FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING **!L6014856** 09/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2649 EAST 75TH ST** VILLA AT WINDSOR PARK CHICAGO, IL 60649 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD) BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S 000 Initial Comments S 000 Complaint Investigation: 21861 70/IL137461 21861 71/IL137462 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610)a) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.1220b)2) 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 beformulated 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 300.1210 General Requirements for Nursing and Personal Care

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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

applicable, must develop and implement a comprehensive care plan for each resident that

a)Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as

TITLE

Affachment A Statement of Licensure Violations

(X6) DATE

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Illino is Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED C B. WING IL6014856 09/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2649 EAST 75TH ST** VILLAAT WINDSOR PARK CHICAGO, IL 60649 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD) BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 indudes measurable objectives and timetables to rneet 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 5)Aregular 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

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pressure sores unless the individual's clinical

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PUN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED C JL6014856 **B. WING** 09/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2649 EAST 75TH ST** VILLAAT WINDSOR PARK CHICAGO, IL 60649 SUMMARY STATEMENT OF DEFICIENCIES (X4) D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL ID BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 2 S9999 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 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 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) THESE REQUIREMENTS WERE NOT MET EVIDENCIED BY Based upon record review, and interview, the facility failed to ensure that ostomy appliances were on to prevent skin breakdown, failed to follow the skin management guidelines, failed to assess pain level, failed to conduct a thorough skin assessment on admission, failed to conduct skin assessments as ordered, and failed to obtain treatment orders for one of six residents R3 in the sample. implement care plan interventions, failed to ensure that treatment orders are entered on the TAR (Treatment Administration Record). failed to apply ostomy bag to stomas, and failed

to follow physician orders for one of six residents

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STATEMENT OF DEFICIENCIES AND PUN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY
		IL6014856	B. WING	<u> </u>		C
NAME	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	09/30/2021	
VILLA	AT WINDSOR PARK	2649 EAS	T 75TH ST ), IL 60649			
(X4) D PREFD TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRINT DEFICIENCY)		Dec	(X5) COMPLETE DATE
S <b>9</b> 99	Continued From pa	ge 3	S9999			
	abdominal wall and ostomies being covered	These failures resulted in pus maceration of her R3 at risk for infection due to ered with diapers and not my bags and R3's 8/25/21				
	Findings include.					
	R3 was admitted on urology clinic on 8/2 facility.	8/13/21 was sent to the 5/21 and did not return to the				
	to facility with coloste stoma site for stool I Change colostomy be ordered/as needed. of bleeding or inflam Monitor for signs or surostomy or stools as has potential for skin mobility and medical	ian states, resident admitted omy/urostomy. Monitor eakage and skin irritation. ag and appliance as Monitor stoma site for signs mation and notify physician. symptoms of pain with not notify physician. Resident breakdown related to comorbidities. Follow facility the prevention of skin				
	include complete skir Click Care) on admis pain every shift include every shift and as near	Physician Order Sheets) n evaluation in PCC (Point sion and weekly. Evaluate de Urostomy/Colostomy care eded check appliance and stomy bag and appliance shift.				
	Administration Record were no physician ord ostomy care and bag/	M, V2 (Director of Nursing) st 2021) TAR (Treatment d) which was blank (there lers). Surveyor inquired if wafer changes are AR V2 stated "They should				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		IL6014856	B. WING			C 30/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DORESS, CITY, STATE, ZIP CODE				
VILLAAT	WINDSOR PARK		T 75TH ST ), IL 60649			•	
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(X4) ID PREFIX TAG			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				
	be."						
	R3's MAR (Medication Administration Record) affirms 8/25/21, dayshift pain evaluation is blank therefore not assessed (as ordered).						
	obtaining resident of Manager) stated, "Congression equipment we may On 9/8/21 at 10:11A R3 V10 (Unit Managambulatory, alert, he	AM, surveyor inquired about ger) stated "She was ad two ostomy's. She would ne bed and it would come off, !					
	R3's ostomy needs. "She (referring to R colostomy if I'm not a bag and I have to something happens out of ostomy suppl	AM, surveyor inquired about V12 (Central Supply) stated, 3) had an ileostomy and mistaken. There's just ten in order twenty just in case ." Surveyor inquired if R3 ran ies while at the facility. V12 refore ostomy invoices were ne.					
٥	concerns with R3's of Nursing Assistant) is she needed someth like two colostomy's The way those bags	AM, surveyor inquired about ostomy's. V13 (Certified stated, "She was real sweet, if ling she asked. She "She had it was a lot going on with her. It was a lot going on with her. It was a lot going and stomy's was big."					
	purchase order which with Convex BA (qua	AM, V12 presented (8/24/21) ch includes urostomy pouch antity: 1) V12 affirmed there estomy orders placed during					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6014856	B. WING			C 30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
VILLAN	VILLAAT WINDSOR PARK 2649 EAST 75TH ST CHICAGO, IL 60649						
(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 SHOUL D BE  CROSS-REFERENCED TO THE APPROI⊃RIATE  DEFICIENCY)		(X5) COMPLETE DATE	
S9999	Continued From pa	ge 5	S9999				
	eleven days after he provided no evidence	lity.The order was placed er admission. The facility ce during this survey that R3's oplies were available.					
	presents today in dipain. She is found to either her ileostomy have not been approtime due to severe descriptions and control of the control	gy history & physical states stress, severe abdominal o have no appliances on or ileal conduit, appears to opriately cared of for some cutaneous maceration and of her abdominal wall. LLQ nt) and RLQ (Right Lower without appliances are er on exam, substantial fecal is covering lower abdomen.					
	she was found to be	al history & physical states be lying on the exam table in a paining of 7/10 pain on skin		i e			
	potential harm to sk not contained in coll Director) stated "You	AM, surveyor inquired about in Integrity if ostomy waste is ection bags V18 (Medical ure going to get skin concern for infection, cellulitis		iti			
:	R3 V16 (Wound Car any records for her (	AM, surveyor inquired about re Nurse) stated "I don't have (R3)" and affirmed she (R3) he wound care team.					
÷	facility protocol for si (Wound Care Nurse comes in, they shou from the admitting n	PM, surveyor inquired about kin assessments V16 ) stated "When the patient ld receive a skin assessment urse and someone from inquired about R3's skin					

