STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145767	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paul House & Health Cr Ctr	3800 North California Avenue Chicago, IL 60618

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. 32819 Based upon record review and interview the facility failed to follow policy procedures and failed to ensure that the Physician, family and/or responsible parties were notified of change in condition for one of four residents (R1) reviewed for pressure ulcers. Findings include: On 10/18/24, IDPH (Illinois Department of Public Health) received allegations that the family was not notified of R1's infected (stage 4) sacral wound. R1's (9/16/24) progress notes state Nurse on duty observed changes in resident skin integrity, right away notified wound nurse. Head to toe skin assessment performed. Notably sacrum MASD (Moisture Associated Skin Damage) measured in (7 x 4.5 x 0). Family member at bedside. All responsible parties aware. On 10/23/24 at 1:14pm, surveyor inquired if V3 (Family) was notified by the facility of R1's skin integrity impairment V3 stated (R1) was sent to the hospital from the facility, I think like in September. The facility staff never even told me about the bed sores and affirmed an infected pressure ulcer was identified by hospital staff. R1's (9/21/24) progress notes state writer made MD (Medical Doctor) aware of resident being lethargic and having altered mental status [change in skin integrity was excluded]. MD ordered for resident to be sent out to Hospital [V13/Agency Licensed Practical Nurse entered the progress note]. R1's (9/21/24) hospital history and physical states patient has large sacral decubitus. Differential diagnosis includes infection. R1's (9/26/24) surgical consult states patient was noted to have sacral decubitus ulcer on admission with imaging/MRI (Magnetic Resonance Imaging) confirming osteomyelitis (bone infection) of the sacrum and coccyx. On 10/30/24 at 1:32pm, surveyor inquired about R1's sacrum skin integrity impairment V13 stated I'm not too familiar with it because I know that someone is there doing wound care. I'm not sure what kind of wound that she had. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The change in resident's condition policy (revised September 18, 2023) states our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. The Nurse will notify the resident's attending physician when: there is a significant change in the resident's physical status. There is a need to alter the resident's treatment significantly. Deems necessary or appropriate in the best interest of the resident. Unless otherwise instructed by the resident, the Nurse will notify the resident's representative when: there is a significant change in the resident's physical condition. The Nurse will record in the resident's medical record any changes in the resident's medical condition or status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon record review and interview the facility failed to follow policy procedures, failed to ensure that care plans are accurate, and/or failed to ensure that comprehensive care plans include required problems/focus and/or approaches/interventions for four of four residents (R1, R2, R3, R4) in the sample. Findings include: 1. R1 was admitted to the facility on [DATE]. R1's diagnoses include obesity and generalized muscle weakness. R1's (12/22/23) risk assessment for skin integrity impairment determined a score of 12 (High Risk). R1's (9/13/24) functional assessment affirms resident is dependent on staff for toileting hygiene and requires substantial/maximal assistance for rolling left and right (turning/repositioning), sit to stand and toilet transfer were not applicable. On 10/29/24 at 12:11pm, surveyor inquired about R1's functional status, V11 (Assistant Director of Nursing) stated She is bedridden, we have to mechanical lift her. R1's comprehensive care plan (received 10/24/24) states (12/24/23) resident is at moderate risk for alteration in skin integrity due to comorbidities [R1 is high risk]. ADL (Activities of Daily Living) care (re: mechanical lift transfer) is excluded. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 2:33pm, surveyor inquired about the requirements for developing comprehensive care plans, V12 (MDS/Minimum Data Set) Coordinator stated When a patient is admitted we do an interim care plan with the risk factors. After that then we do the comprehensive care plan. When we do the MDS assessment, we have to develop comprehensive care plan. The care plan will be completed within 15 to 21 days from the completion of the MDS assessment, which is 14 day plus 7. Surveyor inquired what resident care plans are based on, V12 responded First of all need to do an assessment, physical assessment of the patient, a comprehensive of their physical functional ability, their continence, nutritional status. Surveyor inquired if dependent residents should have an ADL care plan, V12 replied So there's a dependent patient that's usually triggered with developing pressure ulcers, or contractures. Surveyor inquired if the patient is obese and immobile what should be care planned, V12 stated The immobility is the risk factor that we are care planning. Surveyor inquired about R1's functional status, V12 responded I would have to base my answer to the MDS because I don't remember she was here. Her functional status I could see that she's dependent in bed mobility and transfer, she's