Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008270	A. BUILDING: ______ B. WING ______	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT ELMWOOD PARK	7733 WEST GRAND AVENUE ELMWOOD PARK, IL 60707

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S 000	Initial Comments Annual Licensure	S 000		
S9999	Final Observations Statement of Licensure Violation 300.675b)3)4) 300.675c)3)4) Section 300.675 COVID 19 Training Requirements Emergency b) Required Frontline Clinical Staff Training 3) Facilities shall ensure 100% of the frontline clinical staff have completed the CMMS Training by February 28, 2021. 4) Facilities shall require, within 14 days after hiring, CMMS Training for all frontline clinical staff hired after January 31, 2021. c) Required Management Staff Training 3) Facilities shall ensure 100% of management staff have completed the CMMS Training by February 28, 2021. 4) Facilities shall require, within 14 days after hiring, CMMS Training for all management staff hired after January 31, 2021. This requirement is NOT MET as evidenced by: Based on interview and record reviews, the facility failed to ensure a 100% compliance of the Targeted COVID -19 Management staff after February 28, 2021 and failed to ensure that the Targeted COVID - 19 training was completed within 14 days after hiring.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

On 03/07/22 at 10:30am V2 Director of Nursing said, I haven't completed the Manager CMS training, I'm not even sure I'm familiar with that course or requirement. On 03/09/22 at 4:00PM V1 Administrator said, I'm not aware if V2 has completed any of the CMS training, if she says she hasn't, then that is the case. I will update the CMMS documents to reflect that 100% of the staff has not completed the training.
The facility was unable to provide any documentation indicating certification had been obtained.

(B)

300.1010h)
3001210b)
300.1210d)5

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

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological

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S9999	Continued From page 2	S9999		

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 services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Requirements were Not Met as evidenced by:

Based on interviews and record reviews, the facility failed to accurately assess and evaluate pressure ulcer wounds; failed to notify physician and implement necessary treatment orders and interventions in preventing the development and or worsening of pressure ulcers for four (R28, R36, R55 and R133) of nine residents in a sample of 47 reviewed for pressure ulcers. These deficiencies resulted in R28 who was admitted in the facility with intact skin but developed a facility acquired Stage 3 pressure ulcer on the sacrum; R36's Stage 3 pressure ulcer on the coccyx increased in size and became Unstageable;

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S9999	Continued From page 3	S9999		

R55's surgical wound in the abdomen developed into Stage 3 pressure ulcer; and R133's left hip and left elbow wounds worsened into Stage 4 pressure ulcers.

Findings include:

R36 is a 79-year old, female, admitted in the facility on 12/16/2021 with diagnoses of Encounter for Surgical Aftercare Following Surgery on the Digestive System; and Personal History of Malignant Neoplasm of Breast.

According to R36's physician wound notes, the following were documented:
12/21/21: Initial Wound Evaluation and Management Summary
Stage 3 pressure ulcer (PU) wound coccyx - measurement: 4 cm (centimeters) x 0.5 cm x 0.1 cm, admitted with. Low air loss mattress was one of the recommendations.
01/11/22: Wound Evaluation Management Summary
Stage 3 PU coccyx - 9 cm x 9 cm x 0.2 cm
02/24/22: Wound Evaluation and Management Summary
Stage 3 PU coccyx - 3.5 cm x 3 cm x 0.1 cm

R36's census reports recorded:
12/16/21 - admission
02/14/22 - hospital due to difficulty in swallowing
02/22/22 - readmission to facility

Per R36 progress notes dated 03/01/22, time stamped 9 AM, she went to the hospital for an evaluation due to inability to open mouth during medication pass and unable to move hands. She went back into the facility on the same day at 12

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S9999	Continued From page 4	S9999		

PM. There was no assessment documented on 03/01/22 but on 03/03/22, Wound Evaluation and Management Summary indicated that she now has Unstageable PU on the coccyx with measurements of 10 cm x 12 cm x 0.1 cm.