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FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6014856 09/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2649 EAST 75TH ST** VILLAAT WINDSOR PARK CHICAGO, IL 60649 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH CORRECTIVE ACTION SHOULED BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) S9999 S9999 Continued From page 6 assessments. V16 responded "Her admission assessment says she has a urostomy and a colostomy, that's it. No skin impairments" however the 8/13/21 assessment which she was referring to includes skin impairments on the right and left thigh There was no description/measurements for either wound. Treatments were not prescribed for either site. Surveyor inquired if any additional skin assessments were documented in the PCC (as ordered) V16 reviewed PCC and stated. "I cannot see anything for R3." V16 advised "If they check offthe positive sign (during skin assessment) it triggers for the evaluation to be done by wound care. I never assessed her for any wounds, nobody ever reported any issues. Even excoriation is something that they should report." On 9/28/21 at 1:39 pm, V21 (Registered Nurse, RN) stated that she recalled R3 leaving the facility for a doctor's appointment on 8/25/21. V21 stated that R3 did complain of the peristomal skin being "irritated," and when V21 assessed R3's ostomy sites, she would either change R3's ostomy wafer/bag or would reinforce the leaking wafer to R3's skin with tape. V21 stated that when R3 was admitted to the facility, R3's peristomal skin was not excoriated. V21 stated. "When it (peristomal skin) became excoriated here, we used (ointment) to help." The 6/29/21 colostomy, urostomy care policy states it is essential that a pouch be placed over a stoma correctly so the output from the stoma is contained, the skin around the stoma is protected and a patient is free from odor or leakage.

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Change the ostomy pouches when they are 1/3-1/2 full to avoid leakage, which can lead to chemical or enzymatic injury to the skin.

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