STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145219	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burgess Square Healthcare Ctr	5801 South Cass Avenue Westmont, IL 60559

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor for and report changes in existing pressure ulcers, prevent the development of new pressure areas, and failed to ensure pressure ulcer treatments were in place.This failure resulted in delayed identification of a resident's stage two coccyx pressure ulcer deteriorating to a necrotic and unstageable pressure ulcer, with a subsequent delay in treatment changes.This applies to 2 out of 4 (R1and R4) reviewed for pressure ulcers. The findings include:1. The EMR (Electronic Medical Record) showed R4 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis, dementia, muscle weakness, squamous cell carcinoma of skin, abnormalities of gait and mobility, and needs assistance with personal care. The MDS (Minimum Data Set), dated March 24, 2026, showed R4 was cognitively intact and dependent on staff for ADLs (activity of daily living). The MDS continued to show R4 was at risk for developing pressure ulcers because she had existing stage two and stage three pressure ulcers. On May 19, 2026, at 10:25 AM, R4 was in bed. V4 (Wound care Nurses/WCNs) said R4 has a facility-acquired stage two pressure ulcer on her coccyx. V4 and V5 (WCNs) removed R4's foam dressing to assess the wound. R4's coccyx wound bed had approximately 50% slough and necrotic soft tissue. V5 said her wound was last assessed and measured on May 12, 2026, (seven days earlier) and the wound had no necrotic tissue. V5 said the floor nurses performed daily dressing changes, and no one had informed the wound care team the wound had deteriorated. V4 cleaned R4's wound with normal saline and gauze. V4 said the wound measured 2.1 cm (length) (centimeter) x 1.5 cm (width) x 0.2 (depth). V4 confirmed the wound bed had yellowish-black necrotic tissue and believed it was now a stage 3 pressure ulcer. V4 said R4 was last seen by the wound physician in March 2026, and she did not believe R4's wound needed to be re-evaluated or treated by the physician. V4 also said she did not believe R4's wound required any change in treatment and proceeded to apply a xeroform and boarded gauze dressing. R4's Skin Issues note, dated May 12, 2026 (seven days earlier), showed her pressure ulcer was a stage two and was stable with 100% granulation tissue and measured 2.47 cm x 4.57 cm x 0.1 cm. R4's care plan showed she had a wound to her coccyx that was acquired at the facility on March 10, 2026, and R4 was at risk for additional skin impairment. The care plan said she would be free of wound complications and interventions included to follow the facility's protocol for pressure injury, monitor and report abnormalities, assess for progression and declination, and consult the wound care physician. On May 20, 2026, at 12 PM, V4 (WCN) said R4's wound had deteriorated and to her it appeared to now be a stage three. V4 said she had not notified R4's physician or the Wound Physician about the wound changes. V4 said it was her understanding that the Wound Physician did not see all the residents unless their wounds required debridement or a change in treatment orders. V4 continued to say the (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound did not require any mechanical or enzymatic (chemical) debridement for the removal of the necrotic tissue. V4 said wound care nurses were dependent on the nursing staff to inform them of any changes in the wounds. V4 said the nurses were responsible for completing daily wound care dressing changes and reporting wound changes or deterioration to ensure the wound care team reassess and determine proper wound management. R4's Skin Issue note, dated May 19, 2026, said her coccyx pressure ulcer had deteriorated and was now a stage three. The wound measured 1.8 cm x 3.5 cm x 0.2 cm with 10% eschar/maroon tissue. The assessment said R4's wound did not require change in treatment. On May 20, 2026, at 2:00 PM, V19 (NP/Nurse Practitioner) said she was R4's primary NP and she reassessed her coccyx wound on May 20, 2026. V19 said R4's wound was unstageable because the wound bed had 100% slough tissue. V19 said she was going to change the treatment order to Santyl (chemical debriding agent) and she was going to ensure that R4 was re-evaluated by the Wound Physician. V19 said she expected the facility staff to follow their wound care policy and procedure to ensure residents with pressure ulcer were being assessed, monitored, and treated appropriately. V19's progress note, dated May 20, 2026, said R4 was seen due to worsening of her coccyx wound. The note said it was now an unstageable coccyx ulcer. V19 said R4 requires a change in her treatment to remove the necrotic tissue, and it needed to be evaluated by the wound physician. 