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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3)4)A)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 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, 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	S9999		

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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.
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,

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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 ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to a resident who is at high risk for skin impairment. The facility failed to formulate wound/pressure care plan and implement LAL (Low air loss) mattress manufacturer's recommendation in prevention and management of wound care.

These failures resulted R54 to develop DTI (Deep tissue injury) on right heel. This deficiency affects all five residents (R28, R36, R45, R54 and R59) in the sample of 17 reviewed for Wound/Pressure ulcer prevention and treatment management.

Findings include:

On 3/4/25 at 8:07AM, Observed R28 sleeping in a LAL (low air loss) mattress bed with V10 Family member at bedside. V10 said that R28 is totally dependent with ADLs (Activity of Daily Living). V10 said that last week Friday (2/28/25), R28 re-opened her sacral pressure ulcer. V10 said she noticed it when she assisted the CNA (Certified Nurse Assistant) in performing incontinence care and they applied wound

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dressing. V10 said she notified the ADON (Assistant Director of Nursing), and V5 Wound Care Coordinator (WCC) came to see R28, both were aware of R28's re-opened sacral pressure ulcer. Observed R28 has fitted sheet covered the LAL mattress and a cloth pad over the mattress. R28 wears disposable brief.

On 3/4/25 at 8:11AM, Observed R59 lying in LAL mattress bed with flat sheet folded in half and cloth pad over the mattress. R59 wears disposable adult brief. V11 CNA said that R59 should only have flat sheet over the LAL mattress. The night shift CNA is the one who did apply the multi layers of linen over the mattress.

On 3/4/25 at 8:20AM, Observed R36 lying in LAL mattress bed with V11 CNA. Observed R36 has flat sheet and cloth pad over the mattress. R36 wears disposable brief.

On 3/4/25 at 8:25AM, Observed R54 lying in LAL mattress bed with V5 WCC. Observed flat sheet and cloth pad over the mattress. R54 wears disposable brief. V5 said that R54 should only have flat sheet over the mattress. No multi-layer of linens as manufacturer's recommendation.

On 3/4/25 at 8:30AM, Observed R45 lying in LAL mattress bed with V5 WCC. Observed flat sheet and cloth pad over the mattress. R45 wears disposable brief. V5 said that R45 should only have flat sheet over the mattress. No multi-layer of linens. Informed V5 of above observation made to R28, R36 and R59 with multi layers of linen over the LAL mattress. V5 said that residents on LAL mattress should only be on flat sheet so it will not affect the purpose of LAL mattress.

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S9999	Continued From page 4 On 3/4/25 at 10:04AM, V5 WCC said that she is responsible for wound assessment and treatment for resident with pressure ulcers and other skin conditions. She said, resident who is admitted with skin impairment or open wound should have skin assessment with measurement done by the floor nurse or herself. The physician will be notified to obtain appropriate treatment and care plan will be updated. V5 presented list of residents with skin impairment/pressure ulcers in the facility. The list did not indicate R28 and R54. On 3/4/25 at 10:21AM, Informed V5 WCC of V10 Family member reported that R28 has re-opened her sacral pressure ulcer last Friday (2/28/25). V5 said that she is not aware, and this is her first time hearing this report. V10 Family member denied statement of V5 and reminded her that she came to see R28 on 2/28/25 after she reported to ADON about R28's re-opened sacral wound. V10 added that V5 did not see the wound because the floor nurse applied wound dressing, but she reported to her. V5 said, she probably forgot about it. V5 then started preparing to perform wound assessment and treatment. She wears only gloves, she opened R28's disposable brief then she repositioned R28 to her left side and removed her brief. The brief is clean, but the wound dressing is contaminated with black fecal matters. Observed R28 has fitted sheet and cloth pad over the LAL mattress. R28 has sign posted at her door indicated Enhanced Barrier Precaution. V5 cleansed open sacral wound with normal saline solution (NSS). V5 said, R28 has stage 2 pressure ulcer. Observed clean pinkish tissue and whitish color (maceration) at peri wound. V5 measured sacral wound and obtained 0.5cm x 0.4cm x0.1cm. V5 said that she will call R28's physician to obtain treatment order.	S9999		

