STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005607	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

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S 000	Initial Comments Complaint Investigation 2419007/IL180345	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)3)5) 300.1220b)3) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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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.
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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three

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months.

These Requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement interventions to prevent pressure ulcers and failed to identify a pressure ulcer for 2 of 3 residents, R1 and R3, reviewed for pressure injuries in the sample of 3. These failures resulted in R1 developing a Stage 3 sacral pressure wound which later became an infected Stage 4 pressure ulcer and R3's pressure wound not receiving wound care treatment until it was an unstageable pressure injury.

The findings include:

On 11/6/24 at 10:42 AM, V4, Wound Care Nurse, V7, Registered Nurse, and V8, Certified Nursing Assistant transferred R1 from her chair to her bed to provide wound care. R1 had a half dollar coin sized wound to her sacrum.

R1's Admission Record dated 11/7/24 shows R1 was admitted to the facility on 10/19/23. R1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation shows R1 was "At Risk" on 10/20/23, was a "High Risk" on 11/3/23, a "Moderate Risk" on 12/13/23 and 1/4/24, "High Risk" again on 1/15/24 and "Moderate Risk" on 4/18/24. R1's Care Plan initiated on 10/20/23 shows R1 has an ADL (activities of daily living) self-care performance and functional mobility deficit related to confusion, dementia, and impaired balance. On 11/1/23, R1's care plan identifies she is incontinent of bowel and bladder. R1's care plan does not identify that she is at risk to develop pressure injuries with corresponding prevention

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interventions. R1 is totally dependent on staff for toilet use. R1's Full Body Skin Assessment effective 10/20/23 shows R1 has no wounds. R1's Wound Evaluation dated 5/8/24 shows R1 has a new, facility acquired, Stage 2 pressure wound of her "butt crack." R1's Wound Evaluated dated 5/9/24 which was completed by V4, shows R1 has a Stage 3 facility acquired pressure wound of her sacrum. R1's Wound Evaluation & Management Summary completed by the Wound Care Physician, V5, on 5/9/24, shows the visit is an initial evaluation of R1's sacral wound and confirms R1's sacral wound is a Stage 3 Pressure Wound. R1's Wound Evaluation & Management Summary dated 7/18/24 shows R1's Stage 3 sacral Pressure Wound merged with a non-pressure wound of her right upper medial buttock and became a Stage 4 sacral pressure wound with odor, heavy serosanguinous exudate, and 100 percent necrotic tissue. R1's sacral wound culture collected 7/25/24 shows the wound has become infected by Escherichia coli (E-coli), and Morganella morganii. R1's Order Recap Report dated 11/7/24 shows R1 was prescribed an antibiotic on 7/30/24 for eight days related to her wound culture.

R3's Admission Record dated 11/7/24 shows he was admitted to the facility on 4/11/24. R3's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 4/11/24 shows he was a "Very High Risk." R3's Skin/Wound Note dated 4/12/24 at 3:17 PM shows R3's sacrum is clear. R3's Skin/Wound Note dated 5/23/24 at 5:31 PM shows R3 "has MASD (moisture associated skin damage) to sacrum/coccyx, dry healing, also present upon admission, but much improved, this is not a pressure injury." R3's Skin/Wound Note dated 6/21/24 at 3:17 PM shows R3 has an unstageable sacral wound with a 3 centimeter

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(cm) by 3 cm area of slough surrounded by a 10 cm by 7 cm area of redness. It does not note the etiology of the wound. R3's Initial Wound Evaluation & Management Summary dated 6/28/24 shows an unstageable (due to necrosis) sacral pressure wound measuring 11.6 cm by 10 cm by 0.2 cm with heavy sero sanguinous exudate and 70 percent necrotic tissue.

On 11/6/24 at 3:18 PM, V5 (Wound Care Doctor) said (wound) infection is never normal. V5 said he would expect a wound to be identified before it is the size R3's sacral pressure wound was when it was found. V5 said R3 had a "pretty horrific (pressure) ulcer."

On 11/7/24 at 9:45 AM, V4 (Wound Care Nurse) said R1 did not have any pressure wounds on admission, but R1 was at risk of developing a pressure ulcer. V4 said R1 was a 12 on the Braden scale which puts her at high risk of developing a pressure wound. V4 said they should develop a care plan to include pressure injury prevention measures such as frequent turning. V4 said R1's risk factors include limited mobility, need for assistance with ADLs (toileting and transferring), bowel and bladder incontinence, and dementia. V4 said R1 did develop a wound infection this past summer. Signs and symptoms of wound infection include increased redness, drainage, warm to touch, necrotic tissue, increased slough, purulent drainage, increased drainage, and odor. V4 said wound infections are not very common and should not occur as part of the normal wound healing process. V4 said they are still working on healing R1's sacral pressure wound. V4 said R3 was admitted to the facility on 4/11/24 with a history of pressure ulcers. V4 said R3 was at risk for developing pressure ulcers. V4 said R3's

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sacral pressure ulcer was first identified on 6/21/24 as an open, unstageable pressure ulcer with slough and V5 first saw R3 on 6/28/24 regarding the sacral pressure ulcer. V4 said she would expect to have been notified (about R3's pressure ulcer) when there was just redness, before it opened. V4 said she expects nursing to notify her about any change in skin, any alterations of the skin, especially in the pressure point areas such as the sacrum. V4 said it is obvious a wound would not start out at 10 centimeters, she should be notified long before it ever gets to a significant size so she can assess the wound, make sure there is wound treatment and get the wound care physician involved.

The facility's Pressure Injury Prevention Policy (revised 1/10/24) shows the wound team will manage wound care, implement prevention interventions, and monitor compliance with documentation. If a wound is identified, a would assessment is done and should include the type of injury (pressure versus non-pressure related). Identified wounds are assessed and measured on a regular basis at least weekly and documented. Based on the Braden's Scale, any resident who is identified as high risk for developing pressure injuries will have interventions initiated to decrease risks. The IDT (interdisciplinary team) will review care plan ensuring that it includes measurable goals for prevention and management of pressure ulcers with appropriate interventions.

(B)