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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145657 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/24/2025 |
| NAME OF PROVIDER OR SUPPLIER Downers Grove Rehab & Nursing | | STREET ADDRESS, CITY, STATE, ZIP CODE 3450 Saratoga Avenue Downers Grove, IL 60515 | |

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) |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34490</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident's non-pressure wounds received treatments as ordered by the wound physician for 1 of 3 residents (R2) reviewed for wounds in the sample of 7.</p> <p>The findings include:</p> <p>R2's Specialty Physician Wound Evaluation and Management Summary dated 1/14/25 shows that he has a non-pressure trauma wound to his left first toe measuring 0.9 cm (centimeters) x 0.6 cm. The dressing treatment plan is for xeroform gauze (gauze containing bismuth tribromophenate and petrolatum) and gauze roll once daily. This treatment plan is the same on the evaluations dated 1/20, 1/27, 2/3, 2/11 and 2/17.</p> <p>On 2/20/25 at 11:05 AM, R2 had a black scab on his left first toe. R2 did not have a dressing on his left first toe.</p> <p>R2's January and February Treatment Administration Record (TAR) shows a treatment order dated 1/1/25 for, Scattered scabs to L (left) dorsal foot and L great toe: Apply skin prep and leave open to air every day shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care. R2's January and February TAR does not show a treatment order for xeroform and gauze roll daily.</p> <p>R2's Specialty Physician Wound Evaluation and Management Summary dated 1/14/25 shows that he has a non-pressure trauma wound to his right lower lateral leg measuring 4 cm x 2.5 cm x 0.1 cm. The dressing treatment plan is for xeroform gauze and gauze roll once daily. This treatment plan is the same on the evaluations dated 1/20, 1/27, 2/3, 2/11 and 2/17.</p> <p>On 2/20/25 at 11:05 AM, V8 (Wound Licensed Practical Nurse) provided wound care to R2's right lower lateral leg. V8 cleansed the wound, applied silver sulfadiazine and calcium alginate and covered with rolled gauze.</p> <p>R2's January and February Treatment Administration Record (TAR) shows a treatment order dated 1/1/25 for, Right lateral leg: Cleanse with saline, apply calcium alginate with silver, cover with ABD and wrap with rolled gauze every day shift every Mon, Wed, Fri. R2's January and February TAR does not show a treatment order for xeroform, and gauze roll daily.</p> <p>(continued on next page)</p> |

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R2's Specialty Physician Wound Evaluation and Management Summary dated 2/11/25 shows he has a skin tear to his left leg measuring 1 cm x 1 cm x 0.1 cm and a skin tear to his left hip measuring 0.8 cm x 0.9 cm x 0.1 cm. The dressing treatment plan for both of the skin tears was xeroform gauze and gauze roll daily.</p> <p>R2's February TAR does not document any treatment orders for R2's skin tears on his left leg or left hip.</p> <p>On 2/24/25 at 9:48 AM, V10 (Wound Physician) said that wound care is important for wound healing. V10 said that as a wound specialist, she sees the residents and creates a plan for treatment and the treatment plan should be followed. V10 said that she notifies the facility of the treatment plan, and it is in her notes. V10 said that different types of treatments are ordered for different types of wounds and the staff should follow what type of treatment is ordered.</p> <p>On 2/24/25 at 2:30 PM, V8 said that all pressure wounds should have orders and be followed. V8 said that the wound physician see the wounds weekly and comes up with a treatment plan. V8 said that the wound nurse places the wound treatment orders in the electronic medical record if there is a change in treatment after the physician sees the resident. V8 said that if the wound physician wants a specific type of dressing, that is what needs to be applied to the wound.</p> <p>The facility's undated Pressure Injury Prevention and Management Policy shows, The wound consultant will provide timely and accurate information to the nursing facility on the status of the pressure ulcer/injury and will provide recommendations for change in treatment and care of the pressure ulcer/injury Treatments will be ordered by the physician/practitioner. Treatment and interventions may include but are not limited to: Medications and biologicals to promote healing, special wound coverings/dressings orders for pressure ulcer/injury treatment will be specific for each resident Treatments, including preventative interventions, will be documented in the resident's medical record .