STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145792	B. WIN			C 04/01/2009	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	04/0	1/2009
WOODB	RIDGE NURSING PAV	ILION		2	242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	and treatment. On 03/06/09 and 03 conducted with faci review of the allege Facility's policies ar decubitus prevention the proper assessmon of the requirement is measures are implerequirement that phas written. Additional inservice Outside Consultant The Director of Nurmonitor for overall of	ge 13 Jures on decubitus prevention 8/16/09, inservices were lity staff. Inservices included d deficiency, review of the nd procedures, as revised, on on and treatment, review of nent of pressure sores, review that proper preventive emented, and review of hysicians' orders be followed s will be conducted by an beginning 04/01/09. sing and/or her designee will compliance by rounds, general ports from nurses on a daily	F3	314			
F9999	Assurance program completion for all remeasurement/treating Director of Nursing program to the Qua		F99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) DECVIDED SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	LDING	(X3) DATE SURVEY COMPLETED	
		145792	B. WIN	IG		C 1/2009
	PROVIDER OR SUPPLIER	/ILION		STREET ADDRESS, CITY, STATE, ZIP CO 2242 NORTH KEDZIE CHICAGO, IL 60647	•	1/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F9999	h) The facility shall of any accident, injuresident's condition safety or welfare of limited to, the preseducubitus ulcers or percent or more wit facility shall obtain plan of care for the accident, injury or of notification. Section 300.1210 Onursing and Personal The facility must and services to attapracticable physical well-being of the resolution.	Medical Care Policies notify the resident's physician ury, or significant change in a that threatens the health, a resident, including, but not ence of incipient or manifest a weight loss or gain of five thin a period of 30 days. The and record the physician's care or treatment of such change in condition at the time General Requirements for nal Care provide the necessary care ain or maintain the highest all, mental, and psychological sident, in accordance with	F99	999		
	plan of care. Adequative nursing care and potential to each resident to personal care need b) General nursing minimum the follow a 24-hour, seven do 2) All treatments are administered as ord 5) A regular prograpressure sores, her breakdown shall be	care shall include at a ring and shall be practiced on				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED SUBDICED (STATEMENT OF DEFICIENCIES

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145792	B. WIN	G		C 1/2009
	PROVIDER OR SUPPLIER	/ILION		STREET ADDRESS, CITY, STATE, ZIP COD 2242 NORTH KEDZIE CHICAGO, IL 60647		1/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE
F9999	develop pressure s clinical condition de sores were unavoid pressure sores sha services to promote and prevent new promote new	rithout pressure sores does not ores unless the individual's emonstrates that the pressure dable. A resident having all receive treatment and e healing, prevent infection, ressure sores from developing. DNS are not met as evidenced ion, interview, and record tely assess pressure ulcers. , assess, and treat newly	F99	99		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		145792	B. WI	NG _		C 04/01/2009	
	ROVIDER OR SUPPLIER	/ILION	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	sore to R4's left fiftl Z5 was again page On 02/12/09 Z5 was area to left toe Ordout. Z5 ordered ve extremities, normal application of Ulted toe until healed. On 02/16/09 Press flow sheet was comhave a discolored f Stage II wounds to right inner metatars toe, and a blister to of 02/23/09 indicate. There is no evidence pressure ulcers ass. There were no ordeareas. On 03/05/09 at 11:0 her room seated in per nasal canula. If dressings to both fedid not have socks needed to be changed. Surveyor requested treatment to R4. A began removing pill cried out like she weremove the dressin observation R4 had	n toe was found. At 8:30p.m. d about open sore on left toe. s again notified of R4's open lers were obtained and carried nous doppler to both lower saline cleanse, and every three days to left fifth ure sore and skin care weekly pleted which shows R4 to ifth toe (foot not specified), left outer metatarsal, blister to sal, something to right distal right inner foot. Assessment as right fifth toe now necrotic. See physician was notified of sessed on 02/16/09. For any treatment to these on the series of a provide the sale of the series of the	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145792	B. WIN	G			C 1/ 2009
	ROVIDER OR SUPPLIER	/ILION		22	EET ADDRESS, CITY, STATE, ZIP CODE 42 NORTH KEDZIE HICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 17	F99	99			
	pain. E3 proceede R4 cried out in pair informed E3 she m R4 for pain prior to Nurses) was also in be in pain. On 03/05/09 a physmedicate R4 with A	dressing R4 was crying out in d with treatment even though a. At this point Surveyor ust stop treatment and assess proceeding. E2 (Director of a formed that R4 appeared to sician order was obtained to acetaminophen 650mg. rectal n, 30 minutes prior to					
	treatment to R4's le it was confirmed withis dressing earlie Dressing was removed and fifth toe was a outer aspect of left measured 3cm. X 2 necrotic areas and wound was a Stage measured 1.5cm. X Stage III wound.	eyor observed E3 provide off foot. During this treatment th E3 that she had removed and re-dressed the foot. Oved and area between fourth small necrotic area. On the foot were two ulcers. One off were two ulcers. One off stated this elvulcer. The other area off 1.5 cm. E3 stated this was a 3 was asked if there had been ared for these wounds. E3 did question.					
