DEPART CENTER	PRINTED: 01/28/2013 FORM APPROVED OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145923	B. WING		10/22/2012	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	CARE OF HIGHLAND	PARK		2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	outdated food were storage room. A la labeled "Brown Ric of tomato pastes w ounce cans of corn 10/26/11. E13 said used and should be FINAL OBSERVAT LICENSURE VIOL 300.1210b) 300.1210d)5) 300.3240a) Section 300.1210 C Nursing and Person b) The facility shall and services to atta practicable physica well-being of the re each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re d) Pursuant to subs care shall include, a and shall be practic	15 AM several containers of observed in the dry food rge plastic bin holding rice was e 10/26/11"; 2-11 ounce cans ere labeled 10/26/11; 8-50 ed beef hash were labeled that the items were not being e discarded. IONS ATIONS ATIONS ATIONS General Requirements for nal Care provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident. Section (a), general nursing at a minimum, the following ced on a 24-hour,	F 37 <sup>-</sup>	1		
	and shall be practic seven-day-a-week					

If continuation sheet Page 18 of 22

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BU	ILDIN	NG	COMPLETED		
145923		B. WI	NG _		10/22/2012		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 2773 SKOKIE VALLEY ROAD		
MANOR	CARE OF HIGHLAND	PARK			HIGHLAND PARK, IL 60035		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	<ul> <li>5) A regular program pressure sores, head breakdown shall be seven-day-a-week lenters the facility widevelop pressure sores clinical condition de sores were unavoid pressure sores sha services to promote and prevent new pressure sores shares and prevent new pressure sores and prevent new pressure sores to a facility sharesident. (Section 20) (Se</li></ul>	n to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who ithout pressure sores does not ores unless the individual's monstrates that the pressure lable. A resident having Il receive treatment and the healing, prevent infection, essure sores from developing. Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a -107 of the Act) MENTS WERE NOT MET AS on, interview and record ailed to implement appropriate vent development of pressure hastant friction and pressure acility also failed to ensure to was in placed to relieve ontracted knees. This applies lents reviewed for pressure	F9	999			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		PLE CONSTRUCTION G	COMPLETED	
		145923	B. WIN	IG		10/22/2012	
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MANOR	CARE OF HIGHLAND	PARK			773 SKOKIE VALLEY ROAD IIGHLAND PARK, IL 60035		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	diagnoses including Accident) with right and Dementia. R11 requires extens transfers, mobility, according to the Mi dated 5/7/2012 and "Braden Scale " ass 10/17/2012 showed developing pressur Review of physiciar showed that splints extremities were or "Skin Progress Not following: - " Noted a dark put left lateral outer asp (centimeters). in ler intact with redness skin and area tende Review of "Skin Pr 9/10/2012 indicated friction and pressur R11's feet. Review Report" dated 9/11/ initial wound consu - Unstageable DTI Left and Right later - Etiology: Pressure - "(R11) recently pla contracted lower ex appear to be on loc	g CVA (Cerebral Vascular Hemiparesis, Lung Cancer sive assistance of staff for hygiene, and toileting needs nimum Data Sets (MDS) 47/23/2012. Review of the sessment dated 2/23/2012 and d that R11 is at high risk for e ulcer. In telephone order sheet for R11's contracted lower dered on 6/9/2012. Review of es" dated 9/7/2012 reflect the rplish blood blister to (R11's) bect of foot, measured 2 cm ngth and 1.6 cm in width. Skin and swelling to surrounding er to touch. " rogress Notes" dated d that the splints had caused re on both lateral aspect of of "Wound Care Specialist /2012 reflected the following ltation skin assessment: (Deep Tissue Injury) of the al foot,	F99	999			

If continuation sheet Page 20 of 22

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO.	01/28/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145923	B. WI	NG		10/22	2/2012
NAME OF PROVIDER OR SUPPLIER MANORCARE OF HIGHLAND PARK				2	REET ADDRESS, CITY, STATE, ZIP CODE 2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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	<ul> <li>Wound Size of lef 1.6-cm width, and s</li> <li>Wound size of rig length, 0.2 cm, and</li> <li>Review further of "V dated 9/18/2012, 9/ 10/9/2012 showed unstageable pressure of both feet due to b pressure from the s reflects that the uns was noted with blist</li> <li>R11 was sitting in h 10/16/2012 at 11:50</li> <li>P.M. R11's lower e with knees rubbing device in place to p rubbing together an pressure.</li> <li>As documented on 7/30/2012 and 8/1/2 noted with redness</li> <li>On 10/17/2012 at 1 condition was chec (Registered Nurse, We (CNA-Certified Nur Betadine dressing of feet. E3 stated that pressure ulcers due</li> </ul>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ntinued From page 20 /ound Size of left lateral foot: 1.5-cm length, -cm width, and surface area /ound size of right lateral foot: 0.3 cm. in gth, 0.2 cm, and surface area 0.06 cm view further of "Wound Care Specialist Report ed 9/18/2012, 9/25/2012, 10/2/12 and 9/2012 showed that R11 developed stageable pressure ulcer on the lateral aspect both feet due to tissue injury caused by essure from the splints. The 10/2/2012 report ects that the unstageable deep tissue injury s noted with blister that was filled with fluid. 1 was sitting in her motorized wheelchair on 16/2012 at 11:50 A.M., 1:10 P.M. and 2:20 A. R11's lower extremities were contracted h knees rubbing together. There was no vice in place to prevent both knees from ubing together and prevent friction and		999			

Facility ID: IL6014963

If continuation sheet Page 21 of 22

		AND HUMAN SERVICES				FORM	01/28/2013 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
145923			B. WI	B. WING			10/22/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE OF HIGHLAND PARK				2	REET ADDRESS, CITY, STATE, ZIP CODE 2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	the splints to avoid E4 stated during th splints had caused lateral aspect of bo Review of R11's ca shows that there we the splint was moni breakdown. Furthe plan showed that th to prevent pressure E10 (Director Reha Occupational Thera 2:00 P.M. that she separator". E10 also	e dressing change that the R11's tissue injury on the th feet. are plan for the skin alteration ere no interventions on how itored to prevent skin er review of the current care here was also no intervention e from the contracted knees . abilitation Services, apist) stated on 10/16/2012 at would consider a "knee so added that R11's lower ed to be rotated to right side	F9	999				

Facility ID: IL6014963

If continuation sheet Page 22 of 22