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S9999	Continued From page 5 On 3/4/25 at 10:41AM, Observed R54 lying in LAL mattress bed. He has tracheostomy tube connected to ventilator. He has gastrostomy tube connected to feeding bag. He is awake and non-verbal. V5 assisted with V8 Restorative Nurse to remove R54's bilateral heel protectors. Observed R54 dressing on the following: Left dorsal foot, left lateral ankle, right inner/medial lower leg, and right heel. Wound dressing dated 3/2/25. V5 said that she was not aware of this wound dressing because there is no order in his chart. V5 removed all wound dressing and cleansed with NSS then did measurement. Left dorsal foot has 1.5cm x1.5cm dry necrotic scab. Left lateral ankle pressure ulcer measures 2.5cm x 1.3cm with 50% pinkish tissue and 50% necrotic dry scab. Right inner/medial lower leg measures 1.5cm x 0.5cm. Observed bleeding granulating, reddish tissue, full thickness. Right heel DTI measures 4.5cm x 6cm, 35% necrotic tissue, 10% red tissue exposure, 65% maroon discoloration. V5 painted betadine to all wounds and covered with bordered dressing. V5 said that she calls the physician to obtain treatment orders to all new identified skin impairments for R54. On 3/4/25 at 11:19AM, Observed R45 lying in LAL mattress bed. He is alert, responsive but with episodes of confusion. V5 WCC assisted with V18 CNA preparing R45 for wound care. V18 open his disposable brief. He as morbid obese abdomen. Surveyor requested to check for underneath his abdominal folds. R45 screams for pain as V18 lifted his abdomen. Observed MASD (Moisture associated skin disorder) underneath the abdominal folds with fluids. Both V5 and V18 said that the fluid from his urine (due to anatomical position of his genital/penis). R45 continues to scream for pain as V18 and V5 cleansed the abdominal folds. Surveyor asked V5	S9999		

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if R45 has scheduled pain medication. Both said that R45 always complains of pain even just touching him. V5 said that she is not aware of this MASD, and this is new for her. V5 applied barrier cream. Then V18 positioned R45 to his left side. V5 said that R45 has Stage 4 sacral pressure ulcer. She applied collagen sheet and covered with foam dressing. V5 said that she will call R45's physician about MASD on abdominal folds.

On 3/6/25 at 10:03AM, Reviewed R28, R54, R45, R36 and R59 medical records with V5 WCC. R28 is re-admitted on 7/5/24 with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus, Dementia, Contractures on right and left ankle, left and right hand, Gastrostomy, Chronic Kidney disease. Active physician order sheet indicates: Weekly skin checks for wound prevention. Moisture barrier ointment apply to buttocks and peri area topically every shift for skin protection secondary to incontinence. No wound treatment addressing to re-opened sacral wound on 2/28/25. Comprehensive care plan indicated she has as alteration in skin integrity and is at risk for additional and or worsening of skin integrity issues related to impaired cognition related to dementia, impaired mobility, and other medically related diagnosis. Intervention: Skin will be checked during routine care daily and during weekly bath/shower schedules. Any skin integrity issues /concerns will be conveyed to the charge nurse for further evaluation and or treatment changes/new interventions and the physician will be called as needed. Pressure reducing/relieving mattress. Informed V5 that Physician was not notified of re-opened sacral wound, did not obtain appropriate treatment intervention, care plan was not implemented and updated not until the surveyor addressed the concerns during survey. Informed V5 that wound assessment done with

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surveyor on 3/4/25 was dated 3/3/25, it was signed on 3/5/25.