2. R1's EMR showed she was admitted to the facility on [DATE], with multiple diagnoses including right hip pain, lymphedema, obesity, difficulty in walking, and multiple wounds, including pressure ulcers and MASD (Moisture Associated Skin Damage). The EMR also said she had an indwelling catheter and was incontinent of bowel. R1's MDS, dated [DATE], showed R1 was cognitively intact and dependent on staff for dressing, bathing, and toileting assistance. The MDS continued to show that R1 had multiple ulcers present on admission that still required daily treatments. On May 19, 2026, R1 was lying in bed. V4 and V5(WCN) said R1 had multiple pressure ulcers, including in her buttock area, which required daily dressing changes. R1 said she had discomfort in her buttocks and inner thigh areas because of her catheter. V4 and V5 assessed R1's buttock, and there was no dressing present. R1's catheter tubing was also pressing against her left inner thigh, and she requested the tubing be readjusted because it was uncomfortable. R1's left inner thigh had two distinct open linear areas. V4 said she was not aware of the areas, and the wound was a new facility-acquired pressure ulcer related to the catheter's tubing. V4 said the facility provided leg straps to secure catheter tubes. R1 then said that due to her weight, she preferred not to have the strap because of the potential discomfort to her skin. V4 said R1's tubing should have been properly positioned on the anterior of her body to prevent pressure when on her back. V4 said the new wound would be clustered, and the left outer thigh area measured 5 cm x 0.5 cm x 0.1 cm, and the inner was 3.5 cm x 0.3 cm x 0.1 cm. V4 said both had 100% granulation, and the wound was a facility acquired stage two pressure ulcer. V4 said she expects staff to monitor and assess skin during care to ensure changes were reported and treated appropriately. V4 further said that R1's right buttock pressure ulcer should have been covered as ordered to prevent further breakdown. R1's Skin note, dated May 19,2026, said R1 had a new facility acquired medically-device related stage two pressure ulcer (MDRPU) to her rear left thigh. The note said R1's Left posterior thigh noticed with a new MDRPU from Foley tubing. Two linear skins break downs stage 2. One approx. 5 x 0.5 x 0.1 cm and second one approx. 3 x 0.4 x 0.1. Wounds cleansed and covered with xeroform and foam dressing. NP/MD notified of new findings. The note also said R1's right buttock stage two pressure ulcer (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	present on admission now measured 5 x 0.5 x 0.1 cm and had 100% granulation tissue. The ulcer still required daily and as needed xeroform and foam dressings. On May 20, 2026, at 9:45 AM, V8 (Certified Nurse Assistant/CNA) said she was expected to assess the residents' skin for new alterations when rendering care. V8 said she was assigned to R1 on May 18, 2026, and May 19, 2026, and was unable to recall if she assessed her posterior thigh areas for new skin breakdown or if she reported that her buttock wounds required the application of new dressings. On May 20, 2026, at 12 PM, V4 said she reviewed R1's weekly wound assessments, but she was confused because she had MASD to her rear left thigh that was last assessed on May 2, 2026 (at admission), but still determined that the newly identified skin breakdown to her left rear inner thigh was a new facility-acquired MDRPU. V4 said R1's required weekly wound assessments were not completed for the past two weeks. V4 said residents with wounds required weekly wound assessments to ensure they were monitored for potential complications. R1's last Skin note, dated May 1, 2026, said R1 had multiple wounds present on admission, including a stage two pressure ulcer to her right buttock. The wound measured 1.86 x 2 x 0 cm with pink or red tissue. R1 also had MASD on her bilateral rear thighs. The note said both wounds to the right buttock and bilateral thighs required daily xeroform and foam dressings. R1's care plan said she had multiple wounds, including pressure ulcers, and was at risk for additional skin impairment. The care plan said she would be free of wound complications, and the interventions included following the facility's protocol for pressure injury, monitoring and assessing wounds, reporting skin abnormalities, and ensuring her catheter's tubing was stabilized to prevent catheter-related trauma. On May 20, 2026, V2 (Director of Nursing) said she expected staff to monitor the skin of residents during routine care and report abnormalities, especially for those with known skin breakdown. V2 said all nurses were expected to follow treatment orders as ordered. V2 also said all wounds had to be fully assessed weekly to ensure they were being tracked for complications and that they were being treated appropriately. The facility's policy titled Wound Management, dated 2019, stated the facility was committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers. Any resident with a wound would receive treatment and services consistent with the resident's goal of treatment and promoting healing. The wound management program incorporated accepted standards of practice and guidelines, the framework including accountability in prevention by staff observing the skin integrity daily, ongoing comprehensive wound assessments, wound management principles, wound care and the application of dressings as ordered, wound documentation, individualized care planning, proper notifications, and staff education.