

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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
S 000	Initial Comments Complaint Investigation 2197761/IL139398 2198034/IL139746	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1210d)5) 300.3240a) 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 300.1010 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,	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 2</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free from neglect by failing to prevent the development of facility-acquired pressure ulcers, failed to have competent nursing staff to immediately identify and assess new pressure ulcers and implement interventions to prevent worsening of facility-acquired pressure ulcers, and failed to ensure staff was competent to provide wound treatments as ordered by the physician. These failures affect 3 of 3 residents (R1, R7, R8) reviewed for pressure ulcers. These failures resulted in R1 obtaining two Stage 4 pressure ulcers to the right hip and right heel, one Stage 2 pressure ulcer to the left medial knee, and a deep tissue pressure injury to the left hip; R7 obtaining a new facility-acquired Stage 4 pressure ulcer to the upper left buttock; and R8 obtaining a new facility-acquired unstageable pressure ulcer to the right ischium. The facility also failed to maintain a resident's nutritional</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 3</p> <p>status for 1 resident (R1) by failing to ensure dietary recommendations for wound management were carried out for an underweight resident with multiple pressure ulcers, and failed to confirm and monitor a resident's weight as recommended by the licensed dietary nutritionist and ordered by the physician. These failures resulted in R1 having continuing weight loss while residing in the facility.</p> <p>Findings include:</p> <p>1. R1 is a 63-year-old female originally admitted on 7/15/2021 with medical diagnoses that include but not limited to: multiple sclerosis, schizoaffective disorder, multiple wounds, and dysphagia. R1 was transferred to local hospital on 10/7/21 and was not currently in the facility. On 10/22/21, R1 was discharged from local hospital to a long-term acute care hospital.</p> <p>R1's Admission MDS (Minimum Data Set) Assessment dated 7/20/21 documents the following: Section C - Cognitive Patterns: BIMS (Brief Interview for Mental Status) score of 9, which indicates moderately impaired cognition Section G - Functional Status: total dependence, requires 2+ person physical assist Section H - Bladder and Bowel: Urinary and Bowel Continence as Always Incontinent Section K - Swallowing/Nutritional Status: Weight is 147 pounds and Height is 63 inches, with no/unknown weight loss or gain within the past month or six months Section M - Skin Conditions (including history of pressure ulcers or pressure injuries) and pressure relieving devices: (1) Stage 2 Pressure Ulcer present upon admission and (1) Stage 4 Pressure Ulcer present upon admission; Zero</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 4</p> <p>documented Stage 1, Stage 3, unstageable pressure ulcers, or deep tissue injuries upon admission.</p> <p>Braden Score (for predicting pressure ulcer risk) was 13, indicating Moderate Risk of developing pressure ulcers.</p> <p>Full body assessment dated 7/16/2021 at 14:42 completed by V20 (Previous Wound Care Nurse) documents (upon admission):</p> <ol style="list-style-type: none"> 1) Area noted to coccyx, 9.0 x 5.0 3.0, moderate serous exudate, 100% granulation. 2) Area noted left lateral leg, 1.5 x 4.0, 25% granulation, 25% slough, 50% necrotic light serous exudate. 3) Area noted right bunion, 0.2 x 1.5, DTI, 100% deep maroon, no exudate. 4) Area noted to right heel, 5.5 x 5.0, 100% necrotic, no exudate. 5) Right ischial tuberosity, 3.5 x 3.5, 100% necrotic, light serous exudate. 6) Area noted left heel, 3.5 x 5.0, 100% necrotic, no exudate, tx (treatment) implemented, heel protectors to be on at all times, resident denies pain or discomfort, prn pain meds given as needed. <p>Physician treatment orders for July 2021 include:</p> <p>Coccyx: cleanse with nss (normal saline solution)/wound cleanser, skin prep periwound, apply Dakins gauze, cvr (cover) with dry drsg (dressing)qd (every day)/pm every day shift; Start Date: 7/17/21</p> <p>Per TAR (Treatment Administration Record), treatments were not done on the following dates:</p> <p>September 2, 3, 4, 6, 11, 12, 13, 14, 15, 19, 21,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 5</p> <p>23, 28, and 29, 2021 and October 2, 3, 5, and 6, 2021.