

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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 497	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based record review and interview the facility failed to provide 12 hours per year of in-service training education to all CNA's employed at the facility. This is for 2 of 10 CNA files reviewed for yearly in-service training. (E14 and E15. The findings include: Review of E14's (CNA) personnel file showed E14 was hired at the facility in July 1010. Review of in-service education training for E14 from July 2011 to July 2012 showed E14 only had 4.5 hours of inservice education training. Review of E15's (CNA) personnel file showed E15 was hired at the facility on 8/30/10. Review of in-service education training for E15 from 8/30/11 to 8/30/12 showed E15 only had 5.0 hours of in-service education training. Interview with E2 (Director of Nurses) on 9/27/12 noted E2 to say, "All of the CNA's are supposed to have at least 12 hours of in-service education training per year. We are going to have to make sure they all get the 12 hour training."	F 497			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1220b)3)	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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 25 300.3240a) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and	F9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 26</p> <p>modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 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)</p> <p>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on record review, interview and observations facility failed to develop and implement individualized interventions to prevent recurrent falls for three of nine sampled residents for falls (R1, R13 and R17) in the total sample of 19.</p> <p>This failure resulted in: -R1 sustaining multiple falls and emergency room visits, a Lumbar Sacral Sprain with back pain, two separate head contusions and a hip fracture. -R13 sustaining head lacerations, skin tears, and abrasions. -R17 sustaining head lacerations.</p> <p>The findings include;</p> <p>1. R1 has a diagnosis to include Osteo Arthritis, Syncope, Bradycardia and Dementia. R1's 01/26/12 through 9/20/12 Minimum Data Set Assessments (MDS), document moderate cognitive impairment and decreased memory.</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 27</p> <p>R1's 3/15, 4/3, 7/01 and 9/20/12 MDS document R1's assistance need from supervised up to total assistance with transfers and toileting activities. R1's MDS's 01/26, 4/03, 7/01 and 9/20/12 document occasional to frequent urinary incontinence but no toileting programs. R1's urinary incontinence assessments 01/24/12, 7/01/12 and 9/10/12 include R1 knows when she needs to urinate and will self initiate toileting by going into the bathroom. R1's Urinary Incontinence assessments and care plans 01/24 through 9/10/12 do not include development or initiating a toileting plan.</p> <p>R1's 8/2012 and 9/2012 physician orders, medication administration records (MAR) and nurses notes include use of antibiotics for urinary tract infections (UTI), 8/08 - 8/18/12 and 9/04 - 9/10/12. These UTI's were not included in R1's 9/10/12 urinary incontinence assessment or in the fall incident investigation reports.</p> <p>Facility Incident Investigation reports document R1 had five fall incidents between 01/31/12 and 8/05/12 while attempting self transfers. Three occurred attempting to self toilet.</p> <p>- 01/31/12 at 8:00 AM , R1 was found in her room lying on her back on the floor in front of her un-locked wheel chair. R1 complained of stomach pain and vomited twice. R1 was sent to the emergency room and was diagnosed with a lumbar / sacral sprain with complaints of back pain. This incident report documents that R1 has a fall history and is confused / disoriented. Post fall interventions were to complete an observation log and alarm on wheel chair.