STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: _____ B. WING _____	C 04/07/2023

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DOWNERS GROVE REHAB & NURSING	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

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S 000	Initial Comments Complaint Investigation 2372592/IL158098	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)3) 300.1210d)5) 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 300.1210 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 well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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) 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. Based on interview, and record review, the facility failed to ensure a resident's treatment for her	S9999		

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stage IV pressure ulcer was completed as ordered, failed to ensure ongoing assessment and monitoring was done for the pressure ulcer, and failed to ensure the Wound Physician referral was carried out. These failures resulted in R1 being discharged to the hospital on 3/24/23 with a change in condition and a subsequent diagnosis of osteomyelitis to her stage IV pressure ulcer on her right heel.

This applies to one of three residents (R1) reviewed for pressure ulcers in the sample of six.

The findings include:

R1's Face Sheet showed she was admitted to the facility on 3/1/23 and discharged on 3/24/23.

On 4/1/23 at 9:53 AM, V4 (R1's Son) stated R1 had a pressure ulcer to her right heel that started in August 2022 at another facility. R1 had a stroke, went to the hospital and then to another rehab facility. R1 received treatment for her right heel wound at that facility and it improved, and she eventually transferred to this facility. V4 stated he received a call from the facility that R1 was unresponsive and had to go to the hospital. V4 stated when he got to the hospital, the Doctor lifted the cover over R1's feet and there was an awful odor, and the Doctor said the odor was from R1's heel wound. V4 stated the Doctor also told him R1 came in without a dressing on her right heel. V4 stated the boot for R1's right heel had discharge and blood in it and the Doctor told him that R1's pressure ulcer wound looked as if it had not been taken care of. V4 stated an MRI (Magnetic Resonance Imaging) was done that showed the wound to her right heel was infected to the bone. V4 stated the Doctor told him the infection had left R1 with three options: the first

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option would be surgery, but due to being 90 years old it was not advised because she would probably not survive; the second option would be intravenous antibiotics for 6 weeks, but her kidneys would not take that; or the third option would be to put R1 on hospice to die. V4 stated R1 was on hospice and dying.

R1's 3/1/23 Interdisciplinary Discharge Summary from her previous facility showed that on 2/22/23, R1 was seen by a physician for her right heel stage IV pressure ulcer with noted improvement. R1's treatment was changed to include silver alginate, and R1 was to follow up with the physician in one week (3/1/23, day of admission). R1's 3/1/23 Admission Skin Integrity form showed she had a stage 4 pressure injury to her right heel, and no assessment of the pressure injury was documented.

R1's 3/1/23 pressure ulcer risk assessment showed she was at high risk for pressure ulcers. R1's 3/2/23 Physician's Progress Note showed the presence of a right heel wound and a left heel deep tissue injury, and the facility should elevate R1's heels in bed, obtain a wound care consult, and continue dressing changes as ordered.

R1's Physician Order's for her right heel pressure ulcer (effective 3/1/23, printed 4/1/23) showed a treatment order for Dakin's solution to be applied to the right heel pressure ulcer topically on day shift on Monday, Wednesday, and Friday. The right heel was to be cleansed with the solution, rinsed with saline and patted dry, and then calcium alginate with silver applied and covered with a gauze island dressing. R1's orders showed the treatment could also be applied "as needed."

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S9999	Continued From page 4 R1's March 2023 TAR (Treatment Administration Record) reflected entries for the same orders; one entry for a scheduled treatment every Monday, Wednesday, and Friday, and a separate entry for the same "as needed" order. R1's TAR showed the scheduled treatment order entry was never signed off as completed, and instead showed four entries of "9" (on 3/8, 3/10, 3/13, and 3/15). The legend on the TAR showed "9 = Other/See Progress Notes;" however, R1's progress notes from those dates do not contain information regarding R1's stage IV pressure ulcer or her treatment. This same entry on the TAR also showed R1's scheduled order was discontinued on 3/15/23. The "as needed" treatment entry on R1's TAR showed the treatment was completed twice, and last completed on 3/7/23, the same day the entry showed that it was also discontinued. R1's March 2023 MAR (Medication Administration Record) again reflected the same order, and the entry was signed off as completed one time in March on 3/3/23. The MAR showed the treatment was also discontinued on 3/7/23. R1's March 2023 TAR and MAR showed no treatments were done for R1's right heel stage IV pressure ulcer after 3/7/23 (for 17 days), until she was hospitalized on 3/24/23. R1's March 2023 Physician Orders showed orders were good for 30 days unless otherwise noted, did not show that her right heel pressure treatment orders were discontinued, nor did they include Wound Care consult referral. R1's 3/9/23 Weekly Wound Assessment (8 days after admission) showed the admitted stage IV pressure injury to her right heel with 100% granulation tissue present in the wound. The right heel pressure ulcer (in centimeters -cm)	S9999		