</p> <p>Left heel: cleanse with nss/wound cleanser, apply betadine, gauze, cvr with abd pad, wrap in kerlix M-W-F/PRN (as needed) every day shift every Mon, Wed, Fri; Start Date: 7/19/21.</p> <p>Per TAR, treatments were not done on the following dates:</p> <p>September 3, 6, 13, 15, and 29, 2021 and October 6, 2021</p> <p>Left lateral foot: cleanse with nss/wound cleanser, apply betadine gauze, cvr with abd pad wrap in kerlix M-W-F/PRN (as needed) every day shift every Mon, Wed, Fri; Start Date: 7/19/21.</p> <p>Per TAR, treatments were not done on the following dates:</p> <p>September 3, 6, 13, 15, and 29, 2021 and October 6, 2021</p> <p>Right bunion: cleanse with nss skin prep, Iota QD/PRN every day shift; Start Date: 7/17/21; D/C Date: 9/01/2021. There was no documentation as to why this order was discontinued.</p> <p>Right heel: cleanse with nss/wound cleanser, apply betadine gauze, cvr with abd pad, wrap in kerlix M-W-F/PRN (as needed) every day shift every Mon, Wed, Fri; Start Date: 7/19/21</p> <p>Physician treatment orders for August 2021, included the same orders as July 2021 with the addition of:</p> <p>Dakins (1/2 strength) Solution 0.25% (Sodium</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 6</p> <p>Hypochlorite) Apply to left Ischium topically every day shift; for Wound Care Cleanse with NSS, Pat dry and apply Dakins soaked gauze and cover with dry dressing; Start Date: 8/26/21</p> <p>Per TAR, treatments were not done on the following dates:</p> <p>September 3, 6, 13, 15, and 29, 2021 and October 6, 2021.</p> <p>Right ischium: cleanse with nss/wound cleanser, skin prep periwound, apply Dakins gauze, cvr with dry drsg qd/pm every day shift; Start Date: 7/17/21.</p> <p>Per TAR, treatments were not done on the following dates:</p> <p>September 2, 3, 4, 6, 11, 12, 13, 14, 15, 19, 21, 23, 28, and 29, 2021 and October 2, 3, 5, and 6, 2021.</p> <p>Right, lateral ankle: skin prep, LOTA qd/pm every day shift; Start Date: 7/24/21; D/C Date: 9/01/2021. There was no documentation as to why this order was discontinued.</p> <p>Per TAR, treatments were not done on the following dates:</p> <p>September 2, 3, 4, 6, 11, 12, 13, 14, 15, 19, 21, 23, 28, and 29, 2021 and October 2, 3, 5, and 6, 2021</p> <p>Left, medial knee: clean with nss, wound cleanser, apply hydrocolloid MWF/pm every day shift every Mon, Wed, Fri; Start Date: 8/02/21; D/C Date: 9/01/2021. There was no documentation as to why this order was</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 7 discontinued.</p> <p>Right, medial shin: clean with nss, wound cleanser, apply hydrocolloid MWF/pm every day shift every Mon, Wed, Fri; Start Date: 8/02/21; D/C Date: 8/30/2021. No documentation as to why this order was discontinued.</p> <p>Progress Note created by V5 (Wound Care Nurse) dated 9/13/2021 at 12:15 documents that resident was seen by wound nurse and wound specialist (V11/Wound Care Doctor), r/t wound located on Coccyx, Right Ischium, Right Hip, Left heel, Left Distal Lateral Foot, Right Medial Heel, Right distal medial Foot. Wound Improvements are documented.</p> <p>Physician orders for September 2021 remain unchanged with the addition of new orders dated 9/13/21:</p> <p>Right Distal Medial Foot: cleanse with nss/wound cleanser, skin prep periwound, apply Dakins gauze, cvr with dry drsg qd/pm every day shift to promote wound healing; Start Date: 9/13/21.</p> <p>Per TAR, treatments were not done on the following dates:</p> <p>September 13, 14, 15, 19, 21, 23, 28, and 29, 2021 and October 2, 3, 5, and 6, 2021.</p> <p>Right Hip: cleanse with nss/wound cleanser, skin prep periwound, apply Dakins gauze, cvr with dry drsg qd/pm every day shift for wound care; Start Date: 9/13/21.</p> <p>Per TAR, treatments were not done on the following dates:</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 8</p> <p>September 13, 14, 15, 19, 21, 23, 28, and 29, 2021 and October 2, 3, 5, and 6, 2021</p> <p>Review of R1's medical record documents four new facility-acquired pressure wounds:</p> <p>1) Assessment date: 7/30/21, Date Identified: 7/28/21, Stage 2, left medial knee, 1x1x.10cm 2) Assessment date: 10/6/21, Date Identified: 10/6/21, Deep Tissue Pressure Injury, left hip, 4x3.5cm x unknown depth 3) Assessment date: 10/6/21, Date Identified: 10/6/21, Stage 4, right heel, 5x3.5cm x unknown depth 4) Assessment date: 10/6/21, Date Identified: 10/6/21, Stage 4, right hip, 5.5x4.2x2cm</p> <p>There was no documentation in R1's medical record to show that the new, facility acquired wounds were identified/assessed prior to "Date Identified" as Stage 2 and Stage 4, per documentation.