</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 28</p> <ul style="list-style-type: none"> - 3/04/12 at 7:20 AM, R1 found lying on the floor on her right side in front of her locked wheelchair. R1 sustained a contusion with swelling to the right side forehead. R1's initial temperature was recorded as 100.3 degrees Fahrenheit. This Incident report includes R1 said she slid off the gel cushion on her wheel chair seat and hit her head. R1 was sent to the ER and returned to the facility at 11:10 AM. No changes to care implemented. - 3/04/12 11:35 AM R1 was found lying on her left side on the floor, yelling for help in the A-wing common bathroom. R1 was complaining of left hip pain, was sent to the ER and diagnosed with a left hip (femur), fracture. R1 was hospitalized and required surgical interventions to repair the fracture. R1 required a Indwelling Urinary Catheter from 3/05 through 3/23/12 as a result of this fracture. - 6/02/12 12:40 AM R1 found lying on the floor next to her bed with urine on clothing and the floor. R1's body alarm was attached and sounding. No changes implemented to prevent further falls documented. Incident report states Resident will be assessed for incontinence with appropriate toileting plan implemented to assist resident with toileting to prevent incontinence episodes at night. R1's 6/07/12 nurses note by E4 (restorative nurse), includes R1 has no incontinence episodes at night, sensor alarm is used to alert staff at which times she needs to toilet. No toileting plan is needed, resident is aware of her toileting needs. - 8/05/12 10:35 AM R1 found in a fetal position on the floor in the A-wing common bathroom. R1 	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 29</p> <p>had loose bowel movement on herself and the toilet. R1 sustained a bruise to the side of her head. R1 started exhibiting "episodes of altered mental status, tilting her head to the right side with slight tremors. R1 did not respond to her name being called for approximately 45 seconds, then became some what alert with confusion, not remembering her falling episode." R1 was sent to the ER and admitted with diagnosis of Syncope and Bradycardia. R1 was receiving antibiotics for a UTI at the time of this fall but the Incident report investigation did not include it. No changes to care initiated as a result of this fall.</p> <p>R1's 9/04/12 falls care plan includes history of dementia with confusion, experiencing increased confusion with onset of UTI, making comments of leaving, and making attempt to get out of wheel chair. The plan also includes potential for elopement. There was no specific individualized approaches/interventions developed to prevent other potential falls/injuries.</p> <p>On 9/26/12 during interview, E4 said that as of 9/27/12 R1 was not on any type of toileting plan.</p> <p>On 9/25/12 during initial tour, R1 was observed alone in wheelchair sitting in the doorway of the A-wing woman's common bathroom.</p> <p>On 9/26, 9/27 and 9/28/12 R1 was observed up in wheel chair and alone in her room.</p> <p>On 9/27/12 at 2:00 PM, R1 observed alert and independently ambulating in wheel chair. R1 said that she independently transfers, dresses and toilets daily.</p> <p>On 9/28/12 at 11:00 AM E3 (Assistant Director of nurses), provided four fall risk assessments for</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 30</p> <p>R1. E4 said these are the only fall assessments completed on R1 between 01/01/12 and 9/28/12. The fall assessments are dated 3/09/12, 7/02/12, 9/04/12 and 9/28/12. All of these fall assessments scored R1 at risk for falls. No fall re-assessment or care plan revision was completed after the 01/31/12, 6/02/12 and 8/05/12 falls.</p> <p>The facility's fall prevention program policy, Section "V", A. notes "Fall risk assessment to be completed quarterly and with changes to patients / residents condition. Reassessment and documentation of risk to fall status will be as warranted by patient / resident's condition and with any fall occurrence."</p> <p>On 9/28/12 at 11 AM, E3 provided a Urinary Incontinence Assessment, up-dated care plan and nursing note for R1 dated 9/28/12. These documents include initiating a prompted toileting plan. The 9/28/12 nurses note includes "per interviews with staff, she is aware of need to void but does not ask staff for assistance with toileting but will accept assistance when staff asks or approaches her." "R1's assessment reveals stress and urge incontinence. Due to impaired cognition and need for assistance with transfers and toileting, a prompted voiding plan will be implemented. "</p> <p>R1's 9/28/12 urinary incontinence assessment includes history of UTI's in August and September 2012.