R54 is admitted on 2/11/25 with diagnosis listed in part but not limited to Encephalopathy, Respiratory failure, Emphysema, Chronic obstructive pulmonary disease, paralytic syndrome following cerebral infarction bilateral, Tracheostomy status, Gastrostomy status, Muscle wasting and atrophy. Braden scale/skin assessment upon admission (2/11/25) and most recent (3/2/25) indicated that He is at very high risk for developing pressure sore. No admission wound assessment and measurement was done. Admission notes dated 2/11/25 indicated "open areas multiple, scrotum under red, right outer leg open, back open area, multiple scabs back, back upper open area, back middle open area, toenails thick, top right great toe bruise, left hand callus, right ball foot scab, heel right red area, right inner lower leg red open area, left leg multiple scars, right lower leg scars". Active physician order indicated No treatment orders addressing the identified skin impairment upon admission. V5 did not complete skin assessment after admission. Wound care physician initial wound assessment dated 2/17/25 indicated: 1) Diaper dermatitis on perineal and buttocks. Treatment recommended- moisture barrier or zinc oxide, 2) Venous stasis on left big toe. Treatment - betadine paint. 3) Open blister on left mid back. Treatment- zinc oxide or Vit A& D. Treatment ordered were written in physician order sheet and not carried out not until the surveyor addressed the concerns. V5 write the treatment recommended by wound care physician on 2/17/25 not until 3/4/25 during survey. R54 physician order sheet and Treatment administration record indicated that treatment orders recommended by wound care physician was only documented on 3/4/25. Informed V5

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WCC that they failed to implement its policy and procedure on prevention and treatment management of pressure and non-pressure wounds. They failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to resident who is at high risk for skin impairment. R54 developed DTI on right heel, open wound on lateral ankle and open wound on right medial lower leg. It was not identified, documented, and did not obtain appropriate treatment from the physician not until the surveyor identified it during survey. No comprehensive care plan was developed upon admission to address the skin impairment and prevention of developing pressure ulcer. V5 said that the previous MDS/Care plan coordinator was the one responsible for developing wound/pressure ulcer care plan. V5 submitted all new identified wounds with assessment and measurement done with surveyor on 3/4/25, signed and dated on 3/6/25.

R45 is re-admitted on 8/24/23 with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus, Senile degeneration of brain, Chronic obstructive pulmonary disease, Hemiplegia, and hemiparesis following cerebral infarction affecting left non dominant side, Vascular dementia, Muscle wasting and atrophy. Most recent Braden scale/skin assessment (1/24/25) indicated that he is at high risk for skin impairment. Active physician order indicated Sacrum: cleanse with NSS, apply collagen sheet or puracol, zinc oxide around then cover with foam silicone dressing daily and as needed. Weekly skin assessment. Moisture barrier ointment apply to buttocks and peri area topically every shift for skin protectant secondary to incontinence. No treatment order for MASD abdominal folds that was identified on

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3/4/25 with surveyor. Comprehensive care plan indicated that he has an alteration in skin integrity and is at risk for additional and or worsening of skin integrity issues. Interventions: Skin will be checked during routine care on daily basis and during weekly bath /shower. Any skin integrity issues/concerns will be conveyed to the charge nurse for further evaluation and or treatment changes new interventions and the physician will be called as needed. Pressure reducing/relieving mattress (low air loss mattress). Informed V5 WCC that they failed to implement its policy and procedure on prevention and treatment management of pressure and non-pressure wounds and implement care plan interventions. They failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to resident who is at high risk for skin impairment.

R36 is re-admitted on 5/27/24 with diagnosis listed in part but not limited to Parkinson, Dementia, Muscle wasting and atrophy, Stage 3 sacral region pressure ulcer. Active physician order sheet indicates: Low air loss mattress. Treatment sacrum: Apply protective dressing as needed for skin protective dressing. Comprehensive care plan indicated she is at risk for alteration in skin integrity. Most recent Braden scale assessment dated 12/13/24 indicated at risk for developing pressure ulcer sore. Informed V5 WCC of multilayers of linens over the mattress on 3/4/25.