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S9999	Continued From page 5 measured 2.5 x 3.4 x 0.1 cm. This was the last Weekly Wound Assessment documented for R1's stage IV pressure ulcer in her medical record; no other documented assessments were found for R1's right heel for the next 15 days prior to R1's hospitalization on 3/24/23. On 4/5/23 at 1:40 PM, V2 DON (Director of Nursing) verified that R1's 3/9/23 Weekly Wound Assessment was the last assessment in R1's medical record for R1's right heel pressure ulcer. On 4/5/23 at 3:21 PM, V9 (Nurse Practitioner) stated she saw R1 on 3/2/23 and put in a progress note. V9 stated R1 had a dressing on a wound to her right heel. V9 stated the facility should have put in the order for the Wound Care consult because it was documented in her progress note to get a Wound Care consult and it was the facility's protocol. V9 stated if treatments were not being done for R1's right heel wound, it would lead to deterioration of the wound, foul odor, soiled dressings, and infection, including osteomyelitis. V9 stated R1's wound could have taken 2-3 weeks to deteriorate from the 100% granulation tissue to eschar. V9 stated she reviewed her progress note and treatment order in R1's medical record and stated R1 should have been receiving treatments to her right heel wound on Mondays, Wednesdays, and Fridays. V9 described the R1's pressure ulcer treatment order and stated the treatment order was not discontinued. R1's 3/25/23 hospital Podiatry consult showed " ...Patient moaning during dressing change ... Integumentary: There is a 4 cm diameter pressure ulceration on the posterior aspect of the patient's right heel. Covered with loosened eschar [dead tissue] ...mild cellulitis surrounding the wound site ..."	S9999		

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The "Findings" section of R1's 3/25/23 right heel MRI result from the hospital (from the day after R1's facility discharge) showed " ...soft tissue defect, skin at the area of the calcaneus [heel]. There is edema in the calcaneus. This is consistent with osteomyelitis ..." Under "Impression" the result showed "Cellulitis, soft tissue ulcer with osteomyelitis calcaneus ..."

On 4/1/23 at 10:56 AM, V5 LPN (Licensed Practical Nurse/Wound Care Nurse) stated R1 was admitted with the stage IV pressure ulcer to her right heel. The orders were to clean the wound with Dakin's solution, rinse with normal saline, apply calcium alginate and gauze. The treatments were to be done Monday, Wednesday, and Friday. V5 stated R1 came to the facility with these orders, and the treatment orders were to be continued. V5 stated they would not change the treatment unless the wound was deteriorating or not getting better after 2-3 weeks. V5 stated then they would ask the family if the facility could get a consult with their wound care physician.

R1's Care Plan initiated on 3/2/23 with revisions on 3/9/23 and 3/17/23 showed she had a stage IV pressure ulcer to her right heel that was present upon admission. Interventions include to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing, measure length, width and depth where possible, assess and document status of the wound perimeter, wound bed and healing progress, report improvements and declines to the Doctor, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing to make sure it is intact and adhering, and report loose dressing to the treatment nurse.

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S9999	Continued From page 7 On 4/1/23 at 3:20 PM, V5 LPN (Licensed Practical Nurse/Wound Care Nurse) stated if she is not here, the wound treatments still need to be done. V5 stated staff are to follow the treatment orders in the chart and that is why they are there. V5 stated if a dressing is not changed as ordered, the wound could deteriorate and become infected. V5 stated if the provider requests a Wound Care consult, then an order for it should put in. V5's weekly wound round notes showed measurements were done one time for R1 during her stay at the facility. V5 stated the rest of the time, they were just monitoring the right heel. V5 stated she could have missed R1's treatments when she was off with Covid, and added the other nurses are able to do treatments and measurements as well. On 4/1/23 at 4:56 PM, V6 RN (Registered Nurse/Nurse Practitioner) stated when a resident is admitted, a head-to-toe assessment is done and documented. V6 stated any wounds are documented and the Physician is informed. V6 stated an order is obtained for Wound Care to see the resident. V6 stated nurses can measure and describe the wound, but they cannot stage a wound. V6 stated if wound treatments are not done as ordered, the wound can deteriorate, including to the point of infection in the bone and sepsis. R1's 3/24/23 Nurse's Note showed when the nurse went to give R1 a respiratory treatment at 6:00 AM, R1 was very lethargic and could not open both eyes but was responsive to tactile stimuli. The notes showed when the physician was notified, R1 was sent to the emergency room. R1 did not return to the facility.	S9999		

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On 4/5/23 at 12:40 PM, V2 DON (Director of Nursing) stated the facility's process for residents with wounds is to get a wound assessment upon admission and document the assessments in the resident's medical record. V2 stated families are notified about the wound. V2 stated if the Wound Care Doctor has a resident on caseload, then their notes are reviewed for the current treatment plan and those are entered as orders. V2 stated if the resident is not being seen by the Wound Care Physician, then orders are obtained from the primary Physician or Nurse Practitioner for a wound care consult. V2 stated if it is documented in the Physician or Nurse Practitioner progress notes that a Wound Care Consult is needed, the nurse will put in an order. V2 stated assessments of wounds and pressure ulcers are to be done weekly and the results documented in the resident's medical record.

