STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Manor	7433 North Clark Street Chicago, IL 60626

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** 32819 Based upon observation, interview, and record review the facility failed to ensure accuracy of wound location, failed to document a thorough wound assessment, failed to follow physician orders, failed to ensure that treatment administration is not documented when not performed and/or failed to implement care plan interventions for three of three residents (R2, R3, R4) reviewed for wound care. Findings include: On 8/14/24, IDPH (Illinois Department of Public Health) received allegations that the facility does not take wounds seriously. R3's diagnoses include dementia and xerosis cutis (abnormally dry skin). R3's (8/2/24) BIMS (Brief Interview Mental Status) states resident is rarely/never understood. R3's (8/2/24) functional assessment affirms resident is dependent on staff for ADL (Activities of Daily Living) care. R3's (8/15/24) initial skin/wound notes includes the following: right posterior knee abrasion. 4.0 x 1.0 x 0.1cm (centimeters). 100% epithelial. Periwound: intact, fragile. R3's (8/15/24) POS (Physician Order Sheets) includes right posterior knee: cleanse with NS (Normal Saline), pat dry with gauze, apply xeroform to the base of the wound and cover with border gauze dressing every day shift (Tuesday, Thursday, Saturday) and PRN (as needed). R3's (1/25/21) care plan includes abrasion to right posterior knee, intervention: (8/20/24) cleanse with NS, apply xeroform to base of the wound, secure with gauze 3x per week (Tuesday, Thursday, Saturday) and PRN. R3's (8/20/24) skin/wound notes state right posterior knee improving without complication, wound care will follow until resolved [therefore the wound was not resolved]. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 11:16am, surveyor inquired about R3's wound however R3 did not respond. Surveyor inquired if R3 is able to communicate, V4 (CNA/Certified Nursing Assistant) stated Sometime he talk but not really. Two (2) large, scabbed areas (with redness surrounding each) were observed on the back of R3's right lower posterior thigh (not the posterior knee) and there was no dressing present. Surveyor inquired about the appearance of R3's wound, V4 responded It some sore, it look like it was a blister but it dry. Surveyor inquired if a dressing was present on R3's wound, V4 replied When they put him here temporarily last week it wasn't having dressing and affirmed she (V4) did not know that R3's wound required a dressing because he didn't have one on. On 8/20/24 at 11:24am, surveyor inquired about R3's wound, V5 (Licensed Practical Nurse) stated I could call the wound care nurse, I know that they were treating it. V5 inspected R3's wound (as requested) and responded, I see a reddened area and scabbing that's all I can really describe. Surveyor inquired if a treatment was on R3's wound (as ordered) V5 replied I don't see like a patch or anything. R3's (August 2024) TAR (Treatment Administration Record) affirms the right posterior knee dressing was last documented on 8/17 (3 days prior), the PRN entries are blank. On 8/21/24 at 11:39am, surveyor inquired about staff requirements when resident skin alterations are identified, V6 (Wound Care Coordinator) stated Somebody will call me, I (V6) do the assessment, I take picture and I call the NP (Nurse Practitioner). She (NP) will give me the treatment order and when she comes in, she will see the patient. Surveyor inquired about staff requirements if a dressing falls off a resident, V6 responded We will change it again, most of them (Residents) have PRN orders. Surveyor inquired about R3's wound, V6 replied It has like a skin tear like laceration I think it happened on the 15th of August. I called the NP, got the order and when she (NP) came in, she saw him (R3). Surveyor inquired about R3's current treatment orders, V6 stated It's a xeroform 3 times a week and PRN. That's Tuesdays, Thursdays, Saturdays and PRN. Surveyor inquired why R3's (right posterior thigh) wound was observed Tuesday (8/20/24) without a dressing, V6 replied Usually the CNA is supposed to call me when the dressing comes off. They should have called me. ---- R4's diagnoses include dementia and xerosis cutis. The facility wound report includes (R4's) right 5th finger laceration (acquired 8/1/24). R4's (8/1/24) progress notes state, notified by nurse that patient injured his right 5th finger last night, assessed by wound care nurse, noticed the laceration may need to be sutured. Refer to wound care notes for description. R4's (8/1/24) initial wound assessment states, small cut on the 5th finger however measurements and/or a description of the wound were excluded. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 11:49am, surveyor inquired about R4's wound, V6 (Wound Care Coordinator) stated He has like a cut on his 5th finger. Surveyor requested a description of R4's wound, V6 responded Oh, laceration, he (R4) have laceration [laceration was excluded from R1's initial wound assessment]. Surveyor inquired if R4's (8/1/24) wound was measured during the initial assessment, V6 replied I think it was my colleague that did the assessment, there is no measurement there. It's supposed to be measurements there. ---- R2's diagnoses include morbid obesity, xerosis cutis and cellulitis of left lower limb. The facility wound report includes (R2's) left calf partial thickness wound (acquired 7/11/24). R2's (7/12/24) POS includes Gentamycin Sulfate external cream 0.1% apply to left calf topically every day shift for reopened surgical wound. Cleanse with NS, apply gentamycin ointment, cover with bordered gauze. The facility census affirms R2 was hospitalized [DATE] through 8/19/24. R2's (August 2024) TAR (Treatment Administration Record) affirms on 8/15/24 the left calf treatment was documented as administered [R2 was hospitalized at this time]. Surveyor inquired why R2's (8/15/24) treatment administration was documented when R2 was hospitalized [therefore not in the facility] V6 (Wound Care Coordinator) reviewed R2's TAR and responded, It must be a mistake. The wound care policy (revised 1/24/24) states this facility adheres to the Federal and State requirements for wound care management. The facility shall develop a plan of care and implement intervention. The resident's skin alteration/breakdown shall be documented in the resident's clinical records in accordance with the facility's policy and in compliance to current regulatory standards.