</p> <p>Review of physician treatment orders for October 2021 do not include any new treatment orders prior to R1's transfer to local hospital on 10/7/21.</p> <p>Review of R1's care plans includes:</p> <p>Focus: Incontinent of bowel and bladder puts her at risk for infection, alteration in skin and complications associated. Date Initiated: 7/15/21; Interventions: None listed Focus: RD suggests 8/25/21 - Suggest add med pass 2.0 120ml tid, prostat awc 30 ml daily for additional kcals/pro; wkly wt x 4 weeks; Intervention: Prepare/serve the resident's nutritional diet as ordered. Monitor intake and record q meal. Date Initiated: 7/21/21. Multiple focus areas related to skin breakdown</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2021
NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402		
(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	<p>Continued From page 9</p> <p>and pressure ulcers include interventions all with Date Initiated: 7/16/2021</p> <p>Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. If resident refuses treatment, confer with IDT (Interdisciplinary Team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. Monitor/document/report to MD PRN changes in skin status, appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. Notify nurse immediately of any new areas of skin breakdown, such as redness, blisters, bruises, discoloration noted during bath or daily care. Assess/record/monitor wound healing (FREQ). Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD.</p> <p>Review of R1's medical record does not include documentation to show that there was any concern with regard to resident refusing treatment or other explanation for the multiple dates of missed wound treatments.</p> <p>R1's medical record shows that on 10/7/21, R1 was transferred to local hospital. Hospital record documents: inpatient wound care consult report reads: lumbar sacral spine and right buttock, 4cmX6cmX1cm wound bed with sloughing, wound to the right buttock is extensive and dominated entire buttock, and there is exposed bone. Wound base right buttock wound extends to bone: breakdown forms a cavity around exposed ischium, remainder of the injury is to the</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 10</p> <p>spine, there is slough under entire wound bed. There is considerable undermining along most edges of the injury. Right hip; both feet. Wound base right hip lesion is deeply tunneled lesion through which bone can be visualized. Wound area is foul smelling and much of the base appears necrotic. There are wounds to both feet which are similar appearance and involve lateral surfaces of the feet.</p> <p>On 11/11/21 at 11:00am V5 (Wound Care Nurse) said, "I do not remember R1; I will have to check the computer to refresh my memory. I do not think that R1 developed any wounds in house. R1 was admitted on 7/15/2021 with wounds to coccyx, left heel, right heel, right ischium, right bunion and left foot. I cannot tell if the patient developed the wounds here or not." V5 did not provide any further information.</p> <p>On 11/12/21 at 10:30am V2 (Director of Nursing/DON) said, "If the medication and/or treatment record has any open spaces, it indicates to me that the nurses did not do the treatment or the medication was not given. This is not acceptable, but it happens. I know that we have some problems with the wound treatments during the week. We should not have any unsigned treatments, because we do have the dedicated treatment nurse doing them. On weekends it's a different thing. The nurses are responsible for doing the treatments, but more frequently than not, they do not do it because they have other things to do on the floor. I know the treatments on the weekend are not being done. It is not assigned to anyone in particular when V5 is not here. The nurses do not document the sizes or measurements. The only thing they document is the location of the wound, and they are not trained on wounds. We are currently