</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>34490</p> <p>Based on observation, interview, and record review the facility failed to ensure ordered pressure ulcer treatments were in place and failed to ensure pressure ulcer treatments from the Wound Physician were implemented for 3 of 3 residents (R1, R2 and R3) reviewed for pressure ulcers in the sample of 7.</p> <p>The findings include:</p> <p>1. R2's Specialty Physician Wound Evaluation and Management Summary dated 1/14/25 shows he has a Stage 4 pressure ulcer on his left posterior heel measuring 3.0 cm (centimeters) x 2.9 cm x 0.1 cm. The dressing treatment plan is for xeroform gauze (gauze containing bismuth tribromophenate and petrolatum), and gauze roll once daily. This treatment plan is the same on the evaluations dated 1/20, 1/27, 2/3 and 2/11. R2's Specialty Physician Wound Evaluation and Management Summary dated 2/17/25 show that the same wound was now 9 cm x 6 cm x 0.1 cm and the treatment plan changed to silver sulfadiazine and gauze roll once daily.</p> <p>On 2/20/25 at 11:05 AM, V8 (Wound Licensed Practical Nurse) provide wound care to R2's left posterior heel wound. There was no dressing on R2's heel wound. V8 cleansed the wound, applied skin prep to the wound and covered the wound with a bordered foam dressing.</p> <p>R2's January and February Treatment Administration Record (TAR) shows an order dated 1/1/25 for, Left heel: Cleanse with saline, pat dry apply skin prep and cover with comfort bordered foam dressing every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care. R2's January and February TAR does not document any orders for xeroform and gauze roll or silver sulfadiazine to his left heel pressure ulcer.</p> <p>R2's Specialty Physician Wound Evaluation and Management Summary dated 1/14/25 shows he has an unstageable Deep Tissue Injury on his right lateral ankle measuring 1.5 cm x 1.5 cm x 0.1 cm. The dressing treatment plan is for xeroform, and gauze roll once daily. This treatment plan is the same on the evaluations dated 1/20, 1/27, 2/3, 2/11 and 2/17.</p> <p>On 2/20/25 at 11:05 AM, V8 provided wound care to R2's right lateral ankle. V8 cleansed the wound, applied silver sulfadiazine cream and calcium alginate and wrapped with a gauze roll.</p> <p>R2's January and February TAR shows an order dated 1/1/25 for, Right lateral malleolus (ankle bone): Cleanse with saline, pat dry apply calcium alginate with silver and cover with gauze and wrap with rolled gauze every day shift every Mon, Wed, Friday for wound care. R2's TAR does not document any orders for xeroform, and gauze roll to be performed daily.</p> <p>On 2/24/25 at 9:48 AM, V10 (Wound Physician) said that wound care is important for wound healing. V10 said that as a wound specialist, she sees the residents and creates a plan for treatment and the treatment plan should be followed. V10 said that she notifies the facility of the treatment plan, and it is in her notes. V10 said that different types of treatments are ordered for different types of wounds and the staff should follow what type of treatment is ordered.</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>On 2/24/25 at 2:30 PM, V8 said that all pressure wounds should have orders and be followed. V8 said that the wound physician see the wounds weekly and comes up with a treatment plan. V8 said that the wound nurse places the wound treatment orders in the electronic medical record if there is a change in treatment after the physician sees the resident. V8 said that she is not sure if calcium alginate and xeroform are the same but if the orders says a specific type of dressing, that is what needs to be applied to the wound.</p> <p>2. On 2/20/25 at 10:55 AM, V8 (Wound Licensed Practical Nurse) provided wound care to R3's sacral wounds. R3 was turned to her left side. R3's brief was pulled down. R3 had purple/red discolorations to her left and right buttock present. R3 did not have a dressing on either of the wounds. There was no dressing located inside of the incontinence brief. V8 cleaned the wounds with saline, dried area and applied a bordered foam dressing to each of the wounds.</p> <p>R3's TAR shows an order dated 2/7/25 for, Sacrum wound: Cleanse with NS (normal saline), pat dry, apply [bordered foam dressing] daily every day shift for wound care. There is no other sacral/buttock wound orders on the TAR.