STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000558	A. BUILDING: _____ B. WING _____	C 04/13/2023

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Z 000	COMMENTS Complaint Survey 22810162/IL154580 22810313/IL154770	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1230d)1) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. These Requirments are not met as evidenced by: Based on interview and record review, the facility failed to identify, assess, monitor for changes in skin breakdown characteristics, and notify the	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 physician of the changes in skin breakdown characteristics for 1 of 3 (R3) residents, reviewed for pressure ulcers. As a result, R3 developed a very, large sacral pressure ulcer, with necrotic(dead) tissue, that became infected, extended into the muscle and down to the bone, and caused acute osteomyelitis. R3 required an admission to a local hospital and surgery to remove the necrotic tissue. Findings Include: Per review of list of hospitalized residents dated 12/30/22, R3 currently is admitted to a local hospital. Per review of R3's face sheet and person centered plan dated 2/8/22, physician order sheets and shower sheets, R3 was admitted to the facility on 1/10/22, resided in rooms 211-1 and 215-3, and has the following diagnoses: Moderate Intellectual Disability, Epilepsy, Dysphagia following Cerebral Infarction, Meningioma, Depressive Disorder, Osteoporosis, Cerebral Palsy, Brain Tumor, and Failure to Thrive During a telephone interview conducted on 12/30/22 at 9:38 AM, Z1 (Family Member) stated, that R3 has a pressure ulcer to the bone, on the lower back/buttock area. Z1 heard of R3's bedsore from the doctor, at the hospital. Z1 had no knowledge of R3's bedsore before that. During an interview conducted on 12/30/22 at 2:08 PM, E2 (Registered Nurse) stated that E2 usually works on the 2nd floor. The residents with pressure ulcers are R3, who is in the hospital and has a sacral/coccyx wound, R4 who has a buttock/sacral wound, and R5 who is in the	Z9999		

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hospital and has a right buttock wound. When there is a skin concern with a resident, the Certified Nurse Assistants (CNA) will a do skin concern/shower check form, mark the location, and give the nurses a brief report. The nurse and CNA will look at the resident's skin together. That nurse assesses the wound. The nurse completes an incident report. If necessary, the nurse contacts the primary doctor to obtain wound care orders. Once the nurse gives the primary doctor report of the description, of the skin breakdown, the doctor will give the nurse wound care orders and sometimes a wound consult order. On the incident report, the nurse documents the location, how discovered, the original description, and the initial measurements. The nurse communicates all of that to the primary doctor. The nurses take measurements & a brief description, weekly. The nurse taking care of the resident on the day, of the measurements, completes the weekly, skin assessment form. The nurse notes if the wound is larger or the wound bed characteristics, change. E2 went through specialized wound care training with pictures of wound care characteristics, how to do wound measurements, and various treatments. When E2 was the Assistant Director of Nursing (ADON), E2 saw every wound in the building, weekly, on the same day, and would assess the wound status weekly. E2 was over the wound program. E2 would also write a descriptive nursing note. The assigned nurse did and still does the wound care. Since E2 is no longer the ADON, different nurses do the weekly, wound status. Wound measurements should be pretty much the same. Wound characteristics could be interpreted differently. The primary doctor will look at the wound, if the nurse tells him that he/she thinks the wound is getting worse. The nurses assess the wounds, determine the status, and communicate the

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status to the primary doctor. It depends on the communication to the primary doctor, if the wound consult is made.

During an interview conducted on 12/30/22 at 2:47 PM, E1 (Administrator) stated, "The other nurses had training on wound care on orientation and annually. The nurses had the same training."

During an interview conducted on 1/4/23 at 2:08 PM, E1 (Administrator) stated, "The CNAs do skin checks daily when providing care, and during showers, activities of daily living (ADL) care, and incontinence care. The CNA reports skin concerns to the nurse. The nurse assesses the resident and reports the findings to the physician or nurse practitioner.

R3's pressure ulcer risk assessments dated 7/10/22 and 10/10/22, indicate that R3 had a moderate risk for a pressure ulcer.