looking for a</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 11</p> <p>wound care coordinator. V5 (Wound Care Nurse) knows that she is only the wound care nurse. I do not think that she is ready for the coordinator position. I am not as involved with wound care cases because I have a lot of other duties that I am busy with." When asked what type of credentials and training the current wound care nurse has, V2 stated that she was hired because she knew her from another facility and was told that she (V5) was doing wound treatments at a previous job and she just assumed she knew what to do. V2 stated, "I should have confirmed that information or looked into it more."</p> <p>Review of V5's (Wound Care Nurse) personnel file includes but is not limited to: Hire Date: 8/17/21, Wound Care Nurse Orientation and Onboarding Checklist dated 9/16/21 with more than 50% of the competency items not confirmed to be completed; Wound Care: Identification and Assessment training was completed on 10/12/21 and Wound Care Nurse Orientation and Onboarding Checklist dated 11/11/21 that is blank under, "This employee has completed their orientation and has demonstrated reasonable command of each of the topics presented." Options include: PASS/FAIL</p> <p>On 11/18/21 at 11:10am, V21 (Licensed Practical Nurse/LPN/Restorative Director) said, "I am working the floor when we have any call offs. I started here two months ago. If the Certified Nurse Assistant or I notice any new skin problems, I will let the treatment nurse/DON know, and I will do a risk management form documenting the skin breakdown. Wounds are not my strong area; I know redness and abrasion. I cannot do staging; I will only describe what I see. I have not received any formal training since I came here."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 12</p> <p>On 11/18/21 at 11:20am, V22 (LPN) said, "I am the regular nurse on the first floor. When I started working here, I had a wound care day training. I know that if we identify a wound, I will need to let wound care know, do a risk management report of the new wound, call the doctor and let him know what I see and obtain an order and carry it out. I am not comfortable/good with staging. I will only document the appearance of the wound, but I do not do any sizes or staging. I do the treatments if the wound care nurse is not here."</p> <p>On 11/18/21 at 11:35am, V23 (LPN) said, "I started here nine months ago. I am a floater. If we identify a new wound, we make sure to call the doctor and let them know. I can describe what the wound looks like, I will not stage. I am not familiar with staging. I am not able to determine the stage or what kind of wound it is. I have not done any kind of wound training since I started working here."</p> <p>On 11/18/21 at 11:45am V24 (LPN) said, "I started working here six months ago. I am an as needed basis nurse. I have not had any wound care training. I only reviewed some slides (paperwork presentation). If the wound care nurse is not here, we are responsible for the dressing changes. If we identify a new wound, we document in the progress notes and do a risk management, call the doctor and get an order. Once the treatment order is received, I will implement it. I will describe the wound, but I will not stage."</p> <p>On 11/18/21 at 11:55am, V25 (Registered Nurse/RN/Psychotropic Nurse) said, "I started working here three years ago. I work on the floor if we have a call off or if we are in need of a</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2021
NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402		
(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	<p>Continued From page 13</p> <p>nurse. I will make sure to check the patient's skin after a shower and also after incontinence care. If the patient is identified with a wound, I make sure to assess the patient, call the doctor and report what I see. I am not a wound care nurse, I will not stage. The best I can do is describe to the doctor what I see on the wound and carry out the order that the doctor gives me. I have not had any wound care training here at the facility. We do online training on different topics."