</p> <p>As noted above, many of R1's falls were due to R1 attempting to self transfer to the toilet. R1 was not placed on any type of toileting/monitoring program until 9/28/12.</p>	F9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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 2. Review of physician progress note dated 12/14/11 states R13 has urinary frequency, hypertension renal disease, recurrent UTIs and Alzheimer's. It also states R13 "has fallen a couple times at the nursing home in her room as she has tried to get up, states she is a little more confused the last few weeks." E4 (restorative nurse) stated on 9/27/12 at 3:10pm that R13 has been very confused since she was admitted to the facility (10/13/10, per record review) and has been incontinent of urine with recurrent UTIs since then. Per E4 , R13 has been incontinent of urine since admission but would attempt to take self to the bathroom even though she required assistance due to frequent falls. Review of fall log and incident reports details R13's multiple falls and incidents The fall log and incident report showed the following: 10/29/11- resident room - found R13 on floor after losing balance in attempt to self transfer. "prefers to keep door to room closed which impairs staff observations" 11/1/11 - on floor next to wheelchair. Small raised area present to same location where resident previously had sutures from fall. 11/5/11 - Found with skin tear to right shin. Sent to ER. 12/10/11 - Nurse's aide opened door and found R13 on floor in bathroom doorway. Wheel chair unlocked. R13 initiates toileting as necessary. Staff attempts to keep resident's door open but	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 32 she will close it.</p> <p>12/11/11 - Door to room closed. Upon entering found R13 on floor.</p> <p>12/15/11 - Skin tear to left lower leg with bleeding.</p> <p>12/17/11 - 8:40 am - Staff observed resident sitting on floor across from nurses station. Hematoma to right occipital area of head. "Staff members were in the dining room at the time of this occurrence. This resident receives meals in her room per her preference and had already finished eating when she propelled her wheelchair to the nurses station. She exhibits confusion and could not answer what she was attempting to do when she fell."</p> <p>12/17/11 - 10:20 pm -Found on floor next to nightstand. R13 unable to tell staff what happened due to confusion. Assisted to toilet. Slams door shut.</p> <p>12/18/11 -3:10 pm Observed on floor in room. Skin tear to left shin. Staff tries to continue to observe R13 frequently but she does become upset and tells staff to leave and slams door shut.</p> <p>12/28/11 - 10:50 pm Observed lying on floor by her door. Abrasion to lower back and red area to left scapula. Staff attempted to replace the sensor alarm on wheelchair but resident became upset and told everyone to get out of the room and slammed the door shut. It was a brief period after this that staff opened the door to find R13 on the floor.</p> <p>12/30/011 - 9:15 pm -CNA (nurse's aide)</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 33</p> <p>observed R13 walking out of the bathroom when she fell hitting her head on the floor. (R13) had removed sensor alarm from wheelchair again. Staff has found alarms in closet, under bed and in both garbage cans. Unable to retain safety information due to dementia. Small laceration to back of head, complained of pain to left hip and shoulder. Sent to ER for eval.</p> <p>1/9/12 - 9:50 am - Found on floor near bed with wheelchair tipped sideways. Bleeding noted to right occipital area of head. Sent to ER for eval.</p> <p>2/25/12 - Found on floor in room. R13 had pulled the cord apart for the sensor pad causing it to no longer to work properly. Unable to retain safety education.</p> <p>The above documentation indicates R13 was not being supervised as stated on her fall care plan: "high traffic areas while in wheelchair." E2 (director of nursing) and E4 were asked on 9/27/12 and 9/28/12 during the morning meeting if there had been any assessments or behavior interventions regarding R13's refusals to keep the door to her room open. In addition, E4 stated that R13 was not on a toileting program other than prompted even though the facility was aware that R13 was often found after a fall, attempting to take herself to the bathroom.