R3's Person Centered Plan dated 2/8/22, indicates that R3 has limited verbal communication, is non-ambulatory, uses a manual wheelchair, depends on staff to propel the wheelchair, is incontinent of bowel and bladder, requires staff assistance with all activities of daily living (ADL) care, and a mechanical lift for transfers. There is no documentation involving an update to R3's Person Centered Plan, related to the development of a sacral pressure ulcer, prior to R3's hospital admission on 12/5/22.

R3's skin concern forms dated 12/2/22, 12/3/22, 12/4/22, and 12/5/22, indicate R3 had a skin concern on his buttock.

R3's nurse notes indicate the following: 12/2/22

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at 12PM, a skin concern was noted to R3's buttock. Upon assessment, R3 was noted with skin erosion to the buttock, with redness and some minor bleeding. Z6 (Nurse Practitioner) was notified and gave a new order for zinc oxide, 20%, every shift, to R3's buttock; 12/2/22 at 11PM, R3 still had skin erosion to the buttock and zinc oxide was applied to the area; 12/3/22 at 8 AM, new skin concern noted and treatment in place administered; 12/3/22 at 6AM & 9PM & 12/4/22 at 6AM, R3's new skin condition was kept clean & dry and zinc oxide was applied as ordered; 12/5/22 at 12PM, R3 was noted to be lethargic, throughout the day and had a change in mental status. R3 was awake and responsive to voice/touch but was not speaking as per his baseline. These findings were reported to Z6, who gave an order to send R3 to the emergency room for an evaluation; At 1:20 PM, an ambulance transported R3 to a local hospital.

There is no documentation in the nurse's notes, in R3's medical record, after 6AM, on 12/4/22, related to a skin concern on R3.

The facility's 2nd Floor 24-Hour Report Follow-Up reports indicate the following for R3:
12/2/22 - R3 has moisture associated skin damage (MASD) on the buttock, apply zinc every shift
12/3/22 and 12/4/22 - R3 has moisture associated skin damage (MASD) on the buttock, apply zinc every shift and is on 72 - hour monitoring
12/5/22 - There is no documentation regarding R3's MASD to the buttock

Incident Report dated 12/5/22 at 11:45 AM, indicates that R3 was very lethargic, slow to respond, would open his eyes and then fall back

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Z9999	Continued From page 5 to sleep. Physician orders were to send R3 to a local hospital. R3's hospital records dated 12/5/22, indicate that R3 was admitted on 12/5/22. The emergency room physician progress note dated 12/5/22 at 3:09 PM, indicates that R3's chief complaint was altered mental status. R3's physical exam revealed that R3 appeared chronically ill and had a very, large, sacral decubitus ulcer with necrotic (dead) tissue. The assessment and plan indicated that R3's diagnoses included systemic inflammatory response syndrome (SIRS) and unstageable decubitus ulcer, of sacral region. R3 had a fever on arrival with a temperature of 38.6 degrees Celsius (101.5 degrees Fahrenheit). R3's diagnoses include sepsis (blood infection) from sacral decubitus, urinary tract infection (UTI), and pneumonia (lung infection). Surgery will see R3 in the morning, regarding the large sacral decubitus ulcer, with necrotic tissue. The emergency room physician progress note dated 12/5/22 at 3:49 PM, indicates, R3 had a very, large, sacral decubitus ulcer, extending into the musculature (muscle) noted upon rolling R3. There is a concern for possible necrotizing (serious bacterial infection that destroys tissue under the skin) infection, of the sacrum. General surgery, operative note dated 12/6/22 at 10:16 AM, indicates that R3 had pre-operative and post-operative diagnoses of infected sacral wound. Procedure: Excisional debridement (remove dead tissue from wound) of sacral wound measuring 11centimeters (cm)X 8cm X 4cm, down to the sacral bone, with a bone biopsy. Specimens: bone biopsy, bone culture, infected sacral wound. The infection appeared to travel down to the level, of the sacrum, so a bone biopsy was taken. Findings: Infected sacral ulcer	Z9999		

