

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE 800 West Oakton Street Arlington Hts, IL 60004	

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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798</p> <p>Based on observation, interview, and record review, the facility failed to implement interventions to prevent pressure ulcers and failed to identify a pressure ulcer for 2 of 3 residents, R1 and R3, reviewed for pressure injuries in the sample of 3. These failures resulted in R1 developing a Stage 3 sacral pressure wound which later became an infected Stage 4 pressure ulcer and R3's pressure wound not receiving wound care treatment until it was an unstageable pressure injury.</p> <p>The findings include:</p> <p>On 11/6/24 at 10:42 AM, V4, Wound Care Nurse, V7, Registered Nurse, and V8, Certified Nursing Assistant transferred R1 from her chair to her bed to provide wound care. R1 had a half dollar coin sized wound to her sacrum.</p> <p>R1's Admission Record dated 11/7/24 shows R1 was admitted to the facility on [DATE]. R1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation shows R1 was At Risk on 10/20/23, was a High Risk on 11/3/23, a Moderate Risk on 12/13/23 and 1/4/24, High Risk again on 1/15/24 and Moderate Risk on 4/18/24. R1's Care Plan initiated on 10/20/23 shows R1 has an ADL (activities of daily living) self-care performance and functional mobility deficit related to confusion, dementia, and impaired balance. On 11/1/23, R1's care plan identifies she is incontinent of bowel and bladder. R1's care plan does not identify that she is at risk to develop pressure injuries with corresponding prevention interventions. R1 is totally dependent on staff for toilet use. R1's Full Body Skin Assessment effective 10/20/23 shows R1 has no wounds. R1's Wound Evaluation dated 5/8/24 shows R1 has a new, facility acquired, Stage 2 pressure wound of her butt crack. R1's Wound Evaluated dated 5/9/24 which was completed by V4, shows R1 has a Stage 3 facility acquired pressure wound of her sacrum. R1's Wound Evaluation & Management Summary completed by the Wound Care Physician, V5, on 5/9/24, shows the visit is an initial evaluation of R1's sacral wound and confirms R1's sacral wound is a Stage 3 Pressure Wound. R1's Wound Evaluation & Management Summary dated 7/18/24 shows R1's Stage 3 sacral Pressure Wound merged with a non-pressure wound of her right upper medial buttock and became a Stage 4 sacral pressure wound with odor, heavy serosanguinous exudate, and 100 percent necrotic tissue. R1's sacral wound culture collected 7/25/24 shows the wound has become infected by Escherichia coli (E-coli), and Morganella morganii. R1's Order Recap Report dated 11/7/24 shows R1 was prescribed an antibiotic on 7/30/24 for eight days related to her wound culture.</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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(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 - Actual harm Residents Affected - Few	<p>R3's Admission Record dated 11/7/24 shows he was admitted to the facility on [DATE]. R3's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 4/11/24 shows he was a Very High Risk. R3's Skin/Wound Note dated 4/12/24 at 3:17 PM shows R3's sacrum is clear. R3's Skin/Wound Note dated 5/23/24 at 5:31 PM shows R3 has MASD (moisture associated skin damage) to sacrum/coccyx, dry healing, also present upon admission, but much improved, this is not a pressure injury. R3's Skin/Wound Note dated 6/21/24 at 3:17 PM shows R3 has an unstageable sacral wound with a 3 centimeter (cm) by 3 cm area of slough surrounded by a 10 cm by 7 cm area of redness. It does not note the etiology of the wound. R3's Initial Wound Evaluation & Management Summary dated 6/28/24 shows an unstageable (due to necrosis) sacral pressure wound measuring 11.6 cm by 10 cm by 0.2 cm with heavy sero sanguinous exudate and 70 percent necrotic tissue.</p> <p>On 11/6/24 at 3:18 PM, V5 (Wound Care Doctor) said (wound) infection is never normal. V5 said he would expect a wound to be identified before it is the size R3's sacral pressure wound was when it was found. V5 said R3 had a pretty horrific (pressure) ulcer.</p> <p>On 11/7/24 at 9:45 AM, V4 (Wound Care Nurse) said R1 did not have any pressure wounds on admission, but R1 was at risk of developing a pressure ulcer. V4 said R1 was a 12 on the Braden scale which puts her at high risk of developing a pressure wound. V4 said they should develop a care plan to include pressure injury prevention measures such as frequent turning. V4 said R1's risk factors include limited mobility, need for assistance with ADLs (toileting and transferring), bowel and bladder incontinence, and dementia. V4 said R1 did develop a wound infection this past summer. Signs and symptoms of wound infection include increased redness, drainage, warm to touch, necrotic tissue, increased slough, purulent drainage, increased drainage, and odor. V4 said wound infections are not very common and should not occur as part of the normal wound healing process. V4 said they are still working on healing R1's sacral pressure wound. V4 said R3 was admitted to the facility on [DATE] with a history of pressure ulcers. V4 said R3 was at risk for developing pressure ulcers. V4 said R3's sacral pressure ulcer was first identified on 6/21/24 as an open, unstageable pressure ulcer with slough and V5 first saw R3 on 6/28/24 regarding the sacral pressure ulcer. V4 said she would expect to have been notified (about R3's pressure ulcer) when there was just redness, before it opened. V4 said she expects nursing to notify her about any change in skin, any alterations of the skin, especially in the pressure point areas such as the sacrum. V4 said it is obvious a wound would not start out at 10 centimeters, she should be notified long before it ever gets to a significant size so she can assess the wound, make sure there is wound treatment and get the wound care physician involved.</p> <p>The facility's Pressure Injury Prevention Policy (revised 1/10/24) shows the wound team will manage wound care, implement prevention interventions, and monitor compliance with documentation. If a wound is identified, a wound assessment is done and should include the type of injury (pressure versus non-pressure related). Identified wounds are assessed and measured on a regular basis at least weekly and documented. Based on the Braden's Scale, any resident who is identified as high risk for developing pressure injuries will have interventions initiated to decrease risks. The IDT (interdisciplinary team) will review care plan ensuring that it includes measurable goals for prevention and management of pressure ulcers with appropriate interventions.</p>		