STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5 300.1220b)3 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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S9999	Continued From page 1 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 care needs of the resident. 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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S9999	Continued From page 2 services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to complete a comprehensive, individualized assessment of residents skin; develop and implement interventions including positioning to promote healing of wounds and prevention of new pressure sores. This applies to four of five residents (R6, R8, R11, R13) reviewed for pressure ulcers in a sample of 24.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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S9999	Continued From page 3	S9999		

This resulted in R6 acquiring an unstageable wound to his left heel, a wound to his buttocks and a worsening unstageble wound to the right heel.

The findings include:

1. R6 has medical diagnoses of pneumonia, weakness, hypoxemia, COPD (chronic obstructive pulmonary disease), peripheral neuropathy, irritable bowel syndrome without diarrhea, and peripheral vascular disease as documented in R6's EMR (electronic medical record) under diagnoses. R6 also has a BIMS (brief interview for mental status) score of 13 out of 15 on the January 31, 2016 MDS (minimum data set) showing him to be cognitively intact and interviewable.

On January 8, 2016 at 8:00 AM, during the facility initial tour, R6 was in his room laying in bed with the head of the bed at a 45 degree angle. R6 had multiple dark purple bruising and skin tears to both arms. R6 stated he is on long term anticoagulants and oral steroids. R6 stated he didn't have any long sleeve shirts or anything to protect his arms. R6 was also noted to have a flat pillow under his legs with both heels resting on the bed. R6 stated he had burning pain in both heels and and his "butt." When asked if he had any sores he stated, "I'm not really sure."

On February 8, 2016 at 11:35 AM, E12 (CNA) was providing incontinence care for R6. R6's rectal area and buttocks were cleansed and R6 had open red areas on both sides of his buttocks. R6 stated they were tender. E9 (RN, Registered Nurse) then came in to apply a skin protectant to the area and stated the wound looked like a stage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

II pressure ulcer. E9 stated the treatment nurse is the one who monitors these. E12 then removed both socks and R6 had large black areas on both heels. There was no dressing, offloading or heel protectors on R6. There were sero-sanguinous stains on R6's bed sheets under his heels. R6 stated he had heel protectors on in the hospital but not since his admission to the facility. R6 was stood up on both feet with socks on and was transferred to the wheelchair which had a pressure relieving cushion on it and a pillow was placed on top of the pressure relieving cushion.

On February 8, 2016 at 12:00 PM, E10 (treatment nurse) stated R6 came in to the facility with an abrasion on his right heel and abrasions on his buttocks. E10 stated she had not seen R6 in about two days. E10 stated she was not aware of any sores on R6's left heel. E10 came into R6's room and observed large black/brown colored wounds on both heels. E10 stated R6's buttock wound was not a pressure sore it was an abrasion because its not on a bony prominence. There is no documentation, measurements or assessments of R6's buttock wounds. When asked how R6 obtained the abrasion E10 stated she didn't know. E10 stated the interventions R6 had in place to prevent pressure ulcers were skin protectant to his buttocks, air dispensing mattress, and to offload the heels with cushioned heel protector boots. E10 looked in R6's room and confirmed with R6 he did not have any heel protecting boots since his arrival in the facility.

R6 was seen again on February 9, 2016 and February 10, 2016, in his room. On February 9, 2016 in the morning R6 was seen with heel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

protector boots on. On February 9, 2016 in the afternoon R6 was seen in the wheel chair sitting on a pillow on top of his pressure relieving pad. On February 10, 2016 in the morning, R6 was seen in bed with no heel protector boots and no offloading of his heels. On February 10, 2016 afternoon, R6 was seen in his wheelchair sitting on a pillow on top of his pressure relieving cushion

On February 10, 2016 at 8:30 AM, R6 was receiving a nebulized inhaled treatment in his room via a face mask. R6 complained the mask was bothering his right ear. E13 (RN) stated to R6 the treatment was almost done but did not attempt to check the area. R6 was than noted to have a reddened open area behind his left ear. R6 was seen on multiple visits with the oxygen tubing around his ears and the padded area to have been below his ear on both sides.