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Z9999	Continued From page 6 and possible osteomyelitis (inflammation of the bone, usually due to infection). Pathology Report dated 12/8/22, indicates that R3 had bone, sacral biopsy and R3's bone with acute osteomyelitis. During a telephone interview conducted on 3/17/23 at 11:07 AM, E1 stated that one to two nurses work per shift, on each floor, of the facility. E1 reviewed the staffing sheets from 12/2/22 to 12/5/22 and stated that the following nurses cared for R3 on the following shifts: 12/2/22 1st shift - E11 (Registered Nurse); 12/2/22, 2nd shift - E10 (Licensed Practical Nurse); 12/2/22 3rd shift and 12/3/22 on the 2nd and 3rd shifts - Z11 (Licensed Practical Nurse) and Z11 no longer works for the facility. E1 tried to call Z11, multiple times on 3/16/23 and on 3/17/23. E1 has not received a response from Z11 yet. - 12/3/22 1st shift and 12/4/22 on the 2nd shift E12 (Registered Nurse);12/4/22 1st shift - E9 (Registered Nurse); 12/4/22 3rd shift, E4 (Registered Nurse); and 12/5/22 1st shift - E2 (Registered Nurse) Review of the facility's staffing sheets dated 12/2/22 - 12/5/22, indicate the following staff assignments, on the second floor: On 12/2/22, E11 was assigned to the second floor on the first shift, E10 was assigned to the second floor on the second shift, and Z11 was assigned to the second floor on the third shift. On 12/3/22, E12 was assigned to the second floor on the first shift, and Z11 was assigned to the second floor on the second and third shifts. On 12/4/22, E9 was assigned to the second floor on the first shift, E12 was assigned to the second floor on the second shift, and E4 was assigned to the second floor on the third shift. On 12/5/22, E2 was assigned to	Z9999		

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Z9999	Continued From page 7 the second floor on the first shift. During a telephone interview, conducted on 3/17/23 at 11:50 AM, E9 (Registered Nurse) stated, yes, she recalls being assigned to R3 on 12/4/22, on the day shift. When asked about how nurses find out about a resident's skin breakdown, E9 also stated, the nurses rely on the Certified Nurse Assistants (CNA) who do the daily care, on the residents. The CNAs give baths, showers, and change the residents. When the CNAs provide care and note skin breakdown, they report it to the charge nurse. The charge nurse is the nurse on the floor. Then the nurse assesses the resident's skin breakdown and calls the Nurse Practitioner (NP) or Medical Doctor (MD) for treatment orders. The nurse tells the NP/MD a description of the wound, the measurements, if it has redness, if the redness is blanchable, and any other characteristics of the wound. That will give him guidelines, to order the proper treatment. When the nurse receives the treatment order, he/she sends the order to the pharmacy and starts the treatment, when it arrives. The nurse covers the area and makes sure that it's clean and dry, until the treatment is received, from the pharmacy. If a nurse finds the skin breakdown, the nurse follows the same protocol. When a resident has skin breakdown, he/she is put on 72- hour, monitoring, by the nurse who noted the skin breakdown. The nurses assess the wound, each shift and document the characteristics, like if the wound is improving or not and apply the treatment. This is documented in the nurses' notes. The nurses have a 24- hour, report sheet. The nurses read the 24- hour, report. When asked if she wrote a nurse's note, E9 stated, "I don't see a nurse note for 12/4/22. The only nurse's note that E9 sees in R3's chart on 12/4/22, is at 6AM. The monitoring	Z9999		

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of R3's skin concern was missed on 12/4/22, since the skin concern, was not on the 24- hour, report form. E9 doesn't recall assessing R3's buttock on that day (12/4/22). When the skin breakdown was noted on 12/2/22 at 12PM, at that point, R3 should have been put on the 24- hour report sheet and the 72- hour monitoring should have started at that time." When asked about receiving training on the prevention and treatment of pressure ulcers, E9 also stated, E9 had training on the prevention and treatment of pressure ulcers upon hire. The nurses get training, annually. The training consists of assessing the skin and making sure there is no skin breakdown. The training also consists of how to identify a pressure ulcer, how to stage a pressure ulcer, how to measure it, describe the surrounding tissue, note if there is drainage, or an odor, and describe what the wound looks like.

