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	IL6005375	A. BUILDING: _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LIEBERMAN	9700 GROSS POINT ROAD SKOKIE, IL 60076

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S 000	Initial Comments Complaint investigations: 2390778/IL00155840- 2391242/IL00156399-	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 3001210b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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 observation, interview and record review the facility failed to provide an ongoing assessment, monitoring and reporting on skin/wound of resident who are at risk for skin impairment . This failure resulted to (R1) worsening of current skin impairment (MASD-Moisture associated skin disorder) and developed	S9999		

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S9999	Continued From page 2 new wound that the facility is not aware of; and to (R7) for developing necrotic tissues on right lower leg that facility is not aware of. The facility also failed to follow manufacturer recommendation regarding using of low air loss mattress avoiding multilayer linens over the mattress. The facility failed to implement care plan to enhance wound healing and prevent development of new skin impairment. This deficiency affects all four residents (R1, R4, R6 and R7) reviewed for Wound Care Management and Prevention. Findings include: R1 On 2/21/23 at 9:15am, V22 Family member said that R1 has developed sacral wounds last month. On 2/21/23 at 10:58am, Observed R1 transferred to bed from Broda chair using mechanical lift by V9 CNA and V11 CNA. R1 is on special mattress covered with flat sheet with cloth pad on top. V9 CNA repositioned R1 to her right side, opened her disposable adult brief. Observed blood stained at the disposable brief from the open wound on sacral area and soiled with urine. R1 does not have wound covering for open wound. V9 CNA said that R1 has on and off wounds on her sacral area for a while. V9 said that her wound today is worse that the last time he saw it. V9 said that they usually report to the floor nurse if they observed resident does not have dressing for open wound. On 2/21/23 at 11:15am, V6 Wound care Nurse (WCN) preparing wound care for R1. V12 CNA assisted V6 and kept R1 in left side lying position. Sacral area (right and left buttocks) has inflamed excoriation open wounds. V6 cleansed the left buttocks with Normal Saline Solution (NSS).	S9999		

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S9999	Continued From page 3 Asked V6 WCN of wound status. V6 said he does not know. V6 said that he measures and took pictures of R1's wound report weekly, he needs to compare it. V6 took picture of R1's left buttocks and measures the wound. V6 said that R1 has MASD measures 7cm x 5.5cmx 0.1cm with 6 superficial open wounds. V6 said 50% Epithelial tissues (open wound) and 50% intact skin. V6 said this is an improvement from last week. Then he took picture of the left posterior thigh without cleaning it. V6 said it does need to be cleaned because it healed now. Then V6 is about to take picture of the right buttocks with open wound. Surveyor asked him if he could clean the wound before taking the picture and measurements. After V6 cleansed with NSS, he took picture and measured it. V6 said that R1's right buttock has MASD 4.7cm x 4.5cm x 0.1cm with 4 open wounds. 25% Epithelial tissues and Intact skin 75%. V6 said that R1's treatment is skin prep to both left and right sacral area and applied Hydrocolloid/duoderm dressing. He said he changes R1's dressing 3x/week. If the dressing falls off or become soiled the floor nurse will do the wound dressing. Informed V6 that R1 does not have wound dressing when V9 CNA provided incontinence care before he did the wound care. V6 is updating R1's wound records via cellphone while doing treatment. On 2/21/23 at 11:45am, After wound treatment, V6 WCN realized that the left buttock is new to him, and this is the first time he will be documenting it. V6 said he is not aware, and nobody told him until now that he is being observed for wound care. V6 said that that last time he did wound dressing for R1 was last Thursday (2/16/23) and it's only the right buttocks and left posterior thigh. V6 said R2 is not seen by wound care physician. V12 CNA said that she	S9999		

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S9999	Continued From page 4 cannot recall if R1 has left buttocks open wound when she assisted V6 with wound care last week. On 2/21/23 at 11:50am, V13 LPN said that she is the regular nurse for R1. V13 is not aware that R1 has open wound on her both sacral areas. V13 said that she did not receive report from the night shift that R1 has new wound on left buttocks and does not have wound dressing. On 2/21/23 at 12:02pm, Informed V3 ADON of above observation. On 2/21/23 at 1:06pm, V5 WCN said that she used to be the Wound care coordinator and she stepped down as WCN and Floor nurse. V5 said that any skin alteration observed by CNA or no wound dressing for open wound should be reported to the nurse. On 2/21/23 at 3:02pm, V5 WCN said that R1 was admitted on 5/13/2016. They have new management since last year and that she can only access the following Braden scale/skin assessment: 8/31/21, 12/8/22, 1/8/23, and 2/6/23- all indicated high risk score of 10. On 2/22/23 at 2:12pm, Review R1's wound record with V6 WCN. V6 said that R1 has facility acquired MASD on right buttock dated 1/26/23, measures 2cm x 4.5cm x0.10cm, 50% Epithelial tissues (pink/red) and 50% Non-granulating tissues, scant serous exudate. V6 said that the right buttock MASD is worsened most recent measurement on 2/21/23, 4.7cm x 4.5cm x0.10cm, 50% Epithelial tissues (pink/red) and intact skin 50%, scant serous exudate. Informed V6 WCN of concerns on ongoing assessment, monitoring and reporting of R1's	S9999		

