STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002075	A. BUILDING: _____ B. WING _____	C 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL NURSING & REHAB CENTER	5336 NORTH WESTERN AVENUE CHICAGO, IL 60625

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S 000	Initial Comments Complaint Investigation: 2486301/IL00176548	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 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	S9999		

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S9999	Continued From page 1	S9999		

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

These requirements were not met as evidenced by:

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S9999	Continued From page 2	S9999		

Based on observation, interviews, and record reviews the facility failed to follow their wound prevention policy to ensure one [R9] of three residents did not develop pressure wounds. This failure resulted in R9 developing a stage three pressure ulcer to R9's left hip.

Findings Include:

R9 clinical record indicates in part: R9 is a 97-year-old, with the following medical diagnosis includes but not limited to need for assistance with personal care, dementia, essential (primary) hypertension, weakness, legal blindness, cognitive communication deficit, and unsteadiness on feet.

R9's Minimum Data Set (MDS) section [C] dated 7/2/24 score of [6] indicates R9 is moderately impaired. R9s' MDS section [GG] indicates R9 is total dependent for all his activities of daily living such eating, oral hygiene, shower, bathing, upper and lower body dressing, putting on and off footwear, personal hygiene, rolling left and right, toileting, sit to stand, and transfers.

R9's care plan documents in part:
7/14/24: R9 is incontinent of bladder and bowel. R9 will be cleaned, dry and odor free daily. Administer appropriate cleansing and peri care after each incontinent episode.
Initiated on 4/21/23 [Revised on 7/10/24]: Precautions for prevention of pressure ulcers are good pericare, and drying of the skin, apply protective barrier cream, reposition R9 frequently when in bed, or wheelchair, off load heels, pressure reducing relieving mattress and wheelchair cushion.

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S9999	Continued From page 3 On 8/13/24 at 11:22 AM, V41 [R9's Family Member] waved surveyor into the R9's room. Entering R9's room, noted strong offensive odors. R9 was resting in bed lying on his left side. V41 stated, "Please help me, R9 smells like feces and urine, I need someone to check him to see if R9 needs changing." On 8/13/24 at 11:30 AM, V41 and R9 gave surveyor permission to observe incontinence care. V9 [Registered Nurse] detached R9's under brief, surveyor, V9, and V41 observed and half of the under brief was inside R9's buttock crease with three rings [circles] yellow and red tinge in color, dried and wet stool in the under brief, outside the brief and on the pad. V41 requested for nursing administration to see the condition of R9's under brief. V3 [Assistant Director of Nursing] entered R9 room and observed R9's under brief half of the under brief was inside R9's buttock crease with three rings [circles] yellow and red tinge in color, dried and wet stool in the under brief, outside the brief and on the pad. On 8/13/24 at 11:45 AM, V20 [Certified Nurse Assistant] came in the room and stated to surveyor, V41, V9 and V3 "I am R9's certified nurse assistant. I have not checked his under brief today. I was not able to provide ADL care to R9. I started work today at 7AM. I have a heavy assignment and cannot provide care timely. I will clean R9 up now." V20 and V9 turned R9 onto his right side and removed the under brief and noted an open red area with yellowish drainage on his left hip. The incontinent pad was removed, there was dried dark brown substance with several yellow circle on the fitted sheet. V20 stated, "There is feces and urine underneath the incontinence pad, whoever changed R9 last only replace the incontinence pad and did not change	S9999		

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S9999	Continued From page 4 the linen." R9's Wound Evaluation dated 8/13/24 indicate in part: In-house facility acquired pressure injury wound noted on 8/13/24. Wound measurements were 0.5 x 0.6 x 0.2cm [centimeters]. Current wound status -R9 likes to lay on left side, offloaded with pillows. R9 complained of pain when cleansing the wound. On 8/14/24 at 9:44 AM, V45 [Wound Care Nurse] and surveyor observed R9's wound assessment and treatment. V45 stated, "R9 has a facility acquired stage three pressure ulcer on his left hip that measures 0.5 x 0.6 x 0.2cm [centimeters]. I'm placing on a medihoney treatment with dressing. I will initiate wound care interventions of air loss mattress, and off load with pillows. If a resident does not receive incontinent care timely, and reposition, the resident could potentially develop pressure ulcers, skin issues and infection." On 8/15/24 at 10:13 AM V2 [Director of Nursing] stated, "Recently the second and fourth floor decreased from four certified nurse assistants to three, due to the facility low census. The decision comes from corporate during our staffing meeting. Corporate look at the numbers and use a staffing grid for the facility. On the second floor there are approximately [14] residents, and [16] residents on the fourth floor that need mechanical lift transfers, extensive assistance with ADL (activies of daily living) care, incontinent care, bed mobility, and transfers. I received complaints from staff regarding the heavy workload, I asked the staff to give the facility a chance to make their assignments better. V1 (Administrator) was made aware last week there were ADL concerns	S9999		

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S9999	Continued From page 5 and staffing concerns. I expect that all staff including nurses to assist the certified nurse assistants with provided ADL incontinent care to meet the needs of all the residents. If a resident is not provided incontinent care and repositioning at least every two hours, it could potentially cause skin issues and pressure ulcers." Policy document in part: Guidelines for Prevention/Treatment of Pressure Injuries The facility will ensure a resident received care, consistent with the profession standards of practice: to prevent pressure ulcers and does not develop pressure ulcers. Pressure injuries can interfere with the resident's functions and recovery, especially if complicated by pain and or infection. Pressure injury can occur as a result of prolonged pressure. (B)	S9999		