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 ______	C 12/12/2023

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

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S 000	Initial Comments Complaint Investigation: 2399293/IL166430	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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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 observation, interview, and record review, the facility failed to monitor and implement a treatment plan for one resident who was at moderate risk for skin breakdown and readmitted to the facility with a stage two pressure sore.This affected one of three residents (R11) reviewed for pressure sore prevention. This failure resulted in R11's wound worsening and progressing to a stage 4.

Findings include:

R11 was admitted to the facility on 9/12/23 with a diagnosis of dysphagia, respiratory failure, hemiplegia, cerebral infarction, need for

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assistance with personal care, tracheostomy status, and lack of coordination. R11 had no documented wounds on admission.

R11's Braden scale dated 9/13/23 documents a score of 13 which indicates moderate at risk.

R11's progress note dated 10/17/23 documents: R11 was readmitted to facility from local hospital by ambulance via stretcher accompanied by husband. Resident is full code, has left side weakness with right sided contraction, trach collar and wound on the sacrum area.

R11's treatment administration record and physician order sheets for October 2023 does not document any wound treatments or orders for R11's sacrum.

Facility shower sheets dated 10/19/23 and 10/23/23 document an open area on the sacrum.

R11's progress note dated 11/1/23 documents: writer informed by CNA that resident has open wound on buttocks, shower sheet sent to wound care to follow up.

R11's wound evaluation dated 11/2/23 documents: new wound sacrum measuring 8.7 cm length x 8.18 cm width.

On 12/5/23 at 12:12 PM, V2 (Wound Care Nurse) said all resident's skin is assessed upon admission/readmission within a day. A progress note would be documented in the medical record and if any skin breakdown a skin assessment would be completed. V2 said they do not always know when residents return form hospital stay and was unaware of any skin concerns with R11 until 11/2/23. V2 said 11/2/23 is the first skin

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assessment documented on R11.

On 12/1/23 at 2:19 PM, V12 (Director of Nursing, DON) said wound care should conduct an assessment by the next day of any new admission or readmission.

R11's initial Wound Doctor visit dated 11/8/23 documents unstageable necrotic wound has revealed underlying deep tissue at muscle. This wound has revealed itself to be a Stage 4 pressure injury. Wound measurements 8.0 x 10.0 x not measurable due to necrosis.

R11's wound evaluation dated 11/27/23 documents: length 9.86 x 8.59 cm width.

R11's Wound Care Doctor note dated 11/29/23 documents: Stage 4 pressure ulcer measuring 9.1 x 9.7 x 2.2 cm.

R11's skin plan of care dated 9/18/23 documents: assess and document of progress areas weekly; observe and assess regularly.

On 11/30/23 at 12:52 PM, on third floor unit, R11 was observed on her back in the middle of the bed with hands crossed at her wrist on her stomach. Brace observed to her right hand and lower arm. A wedge pillow was observed under her left side of her upper body from her waist to her shoulder. Observations were conducted on R11 every 15 minutes with no staff observed providing any repositioning to the resident and resident remained in same position.

On 11/30/23 at 3:23 PM, V9 (CNA) said, she repositioned R11 around 1:00 PM. V9 said, she is getting ready to reposition R11 now, and R11 was in the same position from when she repositioned

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her around 1:00 PM. R11 needs to be repositioned every two to three hours.

On 12/1/23 at 2:19 PM, V12 (Director of Nursing, DON) said turning and reposition should be conducted at least every two hours.

On 12/1/23 at 12:18 PM, V15 (Wound Care Nurse) said R11 should be turned and repositioned every 2 hours to relieve pressure from the wound.

R11's plan of care for pressure sore dated 11/2/23 documents following interventions: administrator treatments as ordered; remind/assist to change position at least every two hours. R11's skin plan of care dated 9/18/23 documents: assess and document of progress areas weekly; observe and assess regularly.

Facility skin management policy reviewed, dated 6/2023 document under treatment guideline for stage two pressure injuries: turn and reposition every two hours, pressure redistribution devices for bed and/or chair, hydrocolloid dressing; transparent film dressing, hydrogel, thin foam or composite dressing.

On 11/30/23 at 3:35 PM, R11 was observed with a bordered dressing over her sacrum with blood noted on dressing. The adhesive border was observed to be on the wound bed. R11 was observed on top sheet, mattress pad and incontinence brief on air mattress which was set to weight of between 210 and 250 pounds.

On 12/1/23 at 12:05 PM, R11's wound care was performed by V15 (Wound Care Nurse). R11 was observed on air mattress with sheet, mattress pad soiled with dried serosanguinous rings, and

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incontinence product. R11 had bed sheet indentations to her upper back confirmed by V15. R11 had a bordered gauze dressing that was undated and adhesive tape on the wound bed. It appeared to be the same dressing observed on 11/30/23. The dressing was removed with no packing noted with in the wound. Dressing had moderate amount of serosanguinous drainage. Area cleaned and packed and orders followed.

On 12/1/23 at 12:18 PM, V15 (Wound Care Nurse) said, The air mattress should only contain a sheet and/or a pad or incontinence brief. The air mattress should not have all three layers of linen because it will not restrict the airflow. V15 verified the weight setting on R11's air mattress that was set between 210 and 250 pounds . V15 verified R11's weight in her medical record and said it was on the wrong weight which causes the mattress to be more firm not beneficial wound healing. V15 said the old dressing that was removed was not the correct dressing and there was no packing within the wound.

On 12/1/23 at 2:19 PM, V12 (Director of Nursing, DON) stated, Floor nurses are expected to follow the physician orders for wound care and have access to all the supplies. Wound care is responsible for ensuring the air mattress are set appropriately.

On 12/6/23 at 1:10 PM, V16 (Wound Doctor) said he would expect his wound orders to be followed as written. V16 said the wound should be packed with saline gauze if topical antiseptic (Dakins) solution not available to keep the wound moist and clean. Topical antiseptic (Dakin's) solution is an antimicrobial to help clean out bacteria and he would expect to be informed of any treatments missed for more than 24 hours. V16 would expect

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S9999	Continued From page 6 staff to follow facility protocols for turning and repositioning and mattress settings. R11's weight summary documents weight on 11/14/23 163.6 pounds R11's Physician Order Sheet dated 11/24/23 documents: sacrum, clean with dakins, dry with gauze, apply metro gel, insert dakin gauze sponge and cover with abdominal pad (ABD) secure with tape. R11's plan of care for pressure sore dated 11/2/23 documents following interventions: administrator treatments as ordered; remind/assist to change position at least every two hours. R11's skin plan of care dated 9/18/23 documents: assess and document of progress areas weekly; observe and assess regularly. Facility skin management policy dated 6/2023 documents under treatment guideline for stage two pressure injuries: turn and reposition every two hours, pressure redistribution devices for bed and/or chair, hydrocolloid dressing; transparent film dressing, hydrogel, thin foam or composite dressing. Facility skin care prevention policy dated 1/2023 documents: nursing department will review all new admission/readmissions to put a plan in place for prevention based on residents activity level, comorbidities, mental status and other pertinent information, all residents will be evaluated for changes in skin condition weekly. All residents unable to reposition them selves will be repositioned as needed. (B)	S9999		