</p> <p>Other examples of falls and skin tears occurred on 4/25/12, 5/5/12, 5/19/12, 5/21/12, 5/26/12, 6/28/12, 7/30/12, 8/9/12, 8/11/12, 9/11/12.</p> <p>3. Closed record review of R17's admission face sheet showed R17 was admitted to the facility on</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 34</p> <p>3/1/12 with diagnoses including Altered Mental Status and Chronic Renal Disease. R17 was also admitted to the facility for rehabilitation.</p> <p>Review of the facility's incident log showed R17 had 6 falls from 3/6/12 to 4/26/12. With 2 of the falls R17 sustained lacerations. Review of the incident dated 4/25/12 at 9:15 a.m. showed R17 was in the physical therapy room and not under direct observation of therapy staff. The incident showed two other residents observed R17 riding a therapy bike, leaning sideways and felling to the floor striking his head. During this time an occupational therapist was in the room but had his back turned sitting at a desk doing paperwork.</p> <p>R17 was noted with bleeding to his forehead with a 1 cm. irregular laceration to the center of his forehead. R17 was sent to the emergency room for evaluation and treatment. Hospital paper work dated 4/25/12 showed R17's forehead laceration had to be "glued" shut.</p> <p>Review of an incident report dated 4/26/12 for 5:00 a.m. showed R17 was observed on the floor in front of his wheel chair. A small amount of blood was noted to the previous laceration. There was no description of the laceration size, depth, surrounding redness, bruising etc..</p> <p>Review of the interventions addressed after each fall showed 4 of the 6 interventions were the same (sensor alarm, observation log, skilled therapy).</p> <p>Interview with E4 (LPN - Restorative Nurse) on 9/27/12 at 4:30 p.m. noted E4 to say, "All of the interventions are the same. Maybe we should</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 35 have looked at some other interventions for R17 to try and prevent him from having additional falls."</p> <p>Nursing note documentation showed R17 also sustained abrasions to the right elbow, right knee, and left lateral ankle with this fall.</p> <p style="text-align: right;">(B)</p> <p>300.610a) 300.1220b)2)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the</p>	F9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 36</p> <p>nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 37</p> <p>Based on observation, interview and record review the facility failed to assess, plan and implement care/services for three residents to prevent significant weight loss. This is for three of six residents (R6, R15, and R16) sampled for weight loss in a total sample of 19.</p> <p>This failure resulted in a significant unplanned weight losses for all 3 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. R6 is a 86 year old female admitted to the facility on 05/20/2011 with a diagnosis which includes uncontrolled diabetes, hypertension, and peripheral vascular disease. R6 is alert and oriented to person, place, and time. Review of the facility's significant weight losses/gains record showed R6 weighed 124.2 pounds on 3/15/2012. R6 's weight on 9/17/2012 was 109. This was a 15.2 pound weight loss in 6 months. R6 also had a 9 pound weight loss from 3/1/2012 - 3/15/2012 which makes a total of 24.2 pounds in 7 months. <p>Review of nurses notes from 3/27/2012- 3/28/2012 indicate R6 had recurrent emesis after meals. The physician was notified on 3/28/2012 at 7:30 PM. R6 was transferred to the emergency room per physicians order for evaluation. R6 was admitted to the hospital with vomiting and hyponatremia. R6 returned to the facility on 4/2/2012. R6 was again nauseated and having emesis on 4/5 and 4/6/2012.</p> <p>On 6/14/2012 R6 had an episode of dysphasia in the main dining room. While eating a pork chop R6 choked. R6 was able to clear her own air way. R6 then stated she was having difficulty with</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 38</p> <p>swallowing meat lately. R6 stated, "It feels like there is something in my lungs." R6's physician was notified and ordered a chest X-ray and a bed side swallow study. On 6/14/2012 at 4:30 PM the chest X-ray was completed. The chest X-ray result showed a small patch in the right lower lobe compatible with pneumonia. R6 was placed on Z-pak. There was no documentation or report regarding the bed side swallow study. On 9/27/2012 at 3:10 PM, E2 (Director of Nursing) stated R6 refused the bedside swallow study. There was no documentation of the refusal or of the physician being notified R6 refused the bedside swallow study.