

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/06/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDEN VALLEY RIDGE REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108</b>		
(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  Annual Licensure and Recertification Survey	S 000		
S9999	Final Observations  Statement Of Licensure Violations:  300.610a) 300.1210b) 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 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/23/25

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S9999	<p>Continued From page 1</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>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 developin</p> <p>These regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to identify a resident's pressure ulcer. This failure resulted in a delay in assessment, monitoring, and implementation of new interventions for a pressure wound that deteriorated to an unstageable.</p> <p>This applies to 1 of 3 residents (R95) reviewed for pressure ulcers in a sample of 32.</p> <p>The findings include:</p> <p>R95's most recent pressure ulcer risk assessment (dated 04/22/25) showed R95 is at "Mild Risk" for developing pressure ulcers.</p> <p>On 06/03/25 at 9:51 AM, R95 was sleeping in bed. At 9:53 AM, V38 (CNA-Certified Nursing Assistant) said R95 had some redness on her backside. V38 said she was unsure if R95 had</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>any wounds because she only cleans the skin around a dressing when providing incontinence care. At 10:07 AM, V32 (R95's POA-Power of Attorney) said that the facility had not mentioned anything about R95 having any pressure sores or open skin.</p> <p>On 06/04/25 at 2:10 PM, V16 (ADON-Assistant Director of Nursing/IP-Infection Preventionist) reviewed the EBP (Enhanced Barrier Precautions) list and said that R95 was not on the list since she does not have any wounds. V16 stated R95 has only exhibited some rash-like redness and was receiving treatment for Moisture-Associated Skin Damage (MASD).</p> <p>On 06/05/25 at 9:49 AM, V14 (RN-Registered Nurse) said that she had already changed R95's dressing earlier that morning. V14 stated that R95 did not have any pressure-related wounds and only had redness with some "open skin." Per V14, R95's current wound treatment orders were only for the prevention of pressure injury. At 10:00 AM, V14 and V34 (CNA-Certified Nursing Assistant) turned R95 to her left side and V14 removed R95's undated dressing from her sacrum. The dressing was saturated with red and yellow fluid. R95's sacral area had a round, open area, and the wound bed was covered with thick, yellow, stringy slough adhered to it. The wound had a dark gray perimeter around the slough. V14 measured the wound and stated R95's wound was a pressure sore. At 10:15 AM, V14 stated that the last time she saw R95's wound was on 06/03/25 (2 days earlier) and she described it as "a little open with little slough."</p> <p>V14's 6/5/25 1:24 PM wound assessment showed R95 has a "sacral unstageable pressure ulcer" with "90% slough" and "moderate</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>serosanguinous" discharge, with peri-wound measuring [in cm- centimeters] 6.2 cm x 4.2 cm with a pressure ulcer in the center that measured 3.2 cm x 3 cm with an undetermined depth. R95's EMR (Electronic Medical Record) did not include any previous wound assessments for R95's pressure ulcer.</p> <p>R95's POS (Physician Order Sheet) showed a 5/27/2025 order from V33 (PA- Physician Assistant) for a foam dressing and Medi-honey to R95's sacrum every day and evening for "skin condition." The POS also included another order for "in-house Wound Consult." No other new orders or interventions were included in R95's POS to address the unstageable pressure ulcer.</p> <p>On 06/06/25 at 11:03 AM, V33 (PA-Physician Assistant) said that on 05/27/25, facility staff notified her regarding a skin issue with R95's and she did not examine R95's skin herself and based her order for Medi-honey on the staff's description of R95's skin. V33 confirmed that Medi-honey is for pressure-related wounds and stated that she would have ordered a different topical treatment if R95 only had redness.</p> <p>On 06/05/25 at 12:30 PM, V31 (Wound Doctor) said that he had been in the facility on 06/03/25 and was not notified of R95's Wound Consult order and he did not see R95. V31 confirmed that Medi-honey is not an appropriate treatment for redness or MASD as it is typically used as a debridement agent for pressure-related wounds.</p> <p>R95's 12/14/23 care plan showed R95 with a "potential alteration in skin integrity ...previously with MASD to upper inner buttock/gluteal cleft area." R95's care plan had not been updated to</p>	S9999		

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S9999	Continued From page 4  include her actual pressure ulcer until 6/5/25, during the survey, and nine days after the Medi-honey order.  The facility's policy on "Prevention and Treatment of Pressure Injury and other Skin Alterations" includes identifying residents at risk for developing pressure injuries, identifying the presence of pressure injuries and/or other skin alterations, and implementing preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through an individualized resident care plan. The policy also states that "at least daily, staff should remain alert for potential changes in the skin condition during resident care ..."  (B)	S9999		