R6's admission assessment dated January 24, 2016 documents the the skin assessment as: Left iliac crest bilateral oblique region with moderate skin rashes. There is no documentation of any abrasions to the buttock area. The assessment also documents the right heel has a small (approximately quarter sized) brown/black colored wound. There are no other skin abnormalities documented. The Braden score is documented as 19 (low risk) at that time. The next Braden score was done February 7, 2016 and documents R6 to be "at risk" with a score of 15. R6's admission note dated January 24, 2016 documents: "Several wounds found on R6's body. See nursing assessment." There are no measurements or any other comprehensive assessments on these skin alterations/wounds.

R6's TAR (treatment administration record) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 6	S9999		

January and February 2016 documents, "Body audit every day shift, every 7 days for skin observation." There is an "x" checked on every day it was done but no details are documented about the skin assessment.

R6's care plan dated January 24, 2016 documents R6 to be at risk for alteration in skin integrity related to steroid therapy, Braden risk and recent hospitalization. The goal was to decrease breakdown risk. The interventions listed were barrier cream to buttocks, diet and supplements, encourage reposition as needed, float heels as able and pressure reducing device on chair and bed. R6's risk factors were not identified and individualized interventions were not put into place. There is no guidance to staff on how or when to float the heels or what to float heels with or what "as needed" means. R6 came in with a right heel sore. This is not addressed in the care plan. There are no individualized interventions to heal that wound and prevent others. R6 uses oxygen and there are no interventions put in place to prevent pressure sores behind the ears from the oxygen tubing.

On February 10, 2016 at 10:15 AM, E10 stated R6 came in with a discoloration of his right heel. E10 stated she did not assess R6 until "a couple of days after he was admitted." E10 stated she did not write any assessment notes on R6 at that time of initial assessment. E10 stated she reviewed the sore and skin history with R6's wife and was told R6 always had scaly skin issues with his feet and if you pulled them off they would bleed. E10 stated when she observed the wound on the right heel on 2/8/16 it did look different than initially and the left heel wound was newly acquired. E10 stated she then had the nurse practitioner look at the wounds. E10 stated none

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 7	S9999		

of R6's wounds are considered pressure ulcers. R6 had a history of venous insufficiency and that's what caused the wounds. E10 stated concerning R6's arms that are bruised and have multiple skin tears, the physician ordered a Tegaderm to be put on the skin tears. E10 stated for protection they just try to be careful during care. They can apply sleeves for protection or ask R6's wife to bring in long sleeve shirts. When asked why none of those interventions were in place E10 stated, "I can't answer that."

The first wound notes from the Nurse practitioner are dated February 8, 2016 and document, "asked to see R6 due to open wounds on heels." This is over two weeks from the initial identification of the right heel wound and the first time the wounds were measured and documented as assessed. The description is:

Right heel: full thickness ulcer/ abrasion , base 80% dark purple, 20% pink, small amount of sero-sanguineous drainage, no malodor, surrounding skin peeling/scaly. Measurements are 7.0 CM x 2.7 CM x O CM. R6's initial assessment on admission did not have measurements but was described as small quarter sized.

Left heel : Full thickness ulcer/abrasion base 90% pink, 5% slough,5% purple, scant sero-sanguineous drainage, no malodor, surrounding skin peeling/scaly. Measurements: 1.7 CM x 1.0 CM x 0 CM.

R6's nursing notes were reviewed from admission January 24, 2016 until February 10, 2016. On January 27, 2016 there is a nursing note that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

documents, "Assessed bilateral heels and feet. Skin dry with diffuse areas of flaky tissue. Intact reddened bunion area on the lateral side of ball of right foot. R6 complains of pain to right side heel of the right foot when the foot is flat on the bed. Will elevate right heel with pillows when R6 is in bed. RN to re assess in the morning. The next skin related nursing note is January 29, 2016 which documents R6 complained of pain on his buttocks and was put to bed to get pressure off buttocks but refused to be turned. Neither of these days shows a thorough assessment was done of these areas nor was there any documentation that the physician was notified. There is no re-evaluation of these areas or interventions.

On February 10, 2016 at 11:15 AM, Z2 (Physician) stated the Nurse practitioner had notified him on February 8, 2016 about R6's heel wounds.. Z2 stated these are from his feet being dependent on the mattress. Z2 stated R6 does have some degree of PAD (peripheral artery disease) but not to the extent to cause this. Z2 stated if it was related to PAD he would expect the wounds to start in his toes not the heels. The heel wounds are definitely pressure related. Z2 stated the wounds could definitely have been prevented by getting him out of bed or keeping pressure of his heels. Z2 stated he was not made aware of the wound on R6's buttocks. Z2 stated he was told R6 had a rash from the hospital not a wound.