On 03/07/22, R36 was observed in bed, lying on her back, on a regular mattress. V7 (Certified Nurse Assistant, CNA) was observed providing morning care and incontinence care on R36. As V7 turned R36 to the left side to clean the back, it was observed that there was a very soiled dressing covering her (R36) coccygeal area, which was about to come off. Surveyor asked V7 to verify the date on the wound dressing. The date was 03/05, meaning March 05. V7 removed the soiled wound dressing, stating that she will notify the wound care nurse. V7 took some gauze, put some barrier cream on the gauze and placed it in the wound to cover it.

POS (Physician Order Sheet) dated 03/04/22 documented: Santyl ointment: wound care site 3 coccyx-cleanse with NSS (normal saline solution), apply santyl, mupirocin, alginate, cover with dry dressing once a day.

On 03/07/22 at 12:14 PM, V3 (Treatment Nurse/Licensed Practical Nurse, LPN) was asked regarding wound treatment and R36. V3 stated, "I am the wound care nurse in the building. I work Mondays through Fridays from 7 AM to 3 PM. On weekends, I work every Saturday just to do the daily dressing. Sundays, there is no wound care on Sundays. Floor nurses are the one doing the wound care. Her coccygeal wound is a daily dressing. It needs to be clean and dress every day. I was the one who did the March 05 dressing. It was not done on March 06. I don't think it is okay, it should be daily." At 1:35 PM,

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S9999	Continued From page 5 wound care was observed on R36 performed by V3 assisted by Wound Technicians V10 and V11. V10 stated, "When we came, there was no dressing on the wound. It came off." During wound dressing, a new skin redness was noticed on the upper right portion above R36's coccygeal wound. V3 verbalized, "There is a new DTI (deep tissue injury) on the side of the wound. It is new, did not see it last time. The resident (R36) is not being turned and repositioned. She (R36) has a pillow wedge. We have to follow doctor's order for a daily dressing treatment. If the dressing gets soiled and I'm not here, the nurse on the floor needs to change it. We cannot put any medicine on the pressure ulcer wound, barrier cream is fine. I will cover the new DTI with a foam dressing and I will notify V9. The DTI is measured 1.5 cm x 2 cm. Now the coccyx PU is measured 14 cm (centimeters) x 8.5 cm." Progress notes dated 03/09/22 documented: Resident (R36) wound was measured at 14 x 8.5 on 03/07/22. Resident (R36) also has a new DTI on her right buttock, 1.5 x 2. R36's Care Plan on Pressure Ulcer dated 12/21/21 documented: Approach 12/26/21 - Provide treatment as ordered; Conduct a systematic skin inspection daily and weekly. Pay particular attention to the bony prominences; Report any signs of skin irritation and/or breakdown (sore, tender, red, or broken areas). R36's Medication Administration Record (MAR) indicated the following dates with missing signatures from staff related to wound care treatment: Jan 1-31, 2022: Missing signatures on 13, 14, 15, 16, 17, 18, 21, 24, 25, 26, 27, 28, 31	S9999		

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S9999	Continued From page 6	S9999		

February 1-28, 2022: Missing signatures on February 1, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 23, 25, 26, 27, 28
March 2022: Missing signatures on 2, 3, 5, 6

V3(Treatment Nurse/LPN) was asked regarding missing signatures on R36's MAR. V3 replied, "If it is not sign, then it is not done."

On 03/08/22 at 10:15 AM, R36 was observed asleep in bed, lying on her back on a regular mattress. V3(LPN) was asked regarding R36's bed. V3 stated, "She is using a regular mattress. She has Unstageable PU. When she came back last 02/22/22, I asked V2 (Director of Nursing) for a low air loss mattress (LAL). She said she is going to order it. From 02/22/22 to now, she is using a regular mattress. She is supposed to use LAL mattress. With this regular mattress, there is no air flow to the mattress to shift the pressure to wound on the back that needs to be relieved." V3 was also asked if V9 (Wound Physician) was notified of the new DTI on R36's lower back. V3 replied, "I did not call him (V9) for the DTI because he (V9) had a death in the family. I just covered it with a foam dressing, no medication treatment yet. He (V9) is the only wound care doctor."

