STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

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F 000	INITIAL COMMENTS Complaint Investigation #0883735/IL36831-F226 #0883744/IL36850-F226 #0883779/IL36885-F314 #0882810/IL35833-No deficiency #0883725/IL36822-No deficiency #0882690/IL35708-No deficiency #0883055/IL36099-No deficiency	F 000		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of nurses notes, interview and review of the abuse policy the facility failed to reported the allegation of abuse of a resident to the state agency and failed to follow their abuse prevention program for reporting (R4). Findings include: Review of the nurses note dated 08/02/08 at 1:40 PM indicated, E10 (Certified Nurse Aid- CNA) reported to charge nurse and staff nurse member during PM care. Resident became combative turning to her left side, swing her right arm and she hit her left eye on the side rail resulting in swelling discoloration. Further review of the incident report indicated, Injuries-Swelling and discoloration of eye. Physician notified and resident sent to hospital.	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 Per interview with E1 (Administrator) on 08/20/08 stated, "I did not fax the 24 hour preliminary report or the final report to state agency. It was sent on 08/14/08." Review of the abuse prevention program indicated, Within twenty-hours after the occurrence, a written report shall be sent to the state agency. Within five workings day after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the state agency.	F 226		
F 314 SS=J	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and skin check protocol, the facility failed to Identify, comprehensively assess and notify the physician regarding a newly developed pressure sores for two residents (R5 and R9); Treat newly developed pressure sores for R5 and R9; Treat existing pressure sore with the current treatment order for R3; Provide and implement individualized interventions to prevent the development of new pressure sores for R5 and	F 314		

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R9; Provide treatment as ordered and correct treatment of a pressure sore for R9; and Follow the facility skin check protocol for R5, R3 & R9.

These failures resulted in the facility failing to identify, assess and treat the pressure ulcer in a timely manner and notify the physician of a residents change in skin condition (R5). This failure resulted in R5 requiring emergency surgery. These failures resulted in an Immediate Jeopardy. This failure resulted in R5's pressure ulcers, Stage 3-4, not being identified, assessed and treated in a timely. R5 required two debridements at the hospital and was placed on contact isolation for Escherichia Coli and Enterococcus in the wound. The resident was admitted to the Intensive Care Unit (ICU).

E1 and E2 (DON) were notified of the Immediate Jeopardy on 8/21/08 at 12:15 PM. The Immediate Jeopardy began on August 8, 2008 when the facility failed to identify, assess and treat a pressure ulcer in a timely manner and notify the physician of a resident's change in skin condition in which resulted in emergency surgery for R5.

Findings include:

1. R5 was observed on 08/21/08 at 11:45 am in hospital ICU. R5 was in contact isolation with a right surgical leg dressing in place. R5 was on a cardiac monitor, oxygen, multi intravenous fluid and an indwelling catheter.

Review of the hospital medical record for R5 indicated, S/P Mastectomy, S/P Right Lower Extremities Debridement (08/13/08), S/P Redebridement (08/15/08), Hypertension,

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Depression, Diabetes Mellitus, Gastrointestinal Hemorrhage, Clostridium Difficile Colitis, Deep Vein Thrombosis, Aspiration, Pneumonia, Dyslipidemia and B12 Deficiency Anemia.

Interview with Z2 (Physician) on 08/20/08 at 12:00 PM in the conference room stated, "She was transferred from the nursing home for surgery-a simple mastectomy on 08/13/08. We were pre-operative for surgery. There was blood noted on right lower leg pant. Upon investigation their was a 5 cm circular pressure ulcer. It was a Stage 3 or 4 with necrosis edge of the pressure ulcer. It was a foul odor. There was no dressing in place. It was not a new pressure ulcer. It was approximately couple weeks old. On the surgical consent, debridement was added. We debrided on 08/13/08. There was a culture done on the wound. We did the debridement on the same day of the simple mastectomy. She had emergency surgery on 08/15/08 for redebridement of the pressures sores. It was infected."