</p> <p>Progress Note created by V15 (Consultant Registered Dietitian) dated 8/25/21 at 09:22 documents: (R1) Dx (Diagnosis) - severe pro calorie malnutrition; Diet - Mech (Mechanical) soft, thin liquids, no restrictions; Meds reviewed; Wt (Weight) - 8/18 112#, 7/15 147#; Ht (Height) - 63"; BMI (Body Mass Index) - 19.8 underweight status d/t age; Appetite - good; Labs - no current; Wt decrease of 35 lbs (23.8%) x 1 month? Suspect scale error. Possibly incorrect adm (admission) wt? Request reweigh. Per meal documentation: appetite improved, consuming 75-100% of most meals. Diet upgraded to mech soft with good tolerance. Fed per staff. Tx to multiple wounds - coccyx st 4, rt hip - uts (unable to stage), lt (left) lat (lateral) foot - diabetic, rt (right) ankle - diabetic, rt shin - uts, lt med knee - st 2, lt heel - diabetic per 8/18 skin assessment. On MVI (multivitamin) with min., Vit C and zinc. Suggest add med pass 2.0 120ml tid, prostat awc 30ml daily for additional kcals/pro., wkly (weekly) wt x 4 weeks; Monitor wts, labs, skin, po intake.</p> <p>Physician orders reviewed for July 2021 - October 2021 do not include orders or any dietary recommendations to add med pass 2.0 120ml tid, prostat awc 30ml daily for additional kcals/pro.</p> <p>Physician orders include the following:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 14</p> <p>Weight upon Admission x 3 days, then monthly every day shift for weight monitoring AND every day shift every Mon for weight monitoring weeklyx4, Order Start Date: 7/16/21, End Date: 10/29/21</p> <p>Weight weekly every day shift every Mon for weight monitoring, Order Start Date: 7/16/21, End Date: 10/29/21</p> <p>There is no documentation in the medical record to indicate that the resident's admission weight was verified for accuracy (as recommended by RD) or that resident was being weighed per physician orders.</p> <p>Review of R1's medical record only includes the following documented weights:</p> <p>July 2021 - 147 lbs. August 2021 - 112 lbs. September 2021 - 107.5 lbs. October 2021 - 101 lbs.</p> <p>No other weights were provided for R1.</p> <p>On 11/12/21 at 12:20pm, V9 (Infectious Disease Nurse Practitioner) stated, "I had seen that (R1) had a lot of wounds. I was not aware that she lost any weight. I would have contacted the primary physician and requested for a g-tube placement sooner or other nutritional interventions."</p> <p>On 11/12/21 at 2:00pm, V2 (DON) said, "I was not able to see find any recommendations from the RD (Registered Dietician) noted or carried out. I do not know how the RD communicates the recommendations to the nursing department. If she sends e-mails I have currently 17,000 e-mails</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 15</p> <p>to review. In my opinion the RD needs to take the recommendations to the nurse and let me know of the recommendations. There is no specific protocol for carrying out the recommendations."</p> <p>On 11/15/21 at 10:00am, V15 (Consultant Registered Dietitian) said, "I was at the building. I do not remember the patient (R1) but in the notes I documented that the first weigh that the facility documented was possibly incorrect. I do write recommendations and e-mail them to the Director of Nursing, the Dietary tech and the dietary manager. I review to see of my recommendations are noted or carried out. If I do not see any notes or new orders, I will submit the recommendations again. My expectation is that the recommendations are noted and carried out."</p> <p>On 11/15/21 at 11:50am, V16 (Consultant Diet Tech) said, "I was at the building until September. I worked there for almost two years, once a week. I do not have access to the records anymore; I do not remember R1. I cannot check my documentation. The regular procedure was that the RD (Registered Dietician) would assess the resident and send the nutritional recommendations via e-mail to the DON, dietary manager and myself. The nurses were responsible for carrying out the orders. The dietary manager and the Director of Nursing are responsible to follow up and see if the recommendation was noted. I would check to see if the care plan needed to be updated. The RD would see the high risk new admissions such as wounds, dialysis, g tubes and any other compromised patients; I would follow up with patients that were more stable. The facility is responsible for doing daily weight for the first three days, then once a week for four weeks and then monthly or as frequent as the Medical</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 16</p> <p>Provider or the Registered Dietitian recommends."