STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zahav of Berwyn	3601 South Harlem Avenue Berwyn, IL 60402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to identify and treat an open wound. This affected one of three residents (R1) reviewed for skin assessment and wound care. This failure resulted in R1 being admitted to the hospital where the open wound was found and treated for maggots present in the wound. Findings Include: R1 is a [AGE] year old with the following diagnosis: end stage renal disease with dependence on renal dialysis, type 2 diabetes, heart failure, and transient ischemic attacks. A General note dated 7/6/24 documents the nurse contacted the physician to inform them about R1's left leg swelling. Orders were put in to send R1 to the hospital for an evaluation to rule up blood clots. R1 was transported to the hospital at 12:06 AM. R1 was admitted to the hospital to a step down unit. The Hospital Records dated 7/7/24 document R1 presented to the emergency department with increased left leg swelling. R1 had a procedure on 6/17 where R1 underwent revascularization with a left vein angioplasty. R1 has required multiple veinoplasties in the past. Maggots were noted in the right plantar foot wound so a wound consult was ordered. The wound is on the plantar surface of the right foot and was noted to have maggots upon admission. On 7/9/24 at 2:00PM, V2 (CNA) stated R1 received bed baths daily due to being immobile and during the bed bath skin is checked for any issues. V2 denied being aware that R1's feet needed to checked or washed daily as part of the care plan. On 7/9/24 at 2:12PM, V3 (CNA) stated V3 worked with R1 the morning (7/6/24 7AM-3PM shift) before R1 left for the hospital. V3 reported giving R1 a bed bath on this day and denied seeing any open areas or new skin concerns that should have been reported to the nurse. V3 stated overall skins checks are performed daily on residents when care is being provided. V3 reported any concerns with the skin should be documented on the bath sheet and the nurse should be notified so wound treatments can be ordered. V3 reported seeing flies every now and then in the halls and that it is normal. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/9/24 at 2:44PM, V4 (Nurse) stated V4 did a full body skin assessment on R1 before R1 left for the hospital. V4 denied R1 having any open areas on the skin. V4 reported the skin has to be assessed before a resident leaves the facility so the facility is aware of how their skin looks before they leave and to give report to the location the resident is going on what was found. V4 stated the nurse must document a skin assessment was completed before the resident is discharged and what was found on the skin assessment. V4 reported if maggots were found in a wound then the skin would have to be open at least a couple days for the maggots to be there. On 7/9/24 at 3:11PM, V5 (DON) stated R1 previously had wounds that healed, but V5 was not aware of any wounds R1 had upon discharge to the hospital on 7/6/24. V5 confirmed R1 previously had a wound to the right foot that healed. V5 reported skin assessments should be completed when a resident is being bathed and as needed. V5 stated a skin assessment form needs to be completed with each bath given. V5 reported a skin assessment is not needed before going out to the hospital and the facility refers to the resident's last shower day to know what their skin was like when they left. On 7/9/24 at 3:26PM, V6 (CNA) stated V6 just arrived to the facility around 11PM and got R1 cleaned up to go to the hospital. V6 denied doing a complete skin assessment on R1 before leaving due to R1 having socks on. V6 reported R1 left the facility around midnight for the hospital. On 7/9/24 at 3:32PM, V7 (Wound Care Coordinator) stated R1 had pressure injuries on R1's heels when R1 was admitted but R1 did not have any current wounds. V7 reported skin assessments need to be completed on bath days and as needed. V7 stated staff did not bring any new skin concerns to V7's attention before R1 left for the hospital. V7 reported if a wound is left open and untreated then it runs the risk of becoming infected and declining. On 7/9/24 at 3:43PM, V8 (Nurse) stated R1's leg became swollen so V8 got orders to send R1 to the hospital for an evaluation. V8 denied assessing R1's skin before leaving for the hospital because because nothing was brought to my attention anything was wrong. When asked if residents are supposed to have a skin assessment before leaving the facility, V8 said, I don't know. On 7/12/24 at 10:32AM, R1 was interviewed at the hospital. R1 was alert and oriented times three when questioned the date, location, and president. R1 stated R1 came to the hospital due to the left leg swelling but was unaware why the leg was swelling. R1 reported in the emergency room maggots were found in a wound on R1's right foot. R1 was unaware R1 had a wound to the right foot. R1 stated there would be a fly in R1's room once or twice a week but it didn't stay all day. R1 reported R1 would go hours without seeing the fly then it would reappear later. R1 stated the fly would land on R1 and R1's belongings. R1 denied having any wound care to the feet within the last month. R1 reported the wound is still on R1's foot and was infected but is now healing. R1 was wearing a heel protective boot with a dressing to the right foot covered in gauze. The nurse at the hospital reported the dressing change was completed around 8AM that morning and the hospital would not be removing the dressing again for the surveyor to make an observation of the wound. On 7/12/24 at 1:55PM, V10 (Maintenance Director) stated staff notified V10 about a concern for flies downstairs on 7/8/24. V10 reported putting up two fly traps and reminding staff to close the door during deliveries because that is how flies get in the building. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/12/24 at 2:00PM, R5 resided in the room R1 resided in before R1 was sent to the hospital. R5 reported seeing a fly about once a week come into the room but was unaware of where the fly was coming from. R5 stated R5 thought the fly was coming from the hallway when the door was open because the window in the room did not open. R5 reported the fly would land on R5 as well as R5's belongings. R5 reporting making a comment to the flies coming in and out of the room to a staff member but R5 could not remember who the staff member was. R5 stated the flies having been coming in and out of the room all summer. On 7/15/24 at 12:37PM, V12 (Wound Nurse Practitioner) stated R1 was not being seen by V12's company due to R1;s wound healing earlier in the year. V12 reported the only way a resident is treated by V12 is if staff notify V12 that a resident has a skin concern. V12 stated R1 is at risk for developing wounds due to immobility, being incontinent, and previously having wounds in the past. V12 reported most facilities assess resident's skin at least on a weekly basis. V12 reported the wound care company should be notified immediately if there is any openings in a resident's skin so treatment can begin. V12 stated maggots get into a wound by a fly laying eggs in the warm moist environment. V12 said, I can't say exactly how long it takes for the fly eggs to become maggots, but I would say within a day or two. V12 reported in order to prevent maggots from entering a wound he area needs to clear of flies, which is difficult so the wound or any open areas of the skin should be covered to make sure the flies aren't laying eggs. V12 stated maggots can cause infection in a wound and cause the wound to decline and become worse. The SBAR Communication Form dated 7/6/24 documents R1 had swelling to the left lower extremity and was sent to the hospital. The skin evaluation documents there's only swelling to the left leg. There is no other indication that R1 has an open area to any part of the skin. The Hospital Transfer Form dated 7/6/24 documents R1 was sent to the hospital for new or worsening edema. R1 is at risk for pressure ulcers/injuries. The skin assessment documents R1 currently does not have any pressure ulcers or other wounds. The Braden Scale dated 6/8/24 documents a score of 15 indicating R1 is at risk for developing wounds due to being chair fast, very limited mobility, and slightly limited sensation. There is a wound documented that healed on the right plantar foot that was treated in the facility in 05/2024. The Bath Sheets for 07/2024 were reviewed. Per the documentation, R1 received a bed bath on 7/1/24 and 7/4/24 and had no new wounds present at the time of these assessments. There is no documentation of any daily skin checks to the feet were completed. The Care Plan was reviewed and does not document R1 having any current care plan for open wounds. The Care Plan dated 6/28/24 documents R1 is at risk for impairment to skin integrity with a Braden score of 15. An intervention includes to perform skin checks on bath days, report abnormalities to a nurse, and follow appropriate skin impairment protocols. The Care Plan dated 1/1/24 documents R1 has diabetes mellitus. An intervention for this care plan includes to wash feet daily with mild soap and water and inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness then report any issues to the nurse. The Minimum Data Set (MDS) dated [DATE] documents R1 has a Brief Interview for Mental Status score as a 14 (no cognitive impairment). Section M of the MDS documents R1 is a risk for developing pressure ulcers but currently does not have any unhealed pressure ulcers or other wounds present. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Physician Order Sheet was reviewed for all orders and there are no orders for wound treatments for be performed to the right foot. The Medication Administration Record for 06/2024 and 07/2024 were reviewed and does not document any dressing changes to the right foot. Per V1 (Administrator), there is no Treatment Administration Record for R1 for 06/2024 and 07/2024. The policy titled, Wound Prevention and Healing, dated 07/24/23 documents, Policy Statement: To provide wound care treatments/services based on evidence based standards of care under the direction of a physician. 1. Assessment and Prevention . c. Facility will inspect skin during showers, daily and or weekly skin checks as scheduled, and PRN .11. The Multidisciplinary Wound Care Team: 1. The wound care team is responsible for identifying problems, coordinating care, and promoting development of the team in the program. 2. Certified wound care nurses and trained nurses are responsible for oversight of wound care rendered to all wound care patients, including the patient assessments, evaluation, treatment, measurements, plans of care, care outcomes, and cost effective of the treatment plan of care.