According to interview with Z3 (Social Worker) on 08/20/08 12:45 PM in the conference room she stated, "She was transferred from the nursing home on 08/13/08 for a simple mastectomy. It was noted on the lower right extremities a Stage 3 or 4 pressure sore. Necrosis around pressure sore and no dressing. Physician stated that it was there for a while. Surgery debridement was done after the simple mastectomy on 08/13/08. The surgeons had to take her back on Friday night date 08/15/08 for emergency surgery. She had redebridement of the pressure sore."

E3 (Certified Nurse Aide-CNA) was interviewed on 08/21/08 at 7:00 am in the hall and was asked if (E3) gave morning care to R5. E3 stated, "Yes,

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F 314	Continued From page 4 I took care of R5. Her right leg was swollen. She had a large scab and dark discoloration on the right leg. I told E4. It was August 08, 2008." According to interview with E5 (Nurse) on 08/21/08 at 7:10 am at the nurses station, E5 stated, "The CNA told me R5 had a sore on the right leg. R5 was evaluated of the pressure sore. I told the treatment nurse. It was a few weeks ago. E7 (Nurse) was the treatment nurse. I don't know what happened." Surveyor ask for the pressure sore documentation. E5 stated, "I don't remember writing anything." Interview with E2 on 08/21/08 at 12:30 PM, E2 stated, "E7 was the treatment nurse. She left around the last week of July, 2008 or beginning of August, 08. The floor nurses are during the pressure sore treatment. The nurses should assess, care plan and call the physician for treatment orders." An attempt was made to contact E7 by telephone for an interview, but E7 did not return the call. Review of the hospital pre-operative record dated 08/13/08 indicated that R5 was sent to the hospital on 08/13/08 for a simple mastectomy. During pre-operative surgery, a Stage 3 or 4 pressure ulcer was discovered on the right posterior lateral of the leg in which surgical debrided was needed. R5 had debridement of the right lower leg. The wound was somewhat necrosis, but did not appear infected with no erythema of the surrounding tissue. Culture was done of the right leg wound. 08/15/08-Preoperative diagnosis-Necrotizing post operative soft tissue infection of the right leg. Operative performed-Radical debridement of right leg including skin, subcutaneous tissue and	F 314		

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F 314	Continued From page 5 muscle. This is complication of the patient's prior operation on 08/13/08. Operative finding on 08/15/08-5 x 6 cm full thickness defect was present on the posterior aspect of the right leg. The muscle was black with foul smelling odor at the base of the wound. Review of the Discharge Summary/Operative record for R5 dated 08/13/08 indicated that she was admitted in the nursing facility and had a right breast mass. On the day of surgery (08/13/08) the patient was taken to the preoperative area and was noted to have a wound on her right lower leg on the posterior laterals aspect of her calf. This had not been noted by patient or her family member and previously and had no dressing on it. The wound was somewhat necrotic, but did not appear infected with no erythema of the surrounding tissue. Culture done of the right leg wound. 08/15/08 states preoperative diagnosis Necrotizing postoperative soft tissue infection of the right leg. Operative Performed-Radical debridement of right leg including skin, subcutaneous tissue, muscle and biopsy of left leg. This is a complication of the patients complication's prior operation on 08/13/08. Operative Finding on 08/15/08 a 5 x 6 cm full thickness defect was present on the posterior aspect of the right leg. The muscle was black with foul smelling odor at the base of the wound. Biopsy of the left leg lesions did not reveal necrotic tissue." Review of the culture of the wound from the hospital laboratory dated 08/13/08 indicated Isolated Escherichia Coli and Enterococcus. Review of the facility medical record of R5's	F 314		

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confirmed that there was no documentation of the right lower leg pressure ulcer.

Further review of the wound assessment flow sheet, weekly documentation, skin surveillance report and other skin problem sheet confirm their was no documentation of the left lower leg pressure sore.

The facility did not present any documentation of the left lower leg pressure sores.

Review of the Skin Check Protocol indicated that, Skin checks will also be done on all residents that are assisted with bathing (shower, tub or bed bath). CNA is to mark on skin sheet, anything found-red mark, pen area, bruise, scratch or rash. CNA will sign it, and give it to the nurse. The nurse will assess each area. The nurse will notify the Physician, if appropriate and carry out any further orders. The skin sheet will them be given to the DON. The DON will then assess any pressure ulcers for nursing intervention. DON will document interventions and findings to determine if it was avoidable or unavoidable.