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S9999	Continued From page 5 sacral wound/MASD. R1 has treatment on right buttocks and left posterior thigh every Tuesday, Thursday and Saturday and as needed (PRN) if dressing/Hydrocolloid is soiled or loosen. R1 is also incontinent of bladder and bowel. R1 has ordered for skin checks every shift and head to toe skin assessment for any skin alteration. No nurses or CNAs reported to the wound care team of changes in R1's left buttocks (new wound) and worsening of right buttocks. R1 is admitted on 5/13/16 with diagnosis listed in part but not limited to Vascular Dementia, Diabetes Mellitus type 2, Obesity, Polyneuropathy, Fibromyalgia, Major Depression, Anxiety. Physician Order Sheet (POS) indicated: Apply barrier cream on perineal area every shift and PRN, CNA may apply and leave at bedside. May use low air loss (LAL) mattress every shift for preventative care. Skin checks every shift for preventative. Please check from head to toe for any skin alteration. Skin: Turn and reposition at no longer than 2 hours interval and PRN every shift. Treatment: Left posterior thigh and right buttock: cleanse with normal saline, pat dry. Apply skin prep peri-wound and cover with hydrocolloid every T/Th/S and PRN if loose /soiled and PRN dated ordered 1/26/23. Care plan indicated: R1 requires 2 total assist with 2 staff using hoyer lift with transfers (to/from: bed to broda) due to generalized weakness and poor we bearing tolerance. R1 has an ADL self-care performance deficit r/t limited ROM, impaired mobility, decreased endurance/activity tolerance and cognitive impairment. R1 has an actual skin impairment to skin integrity and was assessed to be at high risk for further skin breakdown related to age fragile skin, incontinent of bladder and bowel, impaired physical mobility, decreased ADLs functional ability, Braden scale 10 and	S9999		

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S9999	Continued From page 6 secondary disease process. Wound report dated 2/21/23 indicated: Left buttock- active MASD, incontinence, Facility acquired, identified on 2/21/23 by V6 WCN. Measures- 7cm x 5.5cm x 0.10cm. Intact skin -50%, epithelial pink/red tissue- 50%, scant serous exudate, erythema/maceration on peri wound. Wound summary Right buttock indicated: Active MASD, incontinence, facility acquired dated 1/26/23 identified by V5 WCC. Measures 2cm x4.5cm x 0.10cm, 50% epithelial tissues, 50% non-granulating tissues. 2/21/23 measures 4.7cm x 4.5cm x 0.10cm. 50% intact skin, 50% epithelial tissues red/pink. R4 On 2/21/23 at 12:56pm, V16 RN said that R4 has pressure ulcer. R4 is on enhanced isolation precaution. Observed R4 with V16 RN on special mattress covered with flat sheet, with folded linen in quarter underneath R4. V16 said that R4 should only be on flat sheet over LAL mattress, no folded linen on top of the flat sheet/over the LAL mattress. On 2/22/23 at 10:55am, Observed V6 WCN and V12 CNA preformed wound care to R4. Observed R4's sacrum wound dressing soaked with serous sanguineous with brownish greenish drainage. V6 cleansed the sacrum with NSS. V6 said that R4 has unstageable pressure ulcer which is facility acquired, measures 5.2cm x 4.9cm x 0.70cm, 30% greenish slough attached to wound base, 70% non-granulating tissues. On 2/22/23 at 2:12pm, Review R4's wound record with V6 WCN. Informed V6 of above observation. V6 said that R4 should only have flat sheet over	S9999		

