| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145634 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Astoria Place Living & Rehab | 6300 North California Avenue<br>Chicago, IL 60659 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 interview and record review the facility failed to promote wound healing in one resident (R3); failed to follow their policy to prevent new pressure ulcers from developing in two residents (R1 and R3) and failed to document skin monitoring and/or frequency to observe for skin impairments. This failure resulted in R1 and R3 developing new unstageable pressure ulcers. Findings include:

1. R1 diagnosis include but are not limited to Diabetes, Anemia, Hypertension, Hyperlipidemia, Schizoaffect Disorder, Bilateral Hearing Loss, and has impaired mobility. R1 was transferred to the hospital on [DATE] and did not return to the facility.

R1's Wound Assessment Report dated 12/9/25 Left buttock, incontinence associated dermatitis (IAD), partial thickness, acquired in house on 12/8/25, New, 100% epithelial. Cleanse and apply bordered foam daily.

R1's Skin Alteration Nursing Evaluation/ dated 12/9/25 notes NEW skin alteration. Left buttock, Other, Length 2.0 x With 1.0, Stage N/A. [This evaluation has no mention of intervention for air mattress.]

R1's Wound Assessment Report dated 12/16/25 location: sacrum to buttock, Pressure Ulcer/Injury, unstageable, acquired in house, new, 20% granulation, 80% slough. Cleanse every other day, apply calcium alginate and honey, bordered foam.

R1's Progress Notes dated 12/16/25 written by V19, Wound NP, notes the unstageable sacrum to buttock pressure ulcer. States sharp debridement was not performed due to consent for procedure unable to be obtained. Assessment/plan: Unstageable sacrum to buttock is obscured with adherent slough and currently treated with honey.

R1's Skin Alteration Nursing Evaluation/ dated 12/22/25 notes sacrum to buttock, 9.0 x 10.0, Unstageable, acquired in house, on 12/16/25. 100% slough. Cleanse every other day, apply calcium alginate with santyl and bordered foam.

R1's Skin/Wound Evaluation dated 12/18/2025 documents, in part, an unstageable wound to the sacrum with an onset date of 12/16/2025 with a measurement of Length 8.5 cm Width x 10.00 cm x Depth 0.10 cm. Low Air Loss Mattress on place.repositioning with wedge.

R1's Skin Summary Note dated 12/18/2025 documents skin assessment done and noted with multiple arterial ulcers on the feet and new unstageable pressure ulcer of the sacrum as described above. Continue treatment as ordered. Weekly monitoring by wound specialist.

(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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R1's Shower/Bathing & Skin Monitoring 12/1/25 – 12/17/25. Response of yes on 12/3/25; 12/7/25; 12/10/25; 12/13/25;12/16/25; and 12/17/25. All other dates are No, except 12/5/25 stated not applicable. [There is no documentation to describe skin condition.]<br><br>R1's care plan dated 12/31/2025 documents a focus for at risk pressure ulcer development related to a pressure ulcer development related to Braden Score of 9 starting out as a healed MASD (Moisture Associated Skin Damage). #R1's care plan identifies he requires assistance for repositioning and turning in bed and 1 person to partial assist with turning and repositioning while in bed. 2 staff total assist with transfers, may use Mechanical lift. Can not tolerate full bath or shower, prefer sponge bath. [R1's sacral pressure ulcer was first documented on 12/8/25, 24 days prior to care plan changes.]<br><br>R1's Minimum Data Set Section M dated 10/17/2025 documents R1 is at risk for developing pressure ulcers, number of venous and arterial ulcers present 0, number of stages 1, 2, 3, 4 and unstageable wounds 0. No pressure reducing device for bed is indicated (section M1200b). On 12/8/2025 R1's MDS documents 1 unstageable pressure ulcers, 1 present upon admission/entry or reentry. Pressure reducing device for bed. Section GG identifies R1 requires assistance with hygiene, rolling in bed and is dependent on staff for transfers. [There is a discrepancy in the day the wound was first observed and the day of assessment.]<br><br>R1's wound care assessment report documented by the wound care nurse practitioner documents a left buttock incontinence associated with dermatitis on 12/8/2025.<br><br>R1's wound care assessment report documented by the wound care nurse practitioner documents an unstageable wound from sacrum to buttock dated 12/16/2025.<br><br>R1's Progress notes dated 12/26/25 Noted pressure ulcer to coccyx site worse, large, brown-rusty color unstageable. Had diarrhea. C.diff screening is pending. Assessment plan: ua not suggesting uti, chest x ray not suggesting pna? Pressure ulcer and or diarrhea. C.diff screening result pending. Now on Augmentin.<br><br>R1's Wound Culture dated 12/30/2025 documents result of ESBL (Escherichia coli) Heavy and Providencia Stuartii- Heavy Growth.<br><br>R1's progress note dated 12/30/25 Noted to be febrile, temp 101.8 Assessment/Plan: fever: STAT labs, sacrum and chest x-ray, blood cultures x2, sacral wound culture, insert PICC line, start empiric IV Vancomyycin and Ceftriaxone for suspected infection.<br><br>R1's follow-up question Report dated 12/1/2025 to 12/21/2025 documents, in part, on 12/16/2025 at 9:22 am R1 did take a shower, bath or bed bath. No documentation was found documenting alterations in R1's skin integrity by the Certified Nurse's Assistant, Nurse, or Wound Care Nurse on 12/16/2025.<br><br>Review of concerns and grievances dated 12/22/25 and 1/2/26 both from R1's family reporting concerns related to R1's wounds.<br><br>On 2/25/2025 at 3:35 pm, V3 (Director of Nursing) verified the follow-up question report for skin assessment and showers does not document R1's skin integrity.<br><br>Surveyors requested a policy for Pressure Wound Care and Pressure Wound Prevention and V1<br><br>(continued on next page) |