R59 is re-admitted on 4/10/24 with diagnosis listed in part but not limited to Sequelae of cerebral infarction, Senile degeneration of brain, Metabolic encephalopathy, Subarachnoid hemorrhage, Vascular dementia. Comprehensive

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care plan indicated she is at risk for alteration in skin integrity related to impaired cognition, incontinence of bladder and bowel and impaired mobility. Intervention: Pressure relieving/reducing mattress. Informed V5 WCC of multilayers of linens over the mattress on 3/4/25.

On 3/6/25 at 12:51PM, Informed V24 Medical Director of above concerns identified that the facility failed to ensure ongoing assessment is done to identify new skin impairment, document and notify physician for appropriate treatment in a timely manner to residents who are at high risk for skin impairment. The facility failed to develop wound/pressure care plan and implement LAL (Low air loss) mattress manufacturer's recommendation in prevention and management of wound care. V24 said that they should follow and implement the facility's policy and procedures in prevention, treatment and management of wound/pressure ulcers.

Facility's policy on Wound Assessment indicates:
It is the policy of this facility to complete a systematic, ongoing assessment of all wounds that will provide a consistent means of wound evaluation to determine the response to treatment modalities and to facilitate continuity of care and communication among staff and healthcare providers on an ongoing basis.
Procedure:
I. The presence of wounds, injuries and or other skin abnormalities will be identified upon admission/readmission or identification of a new wound, pressure injury, or other skin abnormality.
A. The staff will complete a complete skin and wound assessment upon admission/readmission, identify any wounds, pressure injuries or other skin abnormality and document it in the medical records.

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B. The wound team will complete a skin and wound assessment and document the presence of any wound assessment in the medical record.
C. Any wound, pressure injury or other skin abnormality identified during the resident's stay will be documented in the same manner as when identified upon admission/re/admission.
II. Wounds are measured weekly by the wound team or designee
A. The status of the wound is documented in the medical record
B. Wound status is also monitored with each dressing change
C. Any changes in the wound are documented at the time identified and the physician and family are notified.

Facility's policy and procedures on Treatment/services to prevent /heal pressure and non-pressure wounds revised 11/2/23 indicated:
Policy:
It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs.
Procedure:
1. The facility will ensure that based on the comprehensive assessment of a resident:
1a. A resident receives care, consistent with professional standards of practice to prevent pressure and non-wounds and does not develop pressure or non-pressure wounds unless the individual's clinical condition demonstrates that they were unavoidable as documented by the wound care specialist.
1b. A resident with pressure ulcers or non-pressure wounds received necessary

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treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new wounds from developing.
2. Upon admission, the resident will receive a head-to-toe skin check to identify any skin issues.
3. Interventions will be implemented by the nurse in the resident's plan of care to prevent pressure sore development when the resident has no areas of concern.
4. When the resident is admitted with a pressure or non-pressure wounds the admitting nurse or wound care nurse will document the size, location, odor, drainage, and current treatment ordered.
5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure and non-pressure wound.
6. The admitting nurse will notify the attending physician as well as the resident and or resident's representative of the condition of the wounds that were observed on admission.
7. The pressure and non-pressure wounds will be evaluated weekly by the wound care nurse and or the wound care specialist.
8. If the wound care specialist changes any treatment or indicates other interventions the wound care nurse will put these orders in the resident's electronic medical record.
9. The nurse will notify the resident and or the resident's representative of any changes related to the improvement, deterioration and or treatment changes on an ongoing basis.

Facility's policy Guidelines for Low Air Loss Mattress use dated 7/18/23 indicated:
Purpose: To provide the features of a support system for the resident that provides a flow of air in managing the heat and humidity (microclimate)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

(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 13 of the skin. Procedure: 8). A single non fitted sheet may need to be utilized on the mattress for assistance in positioning and repositioning the resident. Fitted sheets are not recommended. Quilted reusable pads and incontinent briefs tend to block the airflow and trap moisture against the skin. Disposable, air permeable incontinence pads designed for low air loss mattresses should be used instead. (B)	S9999		