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S9999	Continued From page 7 the LAL mattress. V6 said that R4 is admitted on 9/29/21. R4 has facility acquired MASD on sacrum on 11/1/22 that progress to unstageable pressure ulcer on 12/29/22 until present. R4 is admitted on 9/29/21 with diagnosis listed in part but not limited to Metabolic encephalopathy, Acute pulmonary edema, Malignant neoplasm of uterus, Severe protein calorie malnutrition, Palliative care. POS indicated: Low air loss mattress and check if functioning properly. Care plan indicated: R4 has actual skin impairment and was assessed to be at high risk for further skin breakdown related to age, fragile skin, incontinence of Bladder and bowel, impaired physical mobility, decreased ADLs functional ability, poor appetite, Braden score of 10 and underlying disease process. Wound summary: Sacrum Pressure ulcer. Facility acquired. Date identified 11/1/22. Denuded/MASD. 3cmx3.5cmx0.10cm. Epithelial tissues (pink/red) 50%, Non- granulating tissues (pink /red) 50%. Scant serous exudate. 2/16/23 Unstageable pressure ulcer. 4.70cmx4.50cmx not measurable. Slough white fibrinous 30%, Non granulating tissue (pink/red) 70%. Moderate serous exudate. R6 On 2/21/23 at 1:25pm, V19 LPN said that R6 has pressure ulcer and is on hospice care. Observed R6 with V19 lying in bed on LAL mattress covered with flat sheet, folded sheet in quarter underneath him. V19 said that R6 should only be on a flat sheet over the LAL mattress, no folded sheet underneath over the mattress. On 2/22/23 at 11:03am, Observed V5 WCN, V6 WCN and V12 CNA provided wound care to R6.	S9999		

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S9999	Continued From page 8 Observed R6 on LAL mattress covered with flat sheet and folded linen in quarter underneath R6. Showed observation to V6 and he removed it. V6 said that R6 should only be only flat sheet over the LAL mattress. V6 measures and describes the following wounds: Left back pressure ulcer (with 2 wounds) - 19cmx 8.2cm x not measure due unstageable, 20% necrotic tissue, 10% slough and 10% non-granulating tissue; Midback pressure ulcer (with 3 wounds)- 17cm x2.8cm x not measure due to unstageable, 20% necrotic, 20% slough, 60% intact skin, erythema on peri wound; Right lower back (with 4 wounds)- 6cm x 10cm x 1.9cm undermining 12 to 2 o'clock, 15% slough, 15% necrotic tissue, 20% intact skin and 50% red/pink tissue; Sacrum- MASD, 10cm x 11cm. with open wound measures 1.6cm x1.5cm x0.1cm. On 2/22/23 at 2:12pm, Review R6's wound record with V6 WCN. Informed V6 of above observation. V6 said that R4 should only have flat sheet over the LAL mattress. V6 said that R6 is admitted on re-admitted on 9/29/22. V6 said all R6's wounds are facility acquired. Left back pressure ulcer is facility acquired on 1/2/23 as stage 3, 15cm x 6cm x 0.2cm, 10% non-blanchable erythema, 20% slough white fibrinous, 20% non-granulating tissue and 50% intact skin, light serous exudate. Left back stage 3 progressed to unstageable pressure ulcer on 1/19/23 until present. Left buttocks deteriorated. Midback pressure ulcer is facility acquired on 1/5/23 as stage 3 pressure ulcer, 15cm x 6cm x 0.20cm, 10% on-blanchable erythema, 20% non- granulating tissue, 20% slough white fibrinous and 50% intact skin, light serous exudate, Mid back pressure ulcer remains stage 3 but increased in wound size; Right lower back pressure is facility acquired on 1/2/23 as unstageable pressure ulcer, 5cm x 5cm x	S9999		

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S9999	Continued From page 9 unknown, 20% non-granulating tissue and 80% slough white fibrinous, light serous exudate. Right lower back pressure ulcer remains unstageable but with undermining; Sacrum MASD is facility acquired on 1/2/23, 4cm x 5cm x 0.10cm, 50% epithelial tissue and 50% non-granulating tissue. Sacrum MASD remains but increased in size. R6 is admitted with diagnosis listed in part but not limited to Parkinson's disease, Chronic embolism and thrombosis of deep veins of lower extremities, Neuromuscular dysfunction of bladder, Metabolic encephalopathy, Alzheimer's disease, Cerebral atherosclerosis, Acute kidney failure. POS indicated: Low air loss mattress and check if functioning properly. Care plan indicated: R6 has actual skin impairment and was assessed to be high risk for further skin breakdown related to factors such as age, incontinence of bladder and bowel, impaired mobility, decreased ADLs functional ability, Braden score of 9 and secondary to disease process. R7 On 2/23/23 at 10:37am, Observed R7 up in wheelchair in her room by her bedside dresser with no pants, wearing shorts and blouse. Clothes scattered on the floor. Observed right leg redness and swollen with necrotic/black tissue at the back of her leg. The entire right lower leg is swollen that causing visible skin tightness. Left leg has purplish discoloration, no swelling. Bilateral lower leg has dry skin. Called V24 Agency CNA sitting by the hallway and showed observation. V24 said that she is the CNA taking care of R7, but this is the first time she is assigned to her. V24 does not know about the necrotic wound on her right leg. R7 is dressed up by the night shift. R7 is in the dining room for breakfast and probably came back to her room and undressed herself. V24	S9999		