During a telephone interview conducted on 3/17/23, at 4:45 PM, E10 (Licensed Practical Nurse) stated, yes, E10 recalls taking care of R3 on 12/2/22, on the second shift. E10 confirmed her nurse's note on 12/2/22 at 11 PM, in R3's medical record. When asked about how nurses find out about a resident's skin breakdown, E10 also stated, if a resident has deep redness or a deep wound noted during a shower or a diaper change, the CNA reports it to the nurse. The nurse does an assessment. The nurse completes a skin concern form and then opens 72- hour, monitoring, that goes in the 24- hour report binder, so the other nurses get report of the monitoring. The binder is in the nurses' station. The nurse completes an incident report. When the nurses do the 72- hour monitoring, the resident's skin is checked once a shift or when the CNA changes the resident. The nurses document a nurse's note, by the end of shift. The

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Z9999	Continued From page 9 nurses call the NP/MD immediately about the skin concern that is noted. E10 looked at R3's buttock and E10 saw redness. E10 applied barrier cream. When asked, "What is skin erosion?", E10 also stated that skin erosion is redness, with the skin intact. E10 would not call the NP/MD for that. E10 would call the NP/MD if there are changes again, in the resident's skin breakdown. When asked about receiving training on the prevention and treatment of pressure ulcers, E10 also stated, the nurses get in-services on wounds. During a telephone interview conducted on 3/17/23 at 5:06 PM, when asked about how nurses find out about skin break down on the residents, E11 (Registered Nurse) stated, the CNAs will come to E11 during a shower or when they are changing a resident, if there is skin breakdown on the resident. E11 will go and assess the skin breakdown and measure it. Then E11 calls the MD/NP to let him know what E11 finds. The MD/NP will give orders for treatment. E11 can provide care and find skin breakdown, on the residents. The nurses let the CNAs know what it looks like. The nurses usually assess the skin breakdown, every shift. The nurses do 72-hour, monitoring. The nurses do incident reports when skin breakdown is found and that is when the 72- hour, monitoring form is filled out and 72-hour monitoring is started. The nurses document a nurse's note. At the change of shift, the nurses give report to the following nurse about the residents that are on 72- hour monitoring. If there is a change in the skin break down, the nurses call the MD/NP. E11 does recall taking care of R3 on Friday (12/2/22), that is when E11 is usually, at the facility. The CNA told E11 about R3's skin breakdown. E11 believes that E11 completed an incident report and started the 72-hour monitoring. E11 also put the 72- hour	Z9999		

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monitoring form, in the 24- hour report book. The nurses document their findings and what order the MD/NP gave the nurses. When asked to define skin erosion, E11 stated that is skin peeling, a little bit. It was on R3's buttock on both sides and it was hard to measure that, so E11 didn't measure it. E11 brought the measuring tape with her to do the measurements, but the measurements would have been large, since it was on both sides of R3's buttock. When asked about training on pressure ulcer prevention and treatment, E11 stated, that E11 does not recall receiving training on skin breakdown at the facility.

During a telephone interview conducted on 3/18/23 at 8:12 AM, E4 (Registered Nurse) stated, yes, E4 recalls taking care of R3 on 12/4/22, on the night shift. R3 had more of a rash. E4 would have seen R3. E4 neglected to write a nurse's note. E4 is not sure why E4 did not write a nurse's note. When asked about how nurses find out about a resident's skin breakdown, E4 also stated, the CNAs report the resident's skin breakdown or E4 observes it herself. E4 assesses the skin, documents the appearance, and notifies the MD/NP, to get an order, for treatment, and carries out the treatment. E4 makes an incident report, starts 72- hour monitoring, and gives verbal report, to the next nurse. The 72- hour monitoring sheet goes in the 24- hour report book, that every nurse should look at, at the beginning, of the shift. E4 writes the monitoring, on the 24- hour report sheet. When asked about training about pressure ulcer prevention and treatment, E4 stated, yes E4 was trained, with in-services. E4 does not recall the last time that E4 was trained. E4 received training when E4 started working at the facility and annually. E4 was trained on the

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causes and what to do if E4 sees skin breakdown. E4 looks for redness on the skin and if the redness is blanchable or not. E4 would call the MD/NP if the skin breakdown was worsening, to get a different, treatment orders.