not walking. The only thing she can do is rolling in the bed with substantial assist, but the rest are total care. Surveyor inquired about R1's moderate risk for skin breakdown (not high - as warranted) V12 replied I see it says moderate risk for alteration in skin integrity and it was noted that she has MASD (Moisture Associated Skin Damage) on the sacral area on 9/16 [referring to R1's care plan]. Usually, the term that we are using is that they are at risk. There's a (risk for skin integrity impairment) assessment and it will let you know what the score is, let me see here. The July 21 (2024) says its 13, so that is high risk [Referring to R1's latest risk assessment for skin integrity impairment]. Surveyor inquired if ADL care and/or required mechanical lift transfer is on R1's care plan, V12 stated The only ADL I can see here is turn and reposition. 2. R2 was readmitted to the facility on [DATE]. R2's diagnoses include dementia and generalized muscle weakness. R2's (10/16/24) functional assessment affirms resident is dependent on staff for toileting hygiene and chair/bed to chair transfer. R2's care plan includes ADL self-care performance deficit related to activity intolerance and limited mobility. Toileting: dependent. Interventions: ensure that resident is properly assisted by staff as indicated during ADLs to ensure safety at all times [Interventions exclude required toileting and/or transfer needs]. On 10/29/24 at 3:00pm, surveyor inquired if R2's care plan includes incontinence care, V12 (MDS Coordinator) stated I could see a care plan for the catheter, but I don't see a separate care plan for the bowel incontinence. It's incorporated in the pressure ulcer risks. R2 is incontinent. 3. R3 was admitted to the facility on [DATE]. R3's diagnoses include Parkinson's disease and reduced mobility. R3's (10/3/24) functional assessment affirms resident is dependent on staff for toileting hygiene. R3's (4/5/24) care plan includes ADL self-care performance deficit related to disease process however, interventions exclude incontinence care and/or toileting needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 3:03pm, surveyor inquired if R3's care plan includes incontinence care, V12 (MDS Coordinator) stated It's not a separate care plan, its incorporated in the risk for skin breakdown. Surveyor inquired what interventions were included, V12 responded I would say keep clean and dry, use lotion, check and change. Surveyor relayed concerns with facility care plans excluding specific problems and required interventions, so staff know how to care for each resident. A CNA searching for incontinence care needs is likely not checking the risk for skin breakdown care plan for toileting needs. V12 replied We lost our Restorative Nurse about 2 weeks ago but I'm putting in the check Kardex and will be placing it at the Nurse's station. Because I see that that's a problem when I come in here. 4. R4 was admitted [DATE]. R4's diagnoses include Parkinson's disease and generalized muscle weakness. R4's (9/13/24) initial skin assessment includes a sacral (stage 4) pressure ulcer. On 10/29/24 at 1:07pm, surveyor inquired if preventive interventions were implemented (on admission) for R4's stage 4 wound, V11 (Assistant Director of Nursing) stated Yes, air loss mattress. Surveyor inquired when R4's air loss mattress was implemented V11 responded Next day because he came in late in the afternoon. R4's (9/13/24) care plan states resident has an actual alteration in skin integrity related to sacral wound pressure ulcer [Interventions exclude use of low air loss mattress]. On 10/30/24 at 3:15pm, surveyor inquired if R4's care plan includes use of air loss mattress and/or interventions required for use, V12 (MDS Coordinator) stated I don't see that in the care plan. The low air loss mattress was ordered, it was in place, but I don't' see it in the care plan. The care plan policy (reviewed 1/1/24) states a written, individualized plan of care will be completed by the Interdisciplinary Care Team within 14 days of admission and revised every 90 days or more frequently if a change of status and/or condition warrants an interim review and update. A problem list calls for identification of problems that require intervention in order to maintain or achieve quality of life for the resident involved. Each discipline is responsible for completion and presentation to the Care Team a Care Plan, which identified problems suggests goals, and suggests approaches to reaching the goals.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff are aware of required LALM (Low Air Loss Mattress) settings, failed to ensure that LALM checks were conducted, failed to ensure the LALM is on the correct setting/mode, failed to implement care plan interventions, failed to turn/reposition dependent residents every 2 hours, failed to ensure that wound assessments were accurate & staged correctly, failed to follow physician orders, and/or failed to ensure that treatments were administered as ordered for four of four residents (R1, R2, R3, R4) reviewed for pressure ulcers. These failures resulted in R1 sustaining a (facility acquired) infected large sacrum decubitus which required surgical intervention and osteomyelitis (bone infection) of the sacrum/coccyx. These failures also resulted in R3's (stage 3) sacrum pressure ulcer declining to (stage 4). Findings include: 1. On 10/8/24 and 10/18/24, IDPH (Illinois Department of Public Health) received