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

(Administrator), V2 (Director of Nursing), and V3 (Wound Care Coordinator) stated on 2/24/2026 and 2/25/2026 at different times, the facility does not have a policy with the titles of Pressure Wound Care and Pressure Wound Prevention.

Surveyor requested documentation of skin integrity observation details and facility unable to provide documentation.

On 2/25/25 at 9:54AM V7 (Certified Nurse Assistant-(CNA), stated R1 used a wheelchair and was able to transfer independently in and out of bed; she (V7) performed complete daily skin assessments; R1 required bed care and pull ups and he transitioned from independently transferring to remaining in bed with a gradual decline in condition. V7 said assignments are rotated through care sections weekly, and upon her (V7) returning to R1's section, V7 noticed the presence of a wound. V7 said skin impairments are documented in the electronic record.

On 2/25/2026 at 10:26 AM, V8 (Registered Nurse) stated R1 was observed ambulating and by December, I learned he was no longer able to get out of bed; R1 typically showered during the morning shift. V8 said the wound care nurse completes skin assessments, and we notify her immediately of any changes in skin integrity.

On 2/25/2026 at 10:51 AM, V9 (Certified Nurse Assistant-(CNA), stated in December R1 could not walk anymore but could still use his call light; she (V9) performs skin assessments daily to monitor for any changes in skin integrity.

On 02/25/26 at 11:46am V3 (WCC) stated that she does not have documentation that R3 refused to be placed on an air mattress. Sated R1's skin assessment documented moisture associated skin dermatitis to the sacrum on 12/9/2025. V3 said all nurses may perform skin assessments, but assessments are typically completed when a CNA (Certified Nurse Assistant) reports a skin [NAME]. V3 said skin assessments are done on admission, weekly for four weeks, then monthly and quarterly, unless new changes are reported; new findings are documented as skin observations because they are acquired; the wound care (NP) is notified and performs an assessment. V3 said for high risk residents, interventions such as barrier cream, heel protectors, and turning/repositioning are ordered and documented each shift.

On 2/25/2026 at 12:45 pm, V11 (Infection Preventionist) said R1's sacrum wound started as a moisture associated skin damage; R1 began to show signs of drowsy and labs were ordered with results of increased white blood cell count.

On 02/25/26 at 3:22pm V2 (Director of Nursing/DON) stated that air mattresses are placed for residents that have been identified to have wounds or if a resident is at risk for skin breakdown. V2 stated that refusal of care should be care planned. V2 said The CNA performs skin checks and documents in the electronic chart. V2 said R1's wound began as moisture associated dermatitis and opened on 12/20 and an air mattress ordered on 12/16, 1 week after identification of a skin impairment.

Facility's policy titled Skin Care Regiment and Treatment Formulary revised 07/03/25 documents in part, Policy Statement: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Procedures:. 10. Prevention: c. Use of pressure redistribution mattress. 11. Treatment Protocol: Deep Tissue Injury: Blood-filled blister (intact) keep blister intact. Foam dressing. Relieve pressure

Facility's Policy titled Skin Care Integrity and Treatment Formulary dated 7/3/2025 documents, in

(continued on next page)