</p> <p>On 7/13/2012 nursing notes indicate R6 was coughing during lunch. R6 had an emesis and complained of chest pain. R6's physician again ordered a portable chest X-ray. Chest X-ray showed right lower lobe mild patchy density compatible with pneumonia. R6 was then placed on antibiotic therapy for 10 days. R6 then began having emesis on 7/24/2012. R6 continued to have crackles to lower lung lobes. R6 received respiratory treatments thru 7/27/2012.</p> <p>On 8/17/2012 nursing notes state R6 continues to complain of difficulty swallowing. R6 states, " It feels like anything I eat gets stuck in my chest." The physician saw R6 on 8/17/12 at 8:45 PM ordering an appointment with a digestive disease consultant for dysphasia. Dietary down graded R6's diet to pureed consistency. On 8/23/2012 R6 saw a gastroenterologist for an esophageal gastro- duodenoscopy (EGD).</p> <p>The dietitian note of 4/9/2012 indicates R6 had no chewing or swallowing problems. R6's most</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 39</p> <p>recent weight at this time was 126 pounds; which is significantly down. The dietary note indicates R6 would benefit from Glucerna at this time, however R6 had a strong history of refusal of supplements. R6 has a normal meal intake, therefore a supplement will not be started at this time despite weight loss. 5/7/2012 no change in weight. On 6/6/12 R6 weighed 121 pounds The significant weight change report (greater than 7.5% in 3 months and greater than 10% in 6 months) indicates dietary recommendation to start supplement. The 7/24/2012 dietary note states R6 's current weight is 120.4, a 11.2 % weight loss over 6 months. There were no new recommendations, only to continue dietary supplement. Dietary note dated 8/28/2012 states R6's current weight is 118 pounds. The physician was notified with no new orders given. R6's weight continued to decrease. Weights were as follows:</p> <p>-8/22/2012 - 116.2 pounds -9/04/2012 - 113.8 pounds -9/17/2012 - 109.0 pounds</p> <p>On 8/29/2012 R6 went to the digestive disease office. The office called the facility and reported R6 has a 5 centimeter mass in the distal esophagus. Which was diagnosed as esophageal cancer. The consultant ordered a pureed/liquid diet for R6. R6 refused to eat the pureed diet.</p> <p>Review of the CT scan dated 9/5/2012 showed impression R6 has a distal mass projected near the level of gastroesophageal junction obscuring the lumen.</p> <p>On 9/13/2012 at 10:13 AM orders were received</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 40 for a gastrostomy tube placement as well as an appointment with oncology was received for R 6.</p> <p>R6 began refusing all oral medication and oral food on 9/15/2012 - 9/21/2012. R6 was diagnosed with esophageal cancer with near obstruction on 8/29/2012 but did not get the gastrostomy tube until 9/21/2012. During this time R 6 continued to lose weight and was not able to swallow solid foods but no feeding tube was placed for over a month. On 9/28/2012 E2 (DON) stated there was a scheduling problem and R6 should have had the gastrostomy tube placed sooner. Further interview with E2 noted E2 to say R6 never refused insertion of the gastrostomy tube.</p> <p>On 9/27/12 at 3:15 PM the family of R6 stated they were not aware R6 had refused a bedside swallow evaluation on 6/14/2012. The family indicated the facility is to notify them when R6 refuses a procedure and they will talk to R6 about receiving the procedure. The family also indicated R6 is able to make R6's own medical decisions. The family stated R6 really began to lose weight about two months ago.</p> <p>2. According to the medical record, R15 is a 99 year old female who was admitted to the facility in 2007 with diagnoses including Hypertension, Peptic Ulcer and Anemia. R15's monthly weight records were reviewed for March, 2012 through September 2012. R15's weight on 03/05/12 was recorded as 120.6 lbs. R15's weight on 07/06/12 (4 months later) was documented as 100 lbs.