2. During pressure sore treatment observation with E5, E6 and E8 (Treatment Nurses) on 08/21/08 at 8:15 am, R9 was observed with no dressing on the sacral pressure sores. E5 stated, "These are new pressure sores. They are Stage 2." Surveyor observed three pin point pressures ulcer on the right buttock approximately 0.2 x .4 cm, 0.3 x 0.4 cm and 0.4 x 0.4 cm, Stage 2.

E5 stated, "There was no dressing on the sacral pressure sores. Those are new pressure sores on the buttock. They are Stage 2. There are no

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assessments, treatments or care plan. I am going to call the physician."

According to interview with E9 (CNA) on 08/21/08 at 8:35 am in the hall, E9 stated, "I have not done morning care on R9. E9 was asked what time did you check resident and was there a dressing on the sacral. E9 stated, "I checked her at 7:20 am. There was no dressing on the sacral pressure sore. I did not check for any other open areas on the sacral or buttock."

3. E6 was observed during pressure sore treatment on 08/21/08 at 7:10 am. R3 was observed with a sacral ulcer dressing in place. E6 proceeded to remove the dressing from the sacral area. E6 cleansed the areas with normal saline, applied Xeroderma ointment and a dry dressing.

E6 was asked what was the wound care. E6 stated, "Cleanse with normal saline, apply Xeroderma ointment and a dry dressing."

Review the medical record for R3 indicated that R3 acquired the sacral pressure on 07/24/08. Family notified of breakdown on ischium. There was no documentation identifying the pressure sore, treatment, care plan or that the physician was notified in the change of condition until 08/20/08.

Review of the nurses notes dated 08/20/08 at 6:20 am indicated, Upon daily skin assessment, noted Stage 2 to sacrum pink small drainage. Medical Doctor aware of areas and measure of wound 5.0 x 3.5 x 0.1 cm.

Review of the physician order sheet (POS) dated

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08/20/08 indicated, Sited-Applied Xeroderma, cleanse with warm water and mild soap. Leave open to air. Further review of the physician order indicated that the wrong treatment was done.

Review of the Skin Check Protocol indicates that skin checks will also be done on all residents that are assisted with bathing (shower, tub or bed bath). CNA is to mark on skin sheet, anything found-red mark, pen area, bruise, scratch or rash. CNA will sign it and give it to the nurse. The nurse will asses each area. The nurse will notify the Physician, if appropriates, and carry out any further order. The skin sheet will them be given to the DON. The DON will then asses any pressure ulcers for nursing intervention. DON will document interventions and findings to determine if it was avoidable or unavoidable."

The facility presented the following abatement plan on 08/21/08. While the Immediate Jeopardy was removed on August 21, 2008, the facility remains out of compliance at a Level 2 severity. The facility still needs to evaluate the changes they have implemented and need to assess training inservices.

1. Facility policy and procedures related to wound care will be reviewed to ensure that they are comprehensive and reflect effective strategies to address pressure ulcers. If necessary additions and/or changes will be made to reflect any newly identified needs.

2. All Nursing and CNA staff will be in-serviced by Nursing Administrator on identification of any pressure sores wound care reporting (when to report changes to body and who to report changes to), how to properly complete and

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F 314	Continued From page 9 understand wound assessments and treatment policy and procedures. 3. All residents will identified pressures ulcers will be reassessed to ensure that risk assessments related to pressure ulcers are accurate and updated. 4. All residents in the building will be examined by nursing staff to ensure that all pressure ulcers are identified. 5. A QA tool will be developed and monitored weekly by DON or designee to ensure that pressure ulcers are being treated and charted in accordance with need of the pressure ulcer. 6. This plan will be monitored by the Director of Nurses and or designees on an ongoing basis, through the above mentioned QA tool, review of pressure ulcer documentation and direct observation of wound care. Pressure ulcers will further be addresses in the QA meetings to discuss IDT members problematic patients, review protocol and increase awareness of needs as they are identified relevant to this area. Completion Date: 08/29/2008	F 314		