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| NAME OF PROVIDER OR SUPPLIER Astoria Place Living & Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 6300 North California Avenue Chicago, IL 60659 | |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | part, It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Refer any skin breakdown to the skin care team and physician including wound physician/NP for further review and management as indicated.<br><br>2. R3's medical diagnoses include but are not limited to malignant neoplasm, essential hypertension, anemia, severe protein calorie malnutrition.<br><br>R3's Minimum Data Set, dated [DATE] has a Brief Interview for Mental Status score of 15, indicating R3's cognition is intact.<br><br>R3's Braden scale risk scores dated 11/06/25 are an 8, indicating R3 is high risk for skin breakdown.<br><br>R3 was admitted to the facility on [DATE] with an intact deep tissue injury to R3's sacrum area and skin intact to mid back area.<br><br>R3's wound assessment dated [DATE] documents in part, Sacrum. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity DTI (Deep Tissue Injury) Wound Status: Present on Admission. Size 6cm (centimeter) x (by) 6cm x 0cm. Wound base 100% intact epithelium with evidence of deeper tissue injury.<br><br>R3's wound assessment dated [DATE] documents in part, Sacrum. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity DTI (Deep Tissue Injury) Wound Status: Present on Admission. Size 6cm (centimeter) x (by) 6cm x 0cm. Wound base 100% intact epithelium with evidence of deeper tissue injury. Mid back. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity: DTI. Wound Status: New. Size 12cm x 3cm x 0cm. Wound Base: 100% intact epithelium with evidence of deeper tissue injury.<br><br>R3's wound assessment progress note dated 01/06/26 documents in part, Location: Sacrum. Primary Etiology: Pressure Ulcer/injury. Stage/Severity: Unstageable. Odor Post Cleansing: Malodorous. Size 9cm (centimeter) x (by) 9cm x 0.5cm. Mid back. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity: Unstageable. Wound status: Stalled. Odor Post Cleansing: Malodorous. Size: 16cm x 3 cm x 1cm. wound Base: 100% slough.<br><br>R3's physician progress note dated 11/12/25 documents in part, Mobility and ADL (Activities of Daily Living) limitations due to debility from esophageal cancer now with need for assistance with personal care and rehab needs:. Risk for skin breakdown r/t (related to) limited mobility: offloading, frequent turns, off load bony prominences, skin checks.<br><br>R3's wound assessment progress note dated 11/17/25 documents in part, The patient continues on an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus.<br><br>R3's progress note dated 11/05/25 documents in part, Resident has potential for infection related to: I.V (intravenous line), other.resident will not develop signs and symptoms of infection. assess for signs and symptoms of infection. Initiate proper precautions per facility policy.<br><br>R3's progress note dated 12/02/25 documents in part, R3 has an actual impairment to skin integrity and is assessed high risk for pressure sore development r/t Braden score 8 and disease process.Apply LAL (Low Air Loss) mattress to bed. Date initiated 12/02/25. Resident is educated regarding importance of offloading and repositioning using supportive surfaces as pillows, wedges and hell<br><br>(continued on next page) |

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

protectors. Date initiated 12/17/25.

R3's wound culture results with a collection date of 01/06/26 documents in part, Culture Wound: 1. Staphylococcus aureus – MRSA (Methicillin resistant staphylococcus aureus) light growth. 2. Escherichia coli very light growth.

On 02/24/26 at 12:30pm V16 (Certified Nursing Assistant) stated that R3 never refused care. V16 stated that R3 was in pain the whole shift and would sometimes ask staff to wait a few minutes before turning him. V16 stated that she would wait a few minutes and then R3 would allow her to take care of him.

On 02/24/26 at 1:24pm V4 (Nutritionist) stated that she was informed that R3's wounds were getting worse on 12/18/25. V4 stated that at that time, R3's supplements were increased.

On 02/24/26 at 2:08pm V3 (Wound Care Coordinator/WCC) stated that if a resident is admitted with wounds, she orders an air mattress and turning and repositioning. V3 stated that the orders are reflected as interventions on the resident's care plan. V3 stated that R3 acquired pressure wounds in the facility. V3 stated that if a resident refuses care or any interventions, the refusal should be documented and the resident's next of kin should be notified. V3 stated that she offered R3 an air mattress but R3 refused. V3 stated that she did not place an order for an air mattress for R3 and she thinks there is a standing order for an air mattress for everyone. V3 stated that R3 had redness to his sacrum and heels on admission but the areas later opened. V3 stated that R3 was a very high risk for skin breakdown due to R3 being very skinny and malnourished. V3 stated that R3's sacral wound showed signs of infection.

On 02/25/26 at 11:46am V3 (WCC) stated that she does not have documentation that R3 refused to be placed on an air mattress.

Review of R3's progress notes dated 11/05/25 through 01/08/26 shows one entry of R3 refusing wound care, no other nursing entries of R3 refusing care or refusing air mattress noted.

Review of R3's care plans dated 11/05/25 with revision dates of 12/02/25,12/09/25 and 01/06/26show no documentation of refusal of care.

On 02/25/26 at 11:30am V6 (Licensed Practical Nurse/LPN) stated that if a resident developed new wounds, the resident would need more interventions. V6 stated that the only way that the staff are aware of a resident's interventions are by looking at the resident's care plan. V6 stated that the staff don't look at the residents' care plans often.