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S9999	Continued From page 10 called V25 LPN. On 2/23/23 at 10:43am, V25 LPN said that she is regular nurse who works with R7 but she has not taken care of R7 for the last 3 weeks. V25 said that the night shift nurse just endorsed to her this morning about R7's necrotic wound with redness and swelling of on her right leg. R25 said that she just waiting for the nurse Practitioner to come and see R7. Review R7's e-POS with V25. No treatment order for necrotic wound on right lower leg. R7 has ordered for ace wrap to bilateral lower leg in the morning, remove at bedtime dated 10/6/22. On 2/23/23 at 10:45am, V26 Restorative aide said that she has been treating R7 for daily Restorative program but is not aware of the necrotic/black wound on her right leg. R7 is wearing pants so she did not notice it and R7 did not complaint about it. On 2/23/23 at 11:04am, V6 WCN said that he is not aware of R7's has necrotic wound with redness and swollen right lower leg. No one informed him until now. The last time that he treated R7 was last 10/27/21 when he healed her skin tear on right lower leg. V6 cleansed R7's necrotic wound on right posterior leg. V6 measured necrotic wound, 7cm x 4cm x not measurable due to necrotic tissue, entire right lower leg/foot swollen. R7's left leg has purplish brown discoloration. V6 applied Betadine paint and left open to air. On 2/23/23 at 11:22am, V27 Wound Care Coordinator (WCC),V5 WCN came to R7's room and observed her wound. Informed V5, V6 and V27 of concerns on ongoing assessment, monitoring and reporting of R7's right leg or bilateral legs. R7 has treatment ordered of ace	S9999		

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S9999	Continued From page 11 wrap to both lower leg in the morning, remove at bedtime since 10/5/22. No nurses or CNAs reported to the wound care team of necrotic wound with redness and swelling that causing tightness of the skin. V27 said that she already contacted V28 Wound care Physician for consultation. On 2/23/23 at 1:30pm Informed V1 Administrator, V2 DON, and V3 ADON of above observation. R7 is admitted on 5/18/18 with diagnosis listed in part but not limited to Metabolic encephalopathy, Alzheimer's disease, Urinary tract Infection, Anxiety disorder, Obsessive compulsive disorder, Age related osteoporosis, Peripheral Vascular disease. POS indicated: Apply ace wrap to both lower leg in the morning, remove at bedtime dated 10/5/22. Care plan indicated: Potential for skin impairment and is at risk for further skin breakdown related to factors such as age, fragile skin, impaired mobility, decreased ADLs functional ability, Braden score 16 and secondary to disease process/diagnosis. Interventions: Skin checks every evening shift. Report abnormalities to the nurse. Notify nurse immediately of any of skin breakdown, such as redness, blister, bruises, skin tears, discoloration noted during bath or daily care. On 2/24/23 at 12:11pm, V28 Wound Care Physician said that minimal layer is recommended over LAL mattress like using flat sheet. Placing folded linens created multi layers could inhibits the effectiveness of the LAL mattress overall. Facility's policy on Skin Care Treatment Regimen indicated: It is the policy of this facility to ensure prompt identification, documentation and to	S9999		

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(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	Continued From page 12 obtain appropriate topical treatment for resident with skin breakdown. Procedures: 1. Charge nurses must document in the nurse's notes and or the wound report form any skin breakdown upon assessment and identification. 5. Refer any skin breakdown to the skin care coordinator for further review and management as indicated. Facility's guidelines on Low Air Loss (LAL) Mattress Purpose: LAL have tiny laser made air holes in the mattress top surface that continually blow out air causing a reduction in humidity and heat between the skin and mattress surface (Microclimate). A blower will typically output around 100-150liters of air into the mattress, drying the skin and preventing skin breakdown. Procedure: 3. Provide a breathable sheet on top of the LAL mattress and provide incontinence pad and or brief as necessary only. If the resident is continent, then an incontinence pad or brief is not needed. Please see Specialized Mattress and appropriate Layers of padding policy for more details. Facility's policy on Specialized Mattress and Appropriate Layers of Padding: Procedure: 1. Limit the amount of layers on top of specialized air mattress such as LAL mattress according to the resident's needs and individual's condition in order to manage comfort, positioning and moisture. For LAL mattress, consider 1 fitted or flat sheet on top of the bed for dignity, 1 cloth incontinence pad and 1 absorbent brief to absorb fecal or urinary incontinence and help with repositioning,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005375	A. BUILDING: _____ B. WING _____	C 02/24/2023

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S9999	Continued From page 13 prevent fecal urinary soiling of the entire bed and resident's skin, if the resident is incontinent. (B)	S9999		