V2 (Director of Nursing) was also asked on 03/08/22 at 3:23 PM regarding wound care and R36. V2 verbalized, "She was admitted on 12/16/21 with sacral PU Stage 3 on the coccyx. She went out on 02/14/22 and returned 02/22. She has Stage 3 PU and should be on a LAL mattress. Today is the first time I heard that she was not on LAL mattress. If the order is daily dressing, we need to do treatment as ordered. The wound care nurse is not here on Sundays, the nurses on the floor do the wound care

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S9999	Continued From page 7	S9999		

treatment. The floor nurses are also expected to change the dressing when needed. Staff will observe for skin breakdown and wound care nurse should be notified. If there is a new skin issue and wound doctor (V9) is not available, we can always text him (V9) and he will give orders or will call for orders. Residents, when they come back from the hospital should be assessed for any skin problem."

On 03/09/22 at 1:48 PM: V9 was interviewed regarding R36 and pressure ulcer. V9 stated, "On R36, I have been seeing her since December. 2021. She had a Stage 3 pressure ulcer on the coccyx. She was last seen on 03/03/22, her wound measures 10 cm x 12 cm x 0.14 cm and the wound is Unstageable. In general, treatment orders need to be followed consistently. She has a Stage 3 pressure ulcer, a low air loss mattress should be provided. I need to be notified when there is a new skin issue on a resident. On her (R36), I was not notified regarding her new deep tissue injury on the lower back. Yes, if treatment orders are not administered and followed consistently, along with other interventions and notification, everything combined could be attributed to the worsening of a pressure ulcer."

Facility's policy titled "Wound Care" revised date 05/17 documented in part but not limited to the following:
Objective: To protect the wound from contamination and control bleeding.
E. Wound Care Documentation
1. Follow physician's orders for wound care.
2. Documentation of wound care must be completed each time the treatment is done. This documentation will be done on the Treatment Administration Record (TAR).
7. The physician must be notified of change in the

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S9999	Continued From page 8	S9999		

wound status.

Facility's policy titled "Wound Management Protocol" documented in part but not limited to the following:
Pressure Ulcer Prevention Control Guidelines:
2. All beds in facility will have pressure reducing mattresses unless pressure relieving mattresses are required according to the resident's needs.
4. Residents who are assessed as being at high risk will have a plan of care that will include:
A. Daily skin checks conducted by either the CNA or Licensed Nurse to ensure early identification of potential problem areas.

Facility's policy titled "Management of Wounds" stated in part but not limited to the following:
Policy: Our mission is to facilitate resident independence, promote resident comfort, and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective wound management program, allowing our residents a means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement.
1. Assessing the resident
Daily skin assessment - to be done by RN (Registered Nurse)/LPN) or CNA daily for all at high risk residents.

R28 is a 56 year old resident with diagnoses listed in part with congestive heart failure, chronic obstructive pulmonary disease, morbid obesity and respiratory failure.

MDS (Minimum Data Set) dated 9/15/21 showed R28 assessed as "at-risk" for skin breakdown and with no current pressure ulcers.