</p> <p>On 11/15/21 at 10:50am V1 (Administrator) said, "The registered dietitian will make sure to give the recommendations to nursing and dietary manager. The Director of Nursing is responsible for making sure that the recommendations are noted and carried out. My expectation is that the doctor is notified of the RD recommendations, to input the order and to document in the patient medical record. All recommendations must be followed up on. The previous dietary manager is no longer here per mutual agreement and no contact information is available."</p> <p>During the course of this survey, request was made for facility to provide any documented protocols, policies, or inservices to confirm the procedure for how dietary recommendations should be carried out and/or weight monitoring. None was provided.</p> <p>Facility provided Dietary Consultation Agreement (dated January 1, 2020), which includes:</p> <p>Consultant's duties may include: ...2. To collaborate with the dietary department concerning the following areas: A. Nutritional assessment for residents referred by the facility which may include residents with: Enteral Feeding, Significant weight loss, Pressure ulcers, Poor nutritional intake renal dialysis...3. Review and evaluate with the Administrator and Dietary Manager the progress of the Dietary Department...7. Submit a consultation report after every consultation visit stating hours worked, nutritional assessments completed, and other service performed.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/20/2021
NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402		
(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	<p>Continued From page 17</p> <p>Agreement is signed by V1 (Administrator).</p> <p>2. R7 is a 64 year old male originally admitted on 3/9/2017 with medical diagnoses that include but are not limited to: Paraplegia, spinal stenosis and morbid obesity.</p> <p>On 11/11/21 at 11:10am R7 said, "I developed the wound because they are very short staff here and many times I need to wait for them to come and change my (incontinence brief) for hours. The urine burns my skin; now I cannot be out of the bed as frequent because I need to not put any pressure in my wound, and I need to be in bed. I do not like to be in bed, because I am losing my independence to be up and about in my electric wheelchair. This is the result of them being short and not taking care of me as they should." V5 (Wound Care Nurse) said to (R7), "I am here to do your wound care." R7 said "I am soiled, I need to be cleaned first." Surveyor observed V5 and V7 perform incontinence and wound care with no concerns identified. At this time, V5 was asked if R7's wound was facility acquired. V5 stated, "I am not sure if (R7) developed it in the facility or not, but based on (documentation), it appears that this is facility acquired."</p> <p>R7's Braden (Skin Risk Assessment) score dated 10/25/21 and 11/5/21 are 14 (indicating Moderate Risk).</p> <p>R7's MDS (Minimum Data Set) Assessment dated 9/24/21 documents that R7 is at risk for developing pressure ulcers/injuries and that R7 does not have any unhealed pressure ulcers/injuries. Section M0300 is blank for Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
--	---

(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	<p>Continued From page 18</p> <p>Wound documentation for R7 includes pressure ulcer on the upper left buttock - Date Identified: 7/14/21 - Source: Facility-acquired.</p> <p>Most recent assessment history (at the time of this survey) includes: Date: 10/26/21 - Clinical Stage: Stage 4 - Exudate: Moderate, Serosanguinous - Wound measurements: 0.60x0.60x5.80cm - Wound Progress is documented as No Change on 11/8/21.</p> <p>Review of R7's current care plans include focus area of impairment to skin integrity (dated 9/9/21) with interventions put in place on 9/9/21. Interventions for skin impairment do not document any updates or modifications to the care plan since date initiated (9/9/21).</p> <p>3. R8 is a 66 year old male originally admitted on 8/6/2021 with medical diagnoses that include but are not limited to: hypertensive heart disease, schizoaffective disorder and diffuse large B-cell lymphoma.</p> <p>On 11/11/21 at 11:50am R8 said, "I came here because I have a cancer treatment for my stomach and I have one wound. But I developed another one here because when I came I was sleeping on an old mattress without any cushion. I told the wound care nurse about the mattress. It wasn't until after I developed the new wound while at the facility that they gave me the air mattress. I think they are very short staffed, and I have to wait for a very long time for the CNA (Certified Nursing Assistant) or even the nurse to come and take care of me. I am soiled in urine and feces for hours before they come and help me. It is very uncomfortable for me to be in bed all day long, because I have wounds and I cannot be up in the chair as long as I want to be. I used</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
