STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145429	A. Building B. Wing	04/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wentworth Rehab & Hcc	201 West 69th Street Chicago, IL 60621

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 - Minimal harm or potential for 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** 45111 Based on observations, interviews and records review, the facility failed to follow their policy on weights and pressure ulcer measurements for one (R1) resident of three reviewed. Findings include: R1's Electronic Medical records and current face sheet document R1 was admitted to the facility on [DATE], with medical diagnoses that include but not limited to peripheral vascular disease, unspecified, pressure ulcer of sacral region, stage 4, unspecified severe protein-calorie malnutrition, pneumonia, unspecified organism, pleural effusion, not elsewhere classified, other psychoactive substance abuse with intoxication, unspecified. R1's MDS (Minimum Data Set) section C -Cognitive functions dated [DATE], documents R1's Brief Interview for Mental Status (BIMS) as 15/15 indicating R1's cognition is intact, and MDS section GG-Functional abilities documents R1 requires Substantial/maximal assistance/dependent on staff for activities of daily living (ADL) care. On 04/19/2025, at 12:34 PM, V4 (Wound Nurse-LPN) stated R1 admitted to the facility on [DATE]. V4 stated when she first accesses a new wound, she measures it and documents it in the resident's electronic record to have a record of reference for monitoring wound improvement with treatment. V4 stated without the initial wound measurements, the doctor will not have a point of reference to determine if the wound is getting better or worse. V4 stated she took R1's wound measurements on 03/15/2025, but did not document them. V4 stated if it's not documented, it's not done. On 04/19/2025, at 1:45 PM, V5 (Wound Nurse Practitioner) via phone stated R1 came to the facility with the sacrum wounds on admission and the wound nurse should have taken the initial wound measurements. V5 stated R1 was admitted on [DATE]. V5 saw R1 on 3/20/2025. That is when he took R1's wound measurements. V5 stated before he assessed R1's wounds on 3/20/2025, there were no baseline measurements on file since admission to the facility for V5 to compare with. V5 stated when a resident is admitted to the facility, and the wound nurse practitioner or doctor will not see the resident the same day or the following day, the wound nurse should measure the wounds and document the measurements. This gives a baseline for the wounds and allows the wound care team to know if the wounds are improving, getting worse, or if the treatment is working. V5 stated a small change can determine cause of wound treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145429	A. Building B. Wing	04/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wentworth Rehab & Hcc	201 West 69th Street Chicago, IL 60621

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	On 04/19/2025, at 2:06 PM, V6 (Dietitian) via phone stated R1 was weighed when he came to the facility on [DATE]. The next weigh in was on 4/3/2025. V6 stated the facility missed a few weigh-ins for R1. V6 stated per facility policy, all newly admitted residents are weighed once week to closely monitor nutritional status to make sure they are meeting their daily nutritional needs. On 04/19/2025, at 4:28 PM, V7 (Assistant Director of Nursing) stated R1 came to the facility on [DATE]. The first weight was taken on 3/17/2025. V7 stated R1 should have had his weight taken on day of admission on 3/14/2025, on 3/21/2025, on 3/28/2025 and then on 4/4/2025. V7 stated R1 has two weights on file: 3/17/2025 and 4/3/2025. V7 stated it is important to weigh residents upon admission to obtain a baseline which allows facility to determine if the resident is gaining or losing weight. V7 stated it's a problem when a resident is not weighed weekly for four weeks. It would not give a clear picture of the residents' health because weight is part of the vitals family and would indicate if the resident is gaining or losing weight. V7 stated weekly weights allows the facility to put interventions in place quickly to improve resident health, either by increasing calories with the recommendations of the dietitian or doing a calorie count for the resident to lose weight. R1's Physician Order Sheet (POS) dated 3/20/2025, documents: Check weekly weight for four weeks, everyday shift, every Thursday for four weeks. Policy titled WEIGHTS, DATED 03/02/21, documents: -A baseline weight will be established upon admission. The resident will be weighed weekly for four weeks after admission and monthly thereafter. -Residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain. Policy titled Prevention and treatment of pressure Injury and other skin alterations, dated 03/02/21 document's: -Evaluate residents for actual pressure injuries or other skin alterations on admission or readmission by utilizing the initial nursing assessment.