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S9999	Continued From page 9 A facility wound summary report provided to surveyors on 3/8/22 showed R28 on the list of facility-acquired pressure ulcers. Wound note dated 1/11/22 written by V9 (wound doctor) showed, "Patient presents with a wound on her sacrum. She has a stage 3 pressure wound sacrum for at least 1 days duration. Wound Size (L x W x D): 3 x 10 x 0.2 cm. There is light serous exudate. MDS 3.0 Stage 3. Santyl apply once daily for 30 days; Alginate calcium apply once daily for 30 days. Off-load wound; Reposition per facility protocol. On 3/9/22 at 10:40 AM, wound observation with V3 (wound nurse/LPN). Surveyor asked V3 to describe the wound as she conducted the treatment. V3 stated, "R28 has a stage 2 wound and It measures around 4.5 centimeters x 15 centimeters and I can't tell you the depth because I don't really know what it is. It was necrotic (dead tissue) at one point and it was open but I don't know how it was before I got here. I just took over the wound care last month because the previous wound person just walked out during the shift so she couldn't really train me." Surveyor asked whether the sound was facility-acquired, V3 stated, "I don't know. I wasn't trained to do the assessments. I just do the treatments. Surveyor asked if the increase in measurements would indicate a decline in the wound, V3 stated, "Like I said, I don't know anything about wounds, I was just thrown in this position to do the treatments until they found a wound nurse." Asked how long the facility was without a wound nurse, V3 stated, "Probably around February 14. I just remember it was around Valentines day when the previous wound nurse walked out." Surveyor asked who conducts the wound treatments in the facility, V3 stated, "I work six days a week and on my off days, the nurses should be doing them."	S9999		

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S9999	Continued From page 10 Facility treatment records provided to the survey team on 3/9/22 show from 1/1/22 to 3/9/22 a total 20 missed treatments for R28. Physician orders dated 1/13/22 show, "Wound care: Site 1 sacrum; cleanse with normal saline solution, apply santyl, calcium alginate, cover with a dry dressing; Frequency: Once a day." 03/09/22 01:07 PM Surveyor asked V3 "What is the cause of why the surface area of a wound increased," V3 stated, "Because she wasn't being turned and repositioned is why it increased." At 2:45 PM during an interview with V9 (wound doctor), V9 stated, "I was told that the current wound nurse (V3) was trained. I'm not aware she wasn't. Surveyor asked who communicated to him about which residents to see for wounds, V9 stated, "The DON (V2) will touch base with me once and awhile but she does not tell me who to see, it is the wound nurse V3. Asked the importance of following doctor's orders, V9 stated, "When I give a recommendation it is an doctor's order and I expect them to be followed. It is not acceptable for treatments to be ignored or not followed. R55 is a 73 year old female admitted to the facility 06/12/18 with diagnoses that include generalized muscle weakness, Colostomy, and Rheumatoid arthritis. R55 has a BIMS of 13 and was alert and oriented at the time of this investigation. R55 acquired a pressure ulcer to the left abdomen on 11/24/21 while residing in the facility. On 03/08/22 at 10:51AM, R55 said, I got a sore on my abdomen because they don't change my colostomy bag regularly. I get treatments every three days now and that's when they are supposed to change the bag and the dressing.	S9999		

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S9999	Continued From page 11 R55's wound care notes reviewed and it was noted that R55 had not been evaluated by the V9 Wound MD since 2/08/22. On 03/09/22 at 03:23 PM V9 said, the last visit with R55 was on 2/08/22. I'm not sure why it has been over a month that I've seen this R55. When I come into the facility the treatment nurse gives me a list of residents that need to be seen. So at this time I don't know if the wound is getting better or worse. The pressure sore could have developed either from moisture or something pressing against the skin. I believe this sore was from the colostomy bag. From the Colostomy, it may have been leaking, which can cause an irritation from the skin. It could have been prevented by using a skin barrier that is often used with the appliance. Wound Progress note written 11/24/21 assessed a Stage III pressure ulcer to the left abdomen. The wound demonstrated to be stable and healing from 11/24/21 to 1/20/22. Wound Management Detail Report dated 1/20/22 measures wound length 1.5cm, and width 1.5cm. The following visit was 02/08/22 with measurements: width 3.5cm, and length 3.5cm with a depth of 0.1cm. On 03/09/22, V3 treatment nurse said, the measurements mean the wound has gotten worse. I continue to provide the dressing but I have not documented on the measurements or how the wound looks. I just chart on the Treatment Administration Record. (B)	S9999		