During a telephone interview, conducted on 3/18/23 at 3:35 PM, E12 (Registered Nurse) stated E12 may have taken care of R3, but E12 doesn't recall. E12 takes care of a lot of residents. E12 doesn't recall R3's skin breakdown being brought to E12's attention. When asked about how nurses find out about a resident's skin breakdown, E12 also stated, when the CNAs wash the residents, they let the nurses know if a resident has skin breakdown or redness. E12 assesses it, notifies the MD/NP, and gets treatment orders and follows the orders. When the nurses see something new, including skin breakdown, the nurses put the resident on 72- hour monitoring. Each shift, the nurses assess the resident's skin and follow the treatment orders. 72- hour monitoring is in a book, at the nurse's station. The nurses could identify skin breakdown and would follow the same actions. The nurses call the MD/NP again within the 72 hours to give an update. When asked about training on pressure ulcer prevention and treatment, E12 also stated, yes, E12 was trained, upon hire. E12 was trained on pressure ulcer recognition, the stages of pressure ulcers, treatments, and notifying the MD/NP for treatment. Also, on notifying the Director of Nursing (DON) and administrator.

During a telephone interview, conducted on 3/17/23 at 11:22 AM, E2 (Registered Nurse) stated that E2 recalls caring for R3 on 12/5/22. E2 was assigned to R3 on the day shift, on 12/5/22. E2 confirmed his nurse's note in R3's

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	IL6000558	A. BUILDING: _____ B. WING _____	C 04/13/2023

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ALDEN VILLAGE NORTH	7464 NORTH SHERIDAN ROAD CHICAGO, IL 60626

(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
Z9999	Continued From page 12	Z9999		

medical record on 12/5/22 at 12:00 PM. E2 doesn't recall any skin concerns on R3 that day. E2 sent R3 out to the hospital for something else and not a skin concern. The CNA reported to E2 that R3 wasn't eating good. When E2 went to assess R3, he was lethargic and had a change in mental status. E2 doesn't recall assessing R3 for skin breakdown on that day. E2 was focused on R3's change in condition. E2 took R3's vital signs. R3's vital signs were not normal. E2 called Z6 (Nurse Practitioner). Z6 told E2 to send R3 to the emergency room (ER) for further evaluation. R3 had moisture associated skin damage (MASD). The skin concern was on his buttock. The nurses were doing 72- hour monitoring for it. The nurses assess it every shift and document the assessment. Since R3 had MASD, E2 assumed R3's buttock was excoriated.

During a telephone interview conducted on 2/8/23 at 11:35 AM, there was a discussion with Z4 (Medical Physician), about skin breakdown identified on the residents in the facility and on R3. Z4 stated that Z4 is R3's primary care doctor. When the staff identify skin breakdown, the resident is turned every 2 hours. The staff make sure the resident's incontinence brief is dry, and skin protectant is applied to the area, with every diaper change. Most of the care for the skin break down is done by the nurses. If there are significant changes, the nurses call the nurse practitioner or physician. A skin erosion is a pressure ulcer. Stage 1 involves redness, stage 2 is superficial, stage 3 involves subcutaneous tissue, and stage 4 involves the muscles and to the bone. When asked about the time frame that a pressure ulcer can progress from stage 1 to stage 4. Z4 also stated, "It usually takes a few weeks. The fastest that Z4 has seen, is 10 days." When this surveyor communicated the details of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000558	A. BUILDING: _____ B. WING _____	C 04/13/2023

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Z9999	Continued From page 13 the documentation in R3's nurses' notes (12/2/22 - 12/4/22), regarding the skin breakdown to R3's buttock and the details of the documentation in the physician progress notes in R3's hospital records dated, 12/5/22 and 12/6/22, Z4 stated, "The nurses' assessments were obviously not accurate." The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations policy dated 04/2021, documents the following: Procedure: 5. c. A Comprehensive Pressure Injury Evaluation will be completed for identified pressure injuries. 5. d. Pressure injuries, venous, arterial, diabetic ulcers and deep tissue pressure injuries will be assessed and documented weekly, or as needed by facility staff, utilizing the Weekly Assessment of Skin Alteration (WASA), or other consulting clinician's evaluation, if applicable. 7. At least daily, staff should remain alert of any skin changes during resident care and communicate these changes to the nurse on duty. 8. Identified changes will be communicated to the attending physician. New orders will be carried out and the Individual Program Plan will be updated to reflect the changes. (A)	Z9999		