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	12/06/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent, identify, report and treat a new pressure ulcer wound for one resident (R1) who assessed at risk for developing pressure ulcers in the sample of 3 residents reviewed for pressure ulcer prevention. Findings include:On 12/5/2025 at 10:14 AM, R1 observed in bed with a gown, covered with a blanket. R1 stated that R1 prefers to stay in bed and does not like to be up in R1's wheelchair. R1 stated that R1 does have a bed sore on (R1's) butt, and R1 needs help to from staff to change R1's incontinence brief and turn in bed. R1 agreed to this surveyor's request for a skin check. On 12/5/2025 at 10:34 AM, V5 (Certified Nursing Assistant, CNA) is in R1's room and confirmed that V5 is the CNA for R1. V5 pulls back the blanket and unfastens R1's incontinence brief. V5 crosses R1's legs and log rolls R1 to the left side as R1's reaching over with upper body to hold onto the bed siderail. V5 pulled back the incontinence brief from R1's buttocks showing white barrier cream on R1's sacrum and perineum. This surveyor observed an open skin area on the sacrum, approximately 2 by 2 inches, with epidermis (top skin layer) opened with the red wound base visibly noted. V5 stated that there is no dressing on it, and V5, as the CNA, just puts the white barrier cream over R1's open sacral wound after V5 cleans R1. On 12/5/2025 at 10:43 AM, this surveyor stepped out of R1's room into the hallway, and V8 (Licensed Practical Nurse, LPN) was present. When asked if R1 has an identified wound or is being seen by the wound care team, R1 stated no. On 12/5/2025 at 10:45 AM, V3 (Assistant Director of Nursing, ADON) is observed on R1's floor. When asked if R1 has a pressure ulcer wound or is being seen by the wound care team, V3 stated that V3 doesn't believe that R1 has a wound and will check V3's laptop to confirm. This surveyor and V3 go to nurses' station where V3 looks in the electronic health record (EHR) for R1, and V3 states that R1 has no skin openings and is receiving barrier cream for prevention of wounds.R1's admission Record documents, in part, diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, heart failure, history of falling, sciatica, fibromyalgia, hypertension, hypercholesterolemia, sleep apnea, visual disturbance, weakness, conversion disorder with seizures or convulsions, pain, and long-term use of aspirin.R1's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 12 which indicates that R1 has moderate cognitive impairment. R1's Behavior is assessed with no rejection of care or other behaviors. R1's Functional Abilities for bed mobility (rolling left and right) is assessed substantial/maximal assistance where the staff perform more than half of the effort in rolling R1 from side to side in bed. R1's Skin Conditions are assessed with R1 at risk for developing pressure ulcers/injuries, and R1 has zero (0) unhealed pressure ulcers/injuries, venous and arterial ulcers or other ulcers, wounds or skin problems. On 12/5/2025 at 2:34 PM, V5 (CNA) stated that V5 works different floors in the facility but, when V5 works on R1's floor, R1 is V5's regularly assigned resident. V5 stated that R1 is alert, oriented and does not have bouts of confusion. V5 stated that R1 is a one person assist for bed mobility and a two-person, mechanical transfer lift out of bed. V5 stated that V5 assesses R1's skin whenever V5 is performing incontinence care or bathing of R1. V5 stated that if V5 sees a new skin opening on a resident, V5 must report it right away to the nurse. This surveyor asked V5 that with the observation of this surveyor and V5 viewing R1's sacral pressure ulcer wound with barrier cream on it (on 12/5/2025 at 10:34 AM), was this the first time that V5 had seen R1's sacral wound, and V5 stated no. V5 stated that V5 saw R1's open sacral wound yesterday (12/4/2025) with the white barrier cream on it and reported it to the nurse. V5 stated that V5 forgot the name of the nurse, but R1's sacral skin was open and there was white cream over it on 12/4/2025. V5 reiterated again that V5 could not recall who the nurse was that V5 reported R1's sacral wound to on 12/4/2025. This surveyor informed V5 that surveyor will identify the nurse working with R1 on 12/4/2025 and speak with the nurse about V5 reporting R1's sacral pressure ulcer wound. V5 then stated that V5 did not report it to the nurse and V5 doesn't want to be lying. V5 stated that when V5 saw R1's sacral open wound on 12/4/2025 with barrier cream on it, V5 stated, I (V5) assumed that someone had reported it to the nurse, and V5 did not report R1's sacral skin opening. On 12/5/2025 at 2:27 PM, V8 (LPN) stated that V8 works different floors in the facility but, when V8 works on R1's floor, R1 is V5's regularly assigned resident. V8 stated that skin assessments are done weekly by the nurse, and they are done daily by the CNA during incontinence care and bathing care. V8 stated that if a CNA finds anything abnormal with the resident's skin, the CNA must report it right away to the nurse. V8 stated it could be a red spot on the skin, skin turgor being poor or any opening in the skin. V8 stated that the importance of the direct