</p> <p>R3's Specialist Physician Initial Wound Evaluation and Management Summary dated 2/10/15 shows that R3 has an unstageable deep tissue injury on her right buttock measuring 10 cm x 11.3 cm and an unstageable deep tissue injury on her left buttock measuring 9 cm x 12 cm. The treatment plan for both of the pressure injuries is for skin prep and gauze island with border daily.</p> <p>On 2/24/25 at 9:48 AM, V10 (Wound Physician) said that R3's treatment for her pressure injuries is skin prep to protect the skin and a bordered dressing for extra cushion.</p> <p>On 2/24/25 at 2:30 PM, V8 said that if a dressing comes off during care, the staff should notify the nurse or herself so the dressing can be re-applied.</p> <p>3. R1's Specialty Physician Wound Evaluation and Management Summary dated 1/20/25 shows that R1 had an unstageable (due to necrosis) pressure injury of the left lateral heel measuring 0.9 cm x 3.1 cm. The treatment plan was for skin prep and gauze island with border daily. R1's Specialty Physician Wound Evaluation and Management Summary dated 2/3/25 shows the same wound was measuring 2.4 cm x 1.4 cm and the treatment plan was changed to betadine and gauze island with border daily. R1's Specialty Physician Wound Evaluation and Management Summary dated 2/10/25 shows the treatment plan for the same wound was changed to alginate calcium with silver and gauze island with border daily.</p> <p>R1's January and February TAR shows, and order dated 1/16/25 for, 'Left heel DTI (deep tissue injury): apply skin prep and leave open to air every day shift every Mon, Wed, Fri. R1's February TAR does not document an order for the changed dressing treatments on 2/3/25 or 2/10/25.</p> <p>The facility's undated Pressure Injury Prevention and Management Policy shows, The wound consultant will provide timely and accurate information to the nursing facility on the status of the pressure ulcer/injury and will provide recommendations for change in treatment and care of the pressure ulcer/injury Treatments will be ordered by the physician/practitioner. Treatment and interventions may include but are not limited to: Medications and biologicals to promote healing, special wound coverings/dressings orders for pressure ulcer/injury treatment will be specific for each resident Treatments, including preventative interventions, will be documented in the resident's medical record .</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>34490</p> <p>Based on observation, interview and record review the facility failed to ensure a wound treatment cart was not brought into an isolation room to prevent cross-contamination and failed to remove gloves and perform hand hygiene during wound care to prevent the spread of infection for 1 of 3 residents (R2) reviewed for infection control in the sample of 7.</p> <p>The findings include:</p> <p>R2's Physician's Order Sheet shows an order dated 1/12/25 for: Strict contact isolation for MRSA (Methicillin-resistant Staphylococcus aureus) and C Striatum (Corynebacterium striatum) every shift for wound infection.</p> <p>On 2/20/25 at 11:05 AM, V8 (Wound Care Licensed Practical Nurse) brought the facility's treatment cart into R2's room to do his dressing changes. V8 cleansed R2's right leg wounds using saline and gauze and then with the same gloves on, reached into her treatment cart to get dressing supplies for R2's leg. V8 cleaned R2's right ankle and calf wounds, with the same gloves on, reached into her treatment cart to get additional dressing supplies. V8 removed R2's dressing from his sacrum and cleansed the wound with saline. V8 then picked up a tube of medihoney from R2's beside table and applied it to a piece of gauze and applied it to R2's wound. V8 then applied a bordered foam dressing to the wound. V8 did not perform a glove change or hand hygiene during the dressing change. After V8 was done performing R2's dressing changes, she picked up the tube of medihoney that was used on R2's sacrum wound and placed it into the treatment cart. V8 then placed the medical tape that she had used on R2's leg dressings into the treatment cart.</p> <p>On 2/20/25 at 1:44 PM, V3 (Infection Preventionist) said that treatment carts should not be brought into an isolation room. V3 said that if supplies are brought into an isolation room, they should stay in the room and only be used for that specific resident to prevent the spread of infection. V3 said that gloves should be removed, and hand hygiene performed after removing a soiled dressing.</p> <p>The facility's undated Hand Hygiene Policy shows, All staff are responsible for following hand hygiene procedure .When hands move from a contaminated body site to a clean body site during resident care.</p> | | |