

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2025
NAME OF PROVIDER OR SUPPLIER Beacon Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 South Finley Road Lombard, IL 60148	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician and a resident's representative when a resident was admitted to the facility with a DTI (Deep Tissue Injury), when changes were made to the resident's wound care treatment plan, or when the resident developed a large blister on her heel. This applies to 1 of 3 residents (R1) reviewed for notification of change in condition in the sample of 5. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE], and transferred to the local hospital on May 1, 2025. R1 did not return to the facility. R1 had multiple diagnoses including, atrial fibrillation, COPD (Chronic Obstructive Pulmonary Disease), pneumonia, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, repeated falls, urine retention, spinal stenosis, abdominal aortic aneurysm, depression, personal history of TIA (Transient ischemic Attack) and cerebral infarction, and hypertension. R1's MDS (Minimum Data Set) dated April 21, 2025 shows R1 had moderate cognitive impairment, required set up assistance with eating, oral hygiene, and personal hygiene, and was dependent on facility staff for all other ADLs (Activities of Daily Living). R1 had an indwelling urinary catheter and was frequently incontinent of stool. R1's MDS continues to show R1 had an unstageable DTI (Deep Tissue Injury) upon admission to the facility. R1's admission skin assessment, dated April 15, 2025 at 11:04 PM by V5 (RN-Registered Nurse) shows the location of the skin condition was R1's coccyx, with DTI (Deep Tissue Injury)/dark discoloration, present on admission, right antecubital space with bruising, right inner forearm bruising, left inner forearm bruising, left front axilla bruising. The area of R1's skin assessment entitled Skin issue notification was left blank. The areas of Dietitian, Family, Guardian, Manager, Other legally authorized representative, Provider, and Wound Nurse were not checked as being notified by V5. On April 16, 2025 at 10:43 AM, V6 (Former WCN-Wound Care Nurse) documented, DTI/Pressure sacrococcygeal middle present on admission, measurements, length 2.2 cm. (centimeters), width 2.3 cm., depth 0.3 cm. Wound has 100 percent of wound filled with granulation, pink or red, light serosanguineous exudate, no odor. Goal of care: healable. Dressing: Intact, cleansing solution normal saline, foam dressing, silicone. Education: Resident educated on skin breakdown prevention and management such as keeping skin clean and dry as possible, avoid scratching, good nutritional intake, turning and reposition Q2H (Every 2 hours) or as tolerable, LAL (Low Air Loss) mattress and wheelchair cushion as well as offloading heels while in bed. Practitioner notified. The facility does not have documentation to show V6 or any facility staff member notified R1's representative/responsible party of R1's DTI/pressure of the sacrococcygeal area upon admission to the facility. The facility does not have documentation to show R1 instructed the facility not to notify R1's representative/responsible party. V6's skin and wound evaluation, dated April 22, 2025 shows, DTI; pressure r/t (related to) POA (Present on Admission), wound bed granulation, 100 percent of wound filled with granulation, no evidence of infection, islands of epithelium, moderate amount of serous exudate, no odor, attached edges, surrounding tissue dark reddish brown, black/blue discoloration, fragile skin. Changed treatment: Treatment, normal saline cleansing, primary dressing calcium alginate, film/membrane, silicone, improving. Measurements, 2.9 cm. long by 3.5 cm. wide, by 0.2 cm. deep. The facility does not have documentation to show V6 or any facility staff member notified R1's representative/responsible party of the change in R1's pressure ulcer treatment. The facility does not have documentation to show R1 instructed the facility not to notify R1's representative/responsible party. On April 29, 2025, at 12:12 AM, V5 (RN) documented, [R1] with large blister to right heel, applied dry dressing and elevated right heel with pillows. Informed [V8] (Physician) to see resident tomorrow. Endorsed to next shift. The facility does not have documentation to show V5 or any facility staff member notified R1's representative/responsible party of the change in R1's skin condition. The facility does not have documentation to show R1 instructed the facility not to notify R1's representative/responsible party. On April 29, 2025, V7 (Wound Care Doctor) documented multiple wound assessments, including: Stage 2 pressure wound of the left heel, 4 cm. (centimeters) long by 3 cm. wide by not measureable depth and Unstageable DTI of the right heel, 2 cm. long by 1 cm. wide, by not measureable depth. On July 9, 2025, at 4:09 PM, V5 (RN) said, If a resident's wound is worse, or if the resident develops a new wound, it is not up to me to call and tell the doctor or family, that is the wound care nurse's job. I did not notify [R1's] family regarding the new wound on her heel. On July 10, 2025 at 10:09 AM, V8 (Physician) said, I don't really remember hearing about [R1's] pressure ulcer, but it came to my radar when I saw her and the wound was not in great shape and that was the time I found out just before she was</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer wound care treatments as ordered by the physician, and failed to ensure care plan interventions were followed for residents with pressure ulcers. This applies to 2 of 3 residents (R1, R3) reviewed for pressure ulcers in the sample of 5. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE], and transferred to the local hospital on May 1, 2025. R1 did not return to the facility. R1 had multiple diagnoses including, atrial fibrillation, COPD (Chronic Obstructive Pulmonary Disease), pneumonia, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, repeated falls, urine retention, spinal stenosis, abdominal aortic aneurysm, depression, personal history of TIA (Transient ischemic Attack) and cerebral infarction, and hypertension. R1's MDS (Minimum Data Set) dated April 21, 2025 shows R1 had moderate cognitive impairment, required set up assistance with eating, oral hygiene, and personal hygiene, and was dependent on facility staff for all other ADLs (Activities of Daily Living). R1 had an indwelling urinary catheter and was frequently incontinent of stool. R1's MDS continues to show R1 had an unstageable DTI (Deep Tissue Injury) upon admission to the facility. R1's admission skin assessment, dated April 15, 2025, at 11:04 PM, by V5 (RN-Registered Nurse) shows the location of R1's skin condition was R1's coccyx, with DTI (Deep Tissue Injury)/dark discoloration, present on admission, right antecubital space with bruising, right inner forearm bruising, left inner forearm bruising, left front axilla bruising. On April 29, 2025 at 12:12 AM, V5 (RN) documented, [R1] with large blister to right heel, applied dry dressing and elevated right heel with pillows. Informed [V8] (Physician) to see resident tomorrow. Endorsed to next shift. On April 29, 2025, V7 (Wound Care Physician) documented, a wound care assessment and evaluation of R1. V7's documentation shows the following wounds and wound measurements: Site 2: Unstageable DTI of the right ischium, undetermined thickness. Wound Size 1 cm. long by 1 cm. wide, by not measurable depth. Treatment plan: Zinc ointment apply once daily as needed for 30 days. Gauze island with border, apply once daily as needed. The facility does not have documentation to show the wound treatment for R1's right ischium DTI was entered into the EMR and administered as ordered by V7. Site 3: Stage 2 pressure wound of the left heel, partial thickness. Wound size 4 cm. long by 3 cm. wide, by not measurable depth. Blister: fluid filled. Treatment plan: Betadine apply once daily and as needed for 30 days. The facility does not have documentation to show the wound treatment for R1's facility-acquired Stage 2 pressure wound of the left heel was entered into the EMR and administered as ordered by V7. On July 9, 2025 at 9:37 AM, V7 (Wound Care Physician) said, It is my expectation the nursing staff administer my treatment orders immediately, and as ordered. If the treatment is ordered to be done daily, then they should be doing the treatment daily. 2. On July 8, 2025 at 4:31 PM, R3 was lying in bed in her room. R3's bilateral legs were covered by a blanket. R3 said she was not wearing foam boots on her feet. A foam boot was sitting on the floor of R3's room, next to the wall. V9 (CNA-Certified Nursing Assistant) entered R3's room with a dinner tray and assisted R3 with setting up her dinner meal. V9 pulled back R3's blanket. R3 had a gauze dressing over her entire left foot, up to her ankle. R3 was not wearing foam boots over her left or right foot. R3's bilateral feet were not offloaded from the mattress. V9 said R3 should have foam boots on her feet when she is in bed. V9 was able to find one foam boot in R3's room. V9 said she was unable to find the second foam boot. The EMR shows R3 was admitted to the facility on [DATE] with multiple diagnoses including, acute osteomyelitis of the left ankle and foot, peripheral vascular disease, unsteadiness on feet, non-pressure chronic ulcer of the left foot with necrosis of the bone, Type 2 diabetes, chronic kidney disease, anxiety disorder, and atrial fibrillation. R3's MDS dated [DATE] shows R3 has moderate cognitive impairment, requires setup assistance with eating, supervision with oral hygiene and personal hygiene, substantial/maximal assistance with showering and bed mobility, and is dependent on facility staff for toilet hygiene, lower body dressing, and transfers between surfaces. R3 is frequently incontinent of bowel and bladder. R3's MDS continues to show R3 was admitted to the facility with one Stage 3 pressure ulcer. R3's care plan for actual impairment to skin integrity, initiated on June 25, 2025 shows multiple interventions created on June 25, 2025, including, Offload both feet/heels from the mattress. On July 1, 2025, V7 (Wound Care Physician) documented, Unstageable DTI of the right heel, 3 cm. long by 3 cm. wide by not measurable depth. Patient has [foam boots] provided, she is only wearing them at night. I recommend wearing them during the day as well since she is deconditioned foot surgery. Skin prep apply once daily and as needed. Recommendations: Reposition per facility protocol and offload</p>		