STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE NURSING PAVILION	**2242 NORTH KEDZIE CHICAGO, IL 60647**

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S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210c)3) 300.1210d)5) 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	S9999		

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S9999	Continued From page 1	S9999		

care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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

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.

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:

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.

This requirement is not met as evidence by:

Based upon interview and record review, the facility failed to develop a care plan for a resident at risk for a pressure sore, inform the physician and document a newly developed pressure for implementation of treatment. This applies to one

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of three residents reviewed for pressure ulcer treatment in the sample 9.
Findings include:
R1's Face Sheet indicates that R1 was admitted to the facility on 05/23/2014 with admitting diagnoses that include CVA (cerebrovascular Accident), Parkinson's disease and Dementia. R1 was transferred to local community hospital on 11/30/2015 to rule out Metabolic Encephalopathy/Sepsis/Dehydration.
R1's Minimum Data Set (MDS) on 05/30/2014 indicate that for Activities of daily living R1 needs extensive assistance when self-performed.
R1's Local community hospital emergency room admission record, History and Physical Exam dated 11/30/2014 indicates that R1 was transferred from the facility with Stage II pressure Ulcer on sacrum covered with dry dressing. Emergency Room Physician ordered for wound Nurse for evaluation and treatment.
On 06/22/2015 at 11:10am, Z3 stated " No one informed me of R1's pressure ulcers or any skin changes while R1 was in the facility, but when R1 was transferred to the local community hospital, Emergency Room nurse notified me that R1 has stage II sacral ulcer."
On 06/25/2015 at 11:18am, E2 (Director of Nursing) presented and reviewed R1' s medical records. Admission Nursing Assessment dated 05/23/2014 denote that R1's skin was intact. Weekly skin checks planned and implemented from 05/27/2014 through 11/302014. Pressure risk predicting score evaluation for R1 indicated that R1's skin had no impairment on 05/23/2014, 08/19/2014 and 11/18/2014. Progress notes written by Nurse Practitioner covering R1's primary physician dated 9/26/2014, 10/8/2014, 10/23/2014, 11/4/2014 indicates no impairment of skin. Certified Nursing Assistant (CNA) skin check detail report dated 09/28/2014 through

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11/30/2014 for R1 did not indicate any skin break down. R1 had no documentation in the nursing notes and Physician's progress notes dated 05/23/2014 through 11/30/2014 regarding stage II sacral ulcer.
R1's Care plan dated 5/30/14 did not address the resident's risk for a pressure ulcer nor any skin break down in the sacrum. MDS (Minimum Data Set) on 05/30/2014, 08/19/2014, and 11/18/2014 did not indicate that there was any change in R1's skin condition. No documentation on notification of significant change in R1's skin to the family member noticed.
E2 stated, "Generally, the nurses along with the CNA's do the initial skin assessment upon admission. When CNA's help residents with Activities of Daily Living (ADL's), the CNA's should inspect the skin and if they see a new wound or anything wrong with the skin, they are to report it to the nurse. The certified nursing assistants (CNA's) and Nurses should document the change in skin condition in their charting and in the 24 hour report log. The nurse should notify the doctor and the responsible family member " .
On 06/25/2015 at 3:15 pm, E1 (Administrator) stated " The nurse who transferred R1 to the hospital on 11/30/2014, no longer works in the facility. Staff must have applied dressing but forgot to document and inform the supervisor."
On 06/25/2015 at 3:40pm, Z1 (Primary Care Physician for R1) stated in part: I was never informed of any skin break down or pressure sores on R1.
Facility policy titled, "Change in Resident Status " dated 11/2013, documents in part: Facility shall notify the attending physician, the resident and the resident's family when there is a significant change in the resident's medical condition. A significant change of condition is a decline in the resident's status that: Will not normally resolve

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S9999	Continued From page 4 itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). The charge Nurse will record in the resident' s medical record information relative to changes in the resident' s medical condition. (B)	S9999		