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
	IL6010110	A. BUILDING: ______ B. WING ______	C 01/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

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S 000	Initial Comments Complaint Investigation: 2290492/IL142619	S 000		
S9999	Final Observations Complaint Investigation: 2290492/IL142619 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010g)3) 300.1210b) 300.1210d)3) 300.1210d)2)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 300.1010 Medical Care Policies g)Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following: 3)Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 known as bed sores), with grade, size and location specified, and orders for treatment, if present. (A photograph of incipient or manifest decubitus ulcers is recommended on admission.) Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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. Section 300.1210 General Requirements for Nursing and Personal Care d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2)All treatments and procedures shall be administered as ordered by the physician.	S9999		

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S9999	Continued From page 2 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 regulations were not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow standards of practice and physician's orders for wound care for R2. These failures caused the pressure ulcer wound to increase in size and deteriorate to a Stage IV wound with slough and necrotic tissue. The facility also failed to assess and address pain before wound care to the same resident which caused severe pain of 10/10 for 1 of 3 residents (R2) reviewed for pressure ulcer and pain management in a sample of 3. Findings include: R2 is an 87-year-old female admitted on 12/2/21 with an admitting diagnosis including hemiplegia/hemiparesis secondary to cerebral infarction, vascular dementia, and anxiety disorder. Record review on R2's admission skin assessment dated 12/2/21 document no sacral skin issues and skin has been assessed as being intact with no breakdown. R2 was transferred to the hospital on January 14, 2022 for a change in condition. A review of R2's electronic medical	S9999		

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S9999	Continued From page 3 record indicates that the facility did not document any pressure sores for R2. R2's care plan addresses R2's risk for skin breakdown with a goal for no skin breakdown. A shower sheet dated January 12, 2022 documents only a skin tear on the perineal frontal area but no pressure ulcer. Record review on hospital record dated 1/14/22 document a full-thickness stage 3 pressure wound (5.7 x 4.6 x 0.3 cm) on R2's sacrum upon admission on 1/14/22. On 1/29/22 at 1:20 PM, V2 (Director of Nursing - DON) stated, "R2 was sent out to hospital on 1/14/22 for altered mental status. We didn't notice any sacral wound before her transfer to the hospital on 1/14/22. She was re-admitted with a right buttock wound." The nursing skin assessment upon readmission dated 1/18/22 documents right buttocks wound (4.5 x 2.5 cm) with 80% of wound bed necrosis, 10% slough, and 10% granulation and with a foul order. On January 30, 2022, at 12:25PM, R2 was observed during wound care. R2's wound care orders upon readmission are to: "Normal Saline Cleanse, apply santyl ointment and calcium alginate and dry dressing daily." V2(Director of Nursing), V 3 (Nurse) and V 6 (Certified Nurse Aide) were observed to provide the treatment to R2. R2 was not assessed for pain prior to the procedure. R2's wound was assessed at this time to be Stage IV measuring 5 by 4 by 2 centimeters with slough and necrotic tissue. This measure documents an increase in size for the wound from the re-admission assessment of January 18, 2022.	S9999		

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S9999	Continued From page 4 On 1/30/22 at 12:35 PM, observed V2 (DON) providing wound care to R1's right buttocks wound along with V3 (Nurse) and V6 (certified nursing assistant - CNA) without assessing for pain. Observed a stage 4 sacral wound (5 x 4 x 2 cm) with slough/necrotic tissue with drainage with R2's sacrum. R2 was observed screaming throughout the wound care due to pain and was saying, 'make it quick .... make it quick ...'. R2 replied, "My dressing change is painful" in response to the surveyor's inquiry. "My pain is 10/10". Observed V2 continued dressing change to finish it up by applying dry gauze dressing over calcium alginate covering the wound opening. On 1/30/22 at 12:50 PM, V2 stated, "R2 was given pain medication (Tylenol 500 mg at 10:44 AM) before the wound care, and that's why I didn't assess her for pain. V2 was observed to cleanse R2's wound with wet gauze and not irrigate the wound with saline. V2 attempted to obtain an adequate amount of Santyl ointment to treat R2's wounds from what appeared to be an empty tube of santyl on treatment tray V2 was only able to get about 1/2 inch of ointment that did not cover the entire area and was not enough to treat the entire wound bed. V2 then proceeded to cover the wound with calcium alginate pad about 4 inches by 6 inches. The wound was not packed with calcium alginate. On 1/30/22 at 12:50 PM, V2 stated, "The Santyl ointment is expensive, and we don't have any Santyl available now. It's reordered from the pharmacy. The order doesn't say to irrigate the wound, and that's why I used wet gauze to clean the wound. The order also says to apply calcium alginate. It doesn't say to pack it with the wound."	S9999		

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S9999	Continued From page 5 On 1/31/22 at 10:30 AM, V7 (wound care physician) stated, "Santyl ointment is an enzymatic debriding agent to loosen up slough/necrotic tissue and must be applied to the wound bed. Calcium alginate (absorber) must be packed inside the wound to absorb that loosened necrotic tissue by the Santyl ointment. It's pretty basic nursing to irrigate the wound instead of cleaning with wet gauze. It doesn't need to be in the physician order." On 1/31/22 at 10:30 AM, V7 (wound care physician) stated, "The facility should have followed the standard of practice in assessing for pain before they start wound care. They should have stopped the wound care when R2 reported pain 10/10 to address her pain. They could have used Benzocaine spray to numb the area before wound care." R2's plan of care for skin updated January 18, 2022, documents to "monitor wound care" and "wound care as ordered". Facility presented Policy and Procedure for the Treatment and Prevention of Skin Breakdown (dated 9/2021) document: 12. Use safe and effective ulcer irrigation pressures ranging from 4 to 15 psi (Pound per Square Inch - a unit of pressure). High pressure not exceeding 15 psi is needed for wounds with adherent material in the wound bed. Assess the resident for pain related to the pressure ulcer or its treatment. Avoid assuming that because a resident can't express or respond to pain, it does not exist. (B)	S9999		