The facility policy dated January 2013 titled, "Skin Practice Guide," documents the purpose of the guide is to describe the process steps for identification of residents at risk for developing pressure ulcers and identify interventions to assist with management of pressure ulcers and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 9	S9999		

skin alterations.

Under"Medical Guide Initiative," it shows residents admitted with skin alterations are evaluated by a health professional(MD, NP-Nurse Practitioner, or wound specialist) within 24 hours. This was not provided to R6. R6's Primary physician notes do not address or document any of his wounds. R6 was not seen by the NP until February 8, 2016, over two weeks since admission.

The guide also documents under, "Initial Plan of Care," Upon completing the initial plan of care, a resident specific care plan to include prevention , management and interventions with measurable goals. This was also not evident in R6's initial plan of care.

2. R8 was admitted to the facility on October 12, 2015 with a documented unstageable pressure sore to the coccyx. Measurements at that time were 1.5 cm x 0.5 cm x 0.4 cm. Wound measurements remained stable until December 22, 2015. Measurements on December 22, 2015 were 1.0 cm x 0.5 cm x 0.9 cm. There were no change in treatments. On December 29, 2015 the wound then measured 2.5 cm x 1.2 cm x 1.2 cm. There were no change in treatments. On January 5, 2016 the wound measured 4.3 cm x 1.2 cm x 1.2 cm. There were no change in treatments.

On February 8, 2016 at 1:15 PM, E26 (LPN) stated during R8's wound care the staff nurses change the dressings on a daily and as needed basis and the NP (Nurse Practitioner) and treatment nurse do it weekly. E26 stated the staff nurses do not do measurements or staging. That is done weekly by the NP. E26 was asked how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

they detect changes in the wound during the week. E26 stated that was the way the facility did it.

R8's care plan has non specific, non-individualized interventions for skin integrity. The care plan documents at risk for skin alteration related to cancer, history of pressure ulcer and Braden identified risks. This was initiated on October 12, 2015 and revised on January 11, 2016. R8's wound doubled in size between December 29, 2015 and January 5, 2016 and no new treatments were initiated. The initial interventions such as float heels as able and observe skin condition daily are non specific interventions and do not guide the staff on how to float the heels. The only new interventions added on January 11, 2015 was an indwelling urinary catheter.

R8 was admitted to hospice on December 8, 2016 and there is no guidance for staff on what the goals for hospice are concerning wound care and management.

The facility policy titled "Skin Practice Guide." Dated January 2013 documents, the initial plan of care should have a patient specific care plan with measurable goals to prevent pressure ulcer development, promote healing and prevent infection. The policy under palliative care and advance care planning address the goals of wound care at the end of life. The interdisciplinary team, patient and family are involved in establishing those care plan goals and making decisions for future care. Care planning discussions are documented in the clinical record and integrated into the residents care plan.

On February 9, 2016 at 2:50 PM, E4 (assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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S9999	Continued From page 11	S9999		

director of nursing) stated R11 was admitted to the facility on December 24, 2015 with a right hip brace following a fracture at home. R11 had no skin issues until February 2, 2016 when a small wound was identified on the lower right leg. Nurse's note dated February 2, 2016 at 10:33 AM, shows R11, "complains of right lower leg pain. Norco given, effective result noted, wearing Newport brace on at all times, ambulatory with walker while in therapy." E4 said there is no documentation showing this complaint of pain was evaluated at the time. The next nursing entry is 12 hours later, on February 2, 2016 at 11:47 PM, and states a skin check was done at that time and an open area to the right posterior ankle, 1.0 x 1.5 x 0.5 moist with scant discharge, was observed. The Skin surrounding the area was reddened and swollen. E4 stated R11's brace remained on until February 4, 2016, even after staff identified the wound on February 2, 2016. Nurse's note dated February 4, 2016 at 11:46 PM, states, "Noted skin surrounding wound has bruising which was not present during initial assessment on 2/2/16." Nurse Practitioner note dated February 5, 2016 at 1:39 PM, states, "nursing staff noted unstageable pressure ulcer of right Achilles r/t brace yesterday. 2.0 x 3.5 x 0. Base 80% pink, 20% slough, serosang drainage."