On 02/25/26 at 11:55am V10 (Wound Care Nurse) V10 stated that for residents that are at high risk for pressure ulcers, the facility automatically places the resident on a low air loss mattress. V10 stated that R3 refused the low air loss mattress but she did not document R3's refusal. V10 stated that R3 would not refuse wound care dressing changes but sometimes would ask her to come back later. V10 stated that she would change R3's wound dressings early in the morning and he wanted them changed later in the day. V10 stated that R3 wounds started to show signs of infection, and the wounds had an odor.

On 02/25/26 at 12:44pm V11 (Infection Preventionist) stated that residents are placed on EBP (Enhanced Barrier Precaution) if they have wounds. V11 stated that EBP requires the use of a gown and

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | gloves when performing direct patient care. V11 stated that the facility does not have to place a physician's order for EBP, but EBP is care planned. V11 stated that when a resident is on EBP staff wear PPE (Personal Protective Equipment) to protect the resident from infection.V11 stated that R3 was sent out to the hospital for abnormal vital signs and was informed that R3's hospital diagnosis was sepsis. V11 stated that she was never informed that R3's wound was showing signs of infection. V11 stated that if she was informed that R3 wound showed signs of infection, she would have reached out to the Infectious Disease Nurse Practitioner (ID NP) to possibly start R3 on antibiotics empirically.<br><br>On 02/25/26 at 2:27pm V13 (Infectious Disease Nurse Practitioner) stated that she has not seen R3 since 11/19/25. V13 stated usually if wounds are getting worse, the wound care team calls her. V13 stated that she was never informed of R3's wounds worsening or showing signs of infection.<br><br>On 02/25/26 at 3:21pm V2 (Director of Nursing/DON) stated that air mattresses are placed for residents that have been identified to have wounds or if a resident is at risk for skin breakdown. V2 stated that refusal of care should be care planned.<br><br>Facility's care plan titled Enhanced Barrier Precaution revised 09/16/25 documents in part, Policy: The facility will use Enhanced Barrier Precautions (EBP) to reduced transmission of multi-drug-resistant organisms in the nursing homes. EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents known to be colonized or infected with MDROs (multidrug resistant organisms) as well as residents with wounds and/or indwelling medical devices. Procedure: 1. EBP will be used for any resident in the facility: With open wounds whose drainage can be contained by dressing. Has indwelling medical devices.<br><br>Facility's policy titled Braden Scale revised 06/30/25 documents in part, Policy Statement: It is the policy of this facility to complete the Braden Risk Assessment for all its residents for the following objectives: 1. To be able to assess the resident's potential or risk factors to develop pressure ulcers. 2. To be able to identify each risk factors unique to the resident that can potentially cause for the development of pressure ulcer and properly address them in the resident's care plan interventions. Procedures:. 3. Each risk factor and potential cause should be reviewed individually and addressed in the resident's care plan. 4. Implement interventions per the resident's Braden Score and/or individual risk factors identified as reflected in the care plan.<br><br>Facility's policy titled Skin Care Regiment and Treatment Formulary revised 07/03/25 documents in part, Policy Statement: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Procedures:. 10. Prevention: c. Use of pressure redistribution mattress. 11. Treatment Protocol: Deep Tissue Injury: Blood-filled blister (intact) keep blister intact. Foam dressing. Relieve pressure. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review the facility failed to practice infection control measures during a wound care dressing change on a resident. This failure affected 1 (R2) of 3 residents reviewed for wound care. Findings include:On 2/24/2026 at 10:45 am, V3 (Wound Care Coordinator) began preparing wound care supplies; without performing hand washing or hand sanitizing measures and opening/touching the treatment cart drawers; opened the surgical drape touching with her (V3's) bare hands; touched her glasses and with same hand and began typing on her laptop reading the wound care order; opened another drawer and removed a stack of gauze with her bare hands; and V3 used hand sanitizer and removed other supplies from the cart.On 2/24/2025 at 10:48 am, V3 stated she (V3) should practice handwashing and infection control practices before, between, and after wound care. V3 verified using hand sanitizer after opening the surgical drape and preparing other wound care supplies. V3 stated the purpose of infection control practices such as hand washing/sanitizing is to prevent infection to the wound. On 2/25/2026 at 12:45 pm, V11 (Infection Preventionist) stated for a clean procedure, the nurse should wash his/her hands; gather your equipment; wash your hands again; put on your Protective Personal Equipment; and complete the wound care. V11 stated the outside of the wound care treatment cart is considered dirty; hand hygiene should be done when touching the outside the cart and then opening wound care dressing supplies; and hand hygiene should be performed whether sterile or clean when handling wound care supplies. Facility Policy titled infection control 7/5/2016 revised 6/30/2025 documents, in part, 17: Hand hygiene will be performed by staff and contracted workers before and after direct patient contact and after each situation that necessitates hand hygiene. Alcohol-based hand rubs or hand washing x 20 seconds will be used. |