--	---

(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	<p>Continued From page 19</p> <p>to be a football coach for 30 plus years, and I got sick and now I am at the mercy of others. I do not like that; they tell me I am not the only patient here, that I need to wait."</p> <p>R8's Braden (Skin Risk Assessment) score dated 8/14/21, 9/15/21, and 10/26/21 are 16 (Indicating At Risk).</p> <p>R8's MDS (Minimum Data Set) Assessment dated 8/13/21 documents that R8 is at risk for developing pressure ulcers/injuries and that R8 has unhealed pressure ulcers/injuries. Section (M0300) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage lists: one Stage 4 pressure ulcer.</p> <p>Wound documentation for R8 includes pressure ulcer on the right ischium - Date Identified: 9/8/21 - Source: Facility-acquired.</p> <p>Most recent assessment history (at the time of this survey) includes: Date: 10/26/21 - Clinical Stage: Unstageable - Exudate: Moderate, Serous - Wound measurements: 1.00x4.00x4.00cm</p> <p>On 11/11/21 at 1:00pm V5 (Wound Care Nurse) said, "R8 developed a wound to the right ischium on 9/8/21, but I was not able to see R8's wound until 9/16/21 and it measured 5.5x3.0xUnknown. It was an unstageable pressure wound."</p> <p>Progress note dated 10/18/2021 at 18:46 reads, (R8) seen by V11 (Wound Care Doctor) observed Wound to Right ischium, Full Thickness: 1 x 4.3 x 4.5cm.</p> <p>Facility provided Skin Care Treatment Regimen (Revised date 7/28/21) includes:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
---	---

(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	<p>Continued From page 20</p> <p>It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate topical treatment for residents with skin breakdown.</p> <p>Procedures (include but not limited to):</p> <ol style="list-style-type: none"> 1. Charge nurses must document in the nurse's notes and/or the Wound Report form any skin breakdown upon assessment and identification. Furthermore, topical skin treatment must be obtained from the patient's physician. 2. Routine daily wound care treatment/dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician... 4. TAR Nursing Documentation: <ol style="list-style-type: none"> a. Routine wound care completed by wound care nurse or designee... 5. Refer any skin breakdown to the skin care coordinator for further review and management as indicated... <p>Facility Assessment Tool (Date of assessment or update: 8/3/21) documents...</p> <p>Staff Type (to include) Wound Care Nurses...</p> <p>Staff training/education and competencies: Prior to hiring, human resources audits credentials for applicable candidates. The HR Director tracks the licenses and certifications of the staff per discipline. The facility mandates training upon hire which covers company and facility's policies/procedures and Federal and State regulations.</p> <p>Training and skill competencies are provided upon hire, annually and as needed by the facility. While working, there is a minimum of monthly in service and education provided to direct staff including competencies...</p> <p>Training Topics: Licensed Nursing Staff... Wound Care related to preventing facility</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GROVE OF BERWYN, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SOUTH HARLEM AVENUE BERWYN, IL 60402
--	---

(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	<p>Continued From page 21</p> <p>acquired pressure ulcers including identifying high patients, conducting thorough assessments, nutritional approaches and equipment... Non-Licensed Nursing Staff... Pressure Ulcer Prevention/Wound Care Related Competencies: Nurses...Initial Skin Assessment; Monitoring of Skin Condition; Turning and Positioning</p> <p>(A)</p>	S9999		
-------	---	-------	--	--