On February 9, 2016 at 2:50 PM, E4 stated R11's right Achilles pressure ulcer was a DTI (deep tissue injury) that opened up on February 5, 2016, and this is why the size doubled from over the course of two days. E4 confirmed R11 developed this wound in the facility, most likely caused by the brace.

A Medical Practitioner Progress Note dated February 9, 2016 shows the right lower leg is described as an unstageable pressure ulcer as of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 12	S9999		

the assessment on February 9, 2016: base 90% slough, 10% pink and small amount serosang drainage.

R11 was sitting in her wheelchair on February 9, 2016 at 2:00 PM. The wound to R11's right Achilles was observed to be mostly slough with minimal amount of drainage. R11 said she thought the wound was caused by the brace she use to wear and it doesn't hurt as much as it use to.

R13's electronic medical record under diagnoses shows she is an 80 year old admitted to the facility November 30, 2015 with diagnoses including right hip fracture, ovarian cancer and unspecified protein-calorie malnutrition. According to E10's (treatment nurse) note, R13 was found to have fluid filled blisters on both heels during ADL care on 12/08/15. The right heel was measured at 4.0 x 5.0 x 0 cm (centimeters), stage 2. The left heel measured 3.0 x 3.0 x 0 cm., stage 2.

Z5, NP (nurse practitioner) documented both heels as stage 2 pressure ulcers and ordered skin prep daily, if blister ruptures discontinue skin prep and start Bactroban daily with dry gauze. Z5 also ordered pressure relieving boots when in bed.

R13's initial care plan dated December 01, 2015 was reviewed. R13 was noted to be at risk for alteration in skin integrity related to cancer and Braden identified risk areas for pressure ulcers. Interventions on the care plan were non specific. One intervention was to "encourage to reposition as needed; use assistive devices as needed " and "float heels as able" There were no specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012686	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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) COMPLETE DATE
S9999	Continued From page 13 devices listed to be used in the plan. R13's dressing change was observed on February 09, 2016 along with Z5 and E10 (treatment nurse). R13's pressure relieving boots were on the chair. Z5 stated the pressure relieving boots work better because they stay in place. However, the pressure relieving boots were not ordered until both of R13's heels broke down. On February 9, 2016 at 2:50 PM, E4 (assistant director of nursing) stated R11 was admitted to the facility on December 24, 2015 with a right hip brace following a fracture at home. R11 had no skin issues until February 2, 2016 when a small wound was identified on the lower right leg. Nurse's note dated February 2, 2016 at 10:33 AM, shows R11, "complains of right lower leg pain. Norco given, effective result noted, wearing Newport brace on at all times, ambulatory with walker while in therapy." E4 said there is no documentation showing this complaint of pain was evaluated at the time. The next nursing entry is 12 hours later, on February 2, 2016 at 11:47 PM, and states a skin check was done at that time and an open area to the right posterior ankle, 1.0 x 1.5 x 0.5 moist with scant discharge, was observed. The Skin surrounding the area was reddened and swollen. E4 stated R11's brace remained on until February 4, 2016, even after staff identified the wound on February 2, 2016. Nurse's note dated February 4, 2016 at 11:46 PM, states, "Noted skin surrounding wound has bruising which was not present during initial assessment on 2/2/16." Nurse Practitioner note dated February 5, 2016 at 1:39 PM, states, "nursing staff noted unstageable pressure ulcer of right Achilles r/t brace yesterday. 2.0 x 3.5 x 0.	S9999		

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(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) COMPLETE DATE
S9999	Continued From page 14 Base 80% pink, 20% slough, serosang drainage." On February 9, 2016 at 2:50 PM, E4 stated R11's right Achilles pressure ulcer was a DTI (deep tissue injury) that opened up on February 5, 2016, and this is why the size doubled from over the course of two days. E4 confirmed R11 developed this wound in the facility, most likely caused by the brace. A Medical Practitioner Progress Note dated February 9, 2016 shows the right lower leg is described as an unstageable pressure ulcer as of the assessment on February 9, 2016: base 90% slough, 10% pink and small amount serosang drainage. R11 was sitting in her wheelchair on February 9, 2016 at 2:00 PM. The wound to R11's right Achilles was observed to be mostly slough with minimal amount of drainage. R11 said she thought the wound was caused by the brace she use to wear and it doesn't hurt as much as it use to. (B)	S9999		