM, 10:10 N, 12:10 PM, 12:30 1:50 PM, 2 PM up leaking gel pad. Practical Nurse) ver been sitting on was over the seat of R18 On 1/31/2012 at 1:0 (Director of Nursing no pressure relieving alternating air mattrifunctioning.  On 1/31/2012 at 2:0 and E8 (Certified Ni into bed. On 1/31/2012 at 2:1 Nurse Aides) were considered.	was not served the 60cc of 2  akfast meal, R18 ate a bite of uper cereal and the entire 2 18 consumed none of the ex. serving of milk.  d 8 oz of whole milk or juice as a card.  Meal Intake Log shows R18  er meals 27 times 50% of her meals 30 times served.  on 1/31/2012 at 8:30 AM, 9 0 AM, 10:45 AM, 11:30 AM, 12 PM, 1 PM, 1:07 PM, 1:30 PM, in the wheel chair sitting on a At 2:04 PM E6 (Licensed rified the gel pad R18 had leaking, with gel noted all	F99	999			
		·					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145975	B. WIN	NG	<del></del>	02/0	2/2012	
NAME OF PROVIDER OR SUPPLIER  ROCHELLE REHAB & HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH 3RD STREET ROCHELLE, IL 61068				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	outer buttocks were The facility's Wound 1/25/2012 identifies pressure ulcers on On 1/31/2012 at 2: transparent Tegade cleaned R18's press E6 present showed pressure sores on a and one pressure some assuring 2.4 cm When questioned a was ordered E6 stathick Duoderm to the have a thick Duode working on this wind Duoderm on R18's On 3/31/2012 at 2: have any thick Duote our sister facility On 2/2/2012 at 10 // Care Nurse) confirm stage two pressure bed pad at time of the necrotic/eschar are The facility's May 2 Areas policy states treatment program being closely monit any pressure area is he be instituted."	8's peri area, inner thighs, and e not cleansed  d Tracking sheet dated at the left and right coccyx.  15 PM, E6 removed a thin erm dressing, measured and sure sores. Observation with the land around the coccyx area for with necrotic/eschar tissue to the type of dressing that the left and around the coccyx area for with necrotic/eschar tissue to the type of dressing that the left is ordered to receive the pressure sores. We do not the land around the type of dressing that the left is ordered to receive the pressure sores. We do not the land the l	F99	999				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145975	B. WI	NG _	·····	02/0	2/2012	
NAME OF PROVIDER OR SUPPLIER  ROCHELLE REHAB & HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH 3RD STREET ROCHELLE, IL 61068				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	including Periphera Minimum Data Set assistance of 2 perposition the body w R5's Wound Tracki ulcer of the left side 1/6/12. On 1/30/12 developed on the lemeasurements not minimal drainage.  On 1/31/12 at 2:25 Nurse), measured the Cm. E6 stated, "I dme, so I would gue cm. The treatment normal saline and a On 1/31/12 at 1:35 hurts me." A dark rachilles tendon area was observed the dark red spot as from R5's shoe pre R5's 11/11/11 Press problem of feet/legs pressure on feet.  On 1/31/12 at 2:55 ankle hurt and requipositioned so the piers.	I Neuropathy. R5's 12/8/11 shows a need of extensive sons to turn side to side and hile in bed.  In sheets show a pressure of the foot was healed on a stage II pressure ulcer et side of the foot. The ed as 0.1 x 0.1 x 0.1 cm with the property of the stage of the foot. The ed as 0.1 x 0.1 x 0.1 cm with the property of the stage of the stage of the foot. The ed as 0.1 x 0.1 x 0.1 cm with the property of the stage of the stage of the foot. The ed as 0.1 x 0.1 x 0.1 cm with the stage of the stage o	F9!	999				