	The only treatment R4 was cleanse lef	nent record was reviewed. recorded as administered to t 5th toe with normal saline o every three days until					
	03/18/09. On 03/0	ord runs from 02/20/09 to 5/09 treatment was already ed every three days up to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145792	B. WIN	IG _		C 04/01/2009	
	ROVIDER OR SUPPLIER	/ILION	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 18	F99	999			
	was placed to Z5 to R4's wounds. Z5 to Ultec with dressing Nurses note of 03/here to see R4. Or direct admission to of clostridium diffici and rule out osteon 7:20p.m. R4 was tr Z5 was called on 0 03/19/09 at 2:45p.r call.	05/09 at 6:00p.m. state a call overify orders for treatment to rdered saline cleanse and every three days to wounds. 08/09 at 5:00p.m. states Z5 der to be sent to hospital for Med-Surg floor with diagnosis le, colitis, cellulitis of left foot, hyelitis of left foot ulcer. At ansferred to the hospital. 3/05/09 at 2:07p.m. and h. but did not return Surveyor's					
	and renal insufficie time in bed. Care presistant to re-posit On 03/05/09 survey treatments for R7. proceeded to remo foot. On initial observe two areas on	includes multiple sclerosis ncy. R7 currently spends all plan indicates that R7 is ioning. /or requested to observe E3 (Treatment Nurse) ve dressings from R7's right ervation R7 was observed to the foot/ankle area. The proximately 1 X 1 inch and					
	appeared superficial The lower ulcer of approximately a 2 2 have full thickness. Surveyor asked E3 E3 stated the ulcer ulcer appeared to bulcer. R7 also had	al but skin loss was observed. right foot appeared to be K 3 inch area, appeared to skin loss, and was bleeding. what Stage the ulcers were. s were Stage II. The lower he as least a Stage III to IV a wound to rt. heel which /pink, dry healing area					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		145792	B. WIN	IG _		C 04/01/2009	
	PROVIDER OR SUPPLIER RIDGE NURSING PA	/ILION		2	REET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (ERCY)	ULD BE	(X5) COMPLETION DATE
F9999	this ulcer to be a St Z4 (Physician) was 2:40p.m. and stated ulcers appeared alregranulation. Z4 wo ulcers appeared to On 03/19/09 facility documentation of R 03/06/09 rt. foo 3cm. X 0.2cm., Sta 03/06/09 rt. foo superficial depth, S 03/06/09 rt. foo 5.0cm. X 0.2cm., S 03/13/09 rt. foo 5.0cm. X 0.2cm., S 03/13/09 rt. foo 03/06/09. On 03/16/09 R7's wand four wounds we showed: Rt. foot, inner a X 0.2cm., Stage IV Rt. foot, below II.	X 1/2 inch in size. E3 stated age II. interviewed on 3/05/09 at d he recently saw R7 and most healed with good uld not state what Stage the be. provided the following t7's pressure ulcers: t #2 (ankle area) 5.5cm. X ge IV. t #1 0.5cm. X 0.5cm X Stage II. el 0.5cm X 0.5cm. X 0 depth, t #2 (ankle area) 5.5cm. X tage IV with drainage. t #1 and rt. heel same as younds were again assessed, ere identified. Assessment aspect of ankle, 4.5cm. X 4cm. drainage and slough. ankle, 5.5cm. X 3.5cm., Stage	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145792	B. WIN	1G _		C 04/01/2009	
	ROVIDER OR SUPPLIER	/ILION	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Stage II, 30% granı	4cm. X superficial depth, ulation in center.	F99	999			
	slough area for sev Hydrogel.	nged to Santyl ointment to en days then return to					
	2009 were also rev was being treated f assessment lists all 01/14/09, 01/20/09 measurement is list	its of wounds for January iewed which showed that R7 or three wounds. This I three wounds on 01/07/09, & 01/28/09. Only one ted and it appears to be sel wound which is listed as an slough to heel.					