R1's Face Sheet showed diagnoses of dementia, major depressive disorder, anxiety, congestive heart failure, chronic obstructive pulmonary disease, hypothyroidism, anemia, hypertension, chronic kidney disease, hyperlipidemia, atherosclerotic heart disease, hemiplegia and hemiparesis of the left side. R1's 3/7/23 MDS (Minimum Data Set) showed R1 has moderate cognitive impairment, and bed mobility, toilet use, and personal hygiene occurred only once or twice. This MDS also showed one stage 4 pressure ulcer was present upon admission.

The facility's undated Pressure Injury and Management showed the intent of this organization is to develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries unless clinically unavoidable, and that the facility provides care and services consistent with

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S9999	Continued From page 9 professional standards of practice to promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible). The policy continued, showing that evaluation/assessment of pressure ulcers/injuries will be completed weekly and with significant change in condition of the ulcer/injury by a licensed nurse and/or practitioner. Regarding documentation, the policy showed documentation of the evaluations/assessment of the pressure ulcer/injury will be maintained in the resident's medical record and may include location of ulcer/injury, date acquired, description to include stage, measurements (length, width, depth), type of tissue (epithelial, granulation, slough, necrosis, etc.), presence/absence and type of drainage, surrounding tissue description, and presence/absence of pain with the ulcer/injury .... If a referral is made to a wound consultant, a physician's order will be obtained for the referral ... Treatments will be ordered by the physician/practitioner... The effectiveness of the pressure ulcer/injury treatment will be evaluated weekly during the weekly evaluation/assessment of the wound ... If improvement in the wound is not seen within two weeks, the physician/practitioner will be contacted with the assessment and alternative treatment measure obtained as indicated ... The resident centered care plan will be developed and implemented to address the resident's risk for the development of a pressure ulcer/injury and to promote healing if the resident has a pressure ulcer/injury... (A) 2 of 2 300.610a)	S9999		

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S9999	Continued From page 10 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)5) 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 300.1210 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999		

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S9999	Continued From page 11 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. 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. Based on observation, interview and record review the facility failed to ensure a resident's pressure ulcer treatment was being carried out as ordered. This applies to 1 of 4 residents (R6) reviewed for pressure ulcers in the sample of six. The findings include: On 4/5/23 at 10:26 AM, R6 was in an isolation room, wearing a hospital-type gown that did not cover her while up in her padded wheelchair. R6 was positioned with the right side of her body rubbing on the side of her wheelchair. At 10:31 AM, a skin check was done with V11 CNA (Certified Nursing Assistant) and R6 had a thin, self-adherent dressing to her right hip that was soiled with brown drainage. The dressing was partially rolled back to show an open wound. The dressing was not dated or initialed and no ABD (abdominal) gauze pad covered the self-adherent	S9999		

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dressing. R6's April 2023 wound treatment orders showed to apply calcium alginate and collagen sheet to the wound daily, cover with an ABD gauze pad, secure with tape, and offload the wound.

R6's April 2023 TAR (Treatment Administration Record) showed the treatment in place was clean R6's right hip pressure ulcer with normal saline, pat dry, apply calcium alginate, and cover with ABD pad. R6's TAR did not include the application of a collagen sheet. Additionally, R6's TAR showed treatments were not signed off daily as being completed on 4/1, 4/2, and 4/4/23.

R6's March 2023 TAR R6 showed the treatment in place for March showed the application of calcium alginate, and the wound covered with ABD pad and tape. R6's listed wound treatments for the entire month of March 2023 also did not include the order for a collagen sheet to be applied to the R6's pressure wound. Additionally, R6's March 2023 TAR showed the treatments were not signed off as completed on 3/5, 3/10, 3/14, 3/23 and 3/29.

The addition of the collagen sheet for R6's pressure injury treatment was noted in R6's 2/21/23 Wound Physician's Progress Note (43 days earlier). R6's 3/28/23 Wound Physician's Progress Note showed R6 had a stage 4, full thickness pressure ulcer to her right hip. The wound measured (in centimeters -cm) 2 x 3.8 x 1.4 cm depth, with moderate serous drainage, 95 % granulation tissue and 5 % slough present.

On 4/5/23 at 12:40 PM, V2 DON (Director of Nursing) stated the facility's process for residents with wounds is to get a wound assessment upon admission and document the assessments in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: _____ B. WING _____	C 04/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNERS GROVE REHAB & NURSING	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

(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 resident's medical record. V2 stated families are notified about the wound. V2 stated if the Wound Care Doctor has a resident on caseload, then their notes are reviewed for the current treatment plan and those are entered as orders. R6's Face Sheet showed her diagnoses include dementia, hypertension, hyperlipidemia, hypothyroidism, dysphagia, psychosis, major depressive disorder, vitamin B12 deficiency anemia, chronic kidney disease, and spinal stenosis. R6's 3/11/23 Minimum Data Set (MDS) showed extensive assistance was needed for her activities of daily living and she has severe cognitive impairment. The facility's undated Pressure Injury and Management policy showed the intent of this organization is to develop and maintain systems and processes to ensure .... that the facility provides care and services consistent with professional standards of practice to ... promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible). The policy continued and showed treatments will be ordered by the physician/practitioner .... evaluated weekly during the weekly evaluation/assessment of the wound... (B)	S9999		