</p> <p>On 07/24/12 E6, (Corp. Registered Dietician) documented R15 has a significant weight loss of</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 41</p> <p>6.9% over 1 month, 16.7% over 3 months and 16.1% over 6 months. R15's current weight (Sept 2012) is 100 lbs. BMI (Body Mass Index) 17.2 (underweight). E6 further documented R15 reports ill fitting dentures and mouth pain at times due to dentures. Dietary note documentation showed a nutritional supplement 120 ml 2 times/day was added 6/11/12 due to weight loss over 1 month but the supplement was discontinued on 7/24/12 due to R15's dislike of the supplement. Further dietary note documentation on 7/24/12 showed, "recommend dental consult."</p> <p>On 08/22/12 E6 documented, "R15 reports continued pain in mouth which resident reports telling son in law who is her dentist. No new recommendations, will continue to monitor and update MD of weight change. Encouraged resident to select softer foods at meals for for optimal oral intake."</p> <p>On 09/10/12 E13, (another RD) assessed R15 and documented R15 is at increased risk for future weight fluctuations, increased risk of dehydration and skin breakdown due to variable oral intake, edema, ill-fitting dentures and mouth pain. E13 documented, "Will recommend dental consult due to ill-fitting dentures per MD discretion as resident on comfort care. Improving fit of dentures may aid in mastication (chewing) and encourage oral intake."</p> <p>On 09/27/12 at approximately 2:00 PM upon request R15 was weighed by facility staff and was noted to be 98.2 lbs, a further loss of 5 lbs since 09/21/12 weight of 103 lbs and a total weight loss of approximately 22 lbs. since 04/05/12.</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 42</p> <p>E13 stated on 09/28/12 she did make another recommendation on 09/10/12 that R15 be seen by the dentist due to R15's mouth pain and ill-fitting dentures. E13 further stated the doctor signed off on the consultation but to her knowledge R15 has not yet seen a dentist.</p> <p>During interview with R15 on 09/28/12 at approximately 11:00 AM, R15 stated her mouth hurts when she tries to eat. R15 pointed to her lower set of dentures and stated that it hurts "here." R 15's lower plate was observed to be shifting side to side in her mouth. R15 further stated her son gave her some medicine in a bottle to rub on her gums. R15 produced a bottle of over the counter oral pain reliever from her night stand. R15 also stated it helps somewhat and she also uses salt to help relieve the pain.</p> <p>E13 later stated she was not aware R15 was using a liquid pain medication on her gums.</p> <p>E1 (Administrator) was asked on the morning of 09/28/12 if R15 had been to see the dentist and E1 stated she wasn't sure but R15's son is a dentist.</p> <p>Further review of the record produced no information that R15 has been scheduled to see a dentist.</p> <p>3. According to the medical record R16 is an 84 year old female with diagnoses including Vertebral Compression fracture, Diabetes Mellitus, Hypertension, Hypothyroidism and Anemia. R16's weight record was reviewed from</p>	F9999			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2012
NAME OF PROVIDER OR SUPPLIER PRESENCE OUR LADY OF VICTORY			STREET ADDRESS, CITY, STATE, ZIP CODE 20 BRIARCLIFF LANE BOURBONNAIS, IL 60914		
(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	<p>Continued From page 43</p> <p>May, 2012 to September, 2012. R16's weight on 05/04/12 was noted to be 137.8 lbs. and on 09/21/12 R16 weighed 119.4 lbs.; a weight loss of 18.4 lbs. in 4 months.</p> <p>R16's dietary notes were reviewed and it was noted R16 was assessed by E13 on 07/30/12. R16 was noted to weigh 133.8 lbs. E13 documented R16 lost 2.4 lbs for the month but this was not significant at the present time.</p> <p>R16's weight record notes on 08/01/12 R16 lost another 4 lbs and on 09/04/12 R16 lost another 5.2 lbs. However, R16's continued weight loss was not addressed by the facility for approximately two more weeks when she was assessed again by E13 who noted R16 as having a significant weight loss of 8.5 % for three months. E13 recommended Hi Cal 120 ml 2 times per day and noted the need for an appetite stimulant. R16 was weighed again on 09/21/12 and had a further loss of 5.2 lbs.</p> <p>During interview with E13 on 09/28/12 E13 stated she was not notified by the facility R16 was having continued weight loss since the last time E13 assessed her on 07/30/12.</p> <p style="text-align: center;">(B)</p>	F9999			