	R5 as having a Sta sacrum. Assessme	e sore report for 01/14/09 lists ge IV pressure ulcer to ent of this wound size was 5cm. depth. Tissue pink/red in drainage noted.					
	Medicine Resident. measured 8cm. X 8 depth was not indic further assessment were presented. D	d was assessed by Family Pressure ulcer was Stage IV, 3cm. with 10% slough. Wound ated. Surveyor requested any s of this wound, and none uring interview E3 stated ssess wounds weekly.					
	treatment to R5's p requested to meast treatment was obse ulcer which was 5.5 proceeded to clean and packed wound	yor requested to observe ressure ulcer. E3 was also ure wound. At 12:00p.m. erved. E3 measured sacral 5cm. X 3.5cm. X 1.5 deep. E3 se wound with normal saline with saline soaked gauze. E3 as for wet to dry saline					

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		145792	B. WIN	1G			C 1/2009
	ROVIDER OR SUPPLIER	/ILION	•	22	REET ADDRESS, CITY, STATE, ZIP CODE 242 NORTH KEDZIE CHICAGO, IL 60647		
(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 APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	reviewed for Februat treatment to sacrum dressing change. Physician order for dated 02/20/09 to 0 with normal saline, dressing, cover and Dressing, change eneeded. E3 could be treatment was not I aware of the physic During record revied 01/08/09 R5 had a dressing every two area. Surveyor required, and none were observation on 03/0 observed to be head. 4. R1 was re-admit Diagnoses include hypertension, mild disease. R1 received only and required stre-positioning. Comprehensive ski indicates R1 develors. On 08/5 silvadene to right hormal saline clear.	tration Record (TAR) was ary to March 2009 and is listed only as a daily treatment for this wound 03/19/09 was cleanse wound apply loosely Aquacel Silver disecure with DuoDerm every three days and as not state why this ordered isted on the TAR and was not clan order for treatment. We it was also noted that on physician order for DuoDerm to three days to right ischial quested assessments of this represented. During 05/09 right ischial area was alled. Itted to the facility on 06/30/08. diabetes mellitus, dementia, and Parkinson's red nutrition by tube feeding taff assistance for In assessment dated 08/12/08 oped blister to right heel. Indicate R1 kicks off heel 12/08 physician ordered leel daily and as needed after rise. On 08/13/08 wound was	F99	999			
		rse. On 08/13/08 wound was tage II pressure ulcer (fluid					

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		145792	B. WIN	1G _			C 1/2009
	PROVIDER OR SUPPLIER RIDGE NURSING PA	/ILION	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 1242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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	Treatment Adminis 07/20/08 to 08/19/0 was documented a 08/16/08. There is treatment on 08/13. 08/17/08, 08/18/08. Pressure Sore and states on 08/20/08 ulcer and 100% new was unstageable, 14cm. X 4cm. On 08/20/08 physic Silvadene to right heel, no pressure to possible, re-position protectors daily and venous doppler stu. On the TAR for 08/d dressing to right he treatment is 'apply order for any applic was questioned regtreatment which was and she stated she added that treatment. Arterial doppler of 108/21/08 showed so lower extremities. In dampened flow in the femora, and poplite extremities.	tration Record (TAR) for 8 shows treatment to heel s done only on 08/12/09 and no documentation of 708, 08/14/08, 08/15/08, or 08/19/08. Skin Care Weekly Flow Sheet rt. heel is now an unstageable crotic. By 09/03/08 wound 00%necrotic, and measured sian ordered to discontinue the eel, apply dry dressing to oright heel as much as n every two hours, heel of off at night, and arterial and dies of lower extremities. 20/08 treatment was for dry el daily. Written in on this Santyl.' There is no physician ation of Santyl to heel. E2 parding this writing in of a is not ordered by the physician had no idea who would have	F99	999			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145792	B. WIN			C 04/01/2009	
	ROVIDER OR SUPPLIER	/ILION	•	224	ET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH KEDZIE IICAGO, IL 60647		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	for a wound consul daughter agreed to Nurses note of 09/0 Power of Attorney, right above knee ar Nurses note of 09/0 sweating, skin warr Tylenol given.	tation on 08/30/08 and go with resident. 05/08 state daughter, who is gave consent for surgery for a mputation on 09/08/08. 07/08 state R1 congested, m, temperature 100 degrees, vsician was called and ordered d to hospital. R1's admission	F99	99			