allegations that the facility failed to provide timely/adequate care to prevent stage 4 wounds. (R1) sustained a stage 4 infected wound that required surgery. R1's wound was down to the bone. R1's diagnoses include but not limited to obesity, generalized muscle weakness, hypertensive heart disease, and congestive heart failure. R1 was admitted [DATE] transferred to the hospital on 9/21/24 and did not return to the facility. R1's (12/22/23) risk for skin integrity impairment assessment determined a score of 12 (High Risk). R1's (9/13/24) functional assessment affirms resident is dependent on staff for toileting hygiene and requires substantial/maximal assistance for rolling left and right (turning/repositioning). R1's care plan includes (12/25/23) Resident has alteration of bowel & bladder functioning due to weakness and decreased mobility. (9/16/24) MASD (Moisture Associated Skin Damage) sacrum area. Interventions: perform skin at risk assessment per facility protocol. Notify MD (Medical Doctor) of significant changes. Identify potential causative factors and eliminate/ resolve when possible. Keep skin clean and dry. Turn and reposition every 2 hours. On 10/28/24 at 1:05pm, surveyor inquired about R1's (facility acquired) skin integrity impairment, V2 (Director of Nursing) presented R1's (2/23/24) initial skin alteration record and (3/21/24) weekly skin alteration record and stated 2/23 is when the MASD started and 3/21 is when the MASD got resolved. Then, the 9/16 (2024) MASD was identified next. R1's (9/16/24) initial skin alteration record states sacrum MASD. 7 x 4.5 x 0cm (centimeters). Wound margins/edges: erythema (redness). Peri -wound area erythema, warm to touch, cracked/excoriation. No pain verbalized or observed during treatment. Assist to reposition totally dependent. Preventive measures daily skin checks during CNA routine rounds, reposition every 2 hours and PRN (as needed), moisture barrier, incontinence care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's POS (Physician Order Sheets) include (3/7/24) Air loss mattress checks for function every shift. Turn and reposition every 2 hours. (9/16/24) Medihoney apply to sacrum daily for excoriating/MASD. Cover with foam dressing. R1's (9/16/24) progress notes state wound care provided. R1's (September 2024) TAR (Treatment Administration Record) affirms Medihoney to sacrum was not documented (blank spaces noted) on 9/17, 9/18, 9/19, 9/20, and 9/21 (5 days). R1's (9/13/24) BIMS (Brief Interview Mental Status) determined a score of 12 (cognition intact). R1's (9/21/24) ER (emergency room) progress notes state patient herself reports pain in her butt with pressure ulcer noted to her sacrum. Dressed with white substance and dressing on arrival [Medihoney which was prescribed - is not a white substance]. R1's (9/21/24) history and physical states patient presents to ER, patient is complaining of butt pain. Musculoskeletal: positive for back pain. Skin: Findings: Lesion present. Comments: Large sacral decubitus. Patient does endorse back pain near butt. Patient has large sacral decubitus. Differential diagnosis includes infection. R1's surgical consults state (9/24/24) wound appears likely to involve muscle and likely periostium (membranous tissue that covers the surface of bone). Recommend MRI (Magnetic Resonance Imaging) to evaluate bone involvement. (9/26/24) Patient was noted to have sacral decubitus ulcer on admission with imaging/MRI (Magnetic Resonance Imaging) confirming osteomyelitis of the sacrum and coccyx. Seen by surgery and plan for debridement today. R1's (10/3/24) discharge summary states wound cultures resulted pseudomonas (Bacteria) and VRE (Vancomycin-Resistant Enterococci) faecium (Bacteria). On 10/28/24, surveyor requested credentials for the facility Wound Care Nurse. At 12:05pm, V1 (Administrator) stated that the facility employs two wound care Nurses (V8 & V10) however only presented V10's (Wound Care Nurse) wound care certification. Surveyor inquired when V10 was hired V1 responded He (V10) started last Monday so that would be on October 21st [7 days prior]. On 10/28/24 at 12:47pm, V1 stated that (V8/Wound Care Nurse) Does not have wound care certification and subsequently affirmed in writing that V8 does not possess the WCC (Wound Care Certified) certification. This employee (V8) was hired on September 18, 2023 (over 1 year ago). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 12:11pm, surveyor inquired who's responsible for wound care at the facility V11 (ADON/Assistant Director of Nursing) stated I troubleshoot for the facility just to do the dressing when the wound care is not here and affirmed that when V8 (Wound Care Nurse) is not working she (V11) provides wound care. Surveyor inquired when V8 works at the facility V11 responded Friday, Saturday, Sunday and Monday. Surveyor inquired if V11 is wound care certified V11 replied No, I'm not. Surveyor inquired about R1's cognitive and functional status V11 stated She is bedridden. She's incontinent both of urine and stool. She's alert 2-3, she can tell you change me, or I have poop. Surveyor inquired about R1's skin integrity impairment (prior to 9/21/24) hospital transfer V11 responded she (R1) has excoriation because she is incontinent of urine and stool. Surveyor inquired what causes excoriation V11 replied Urine and stool, urine is very corrosive and stool. Surveyor inquired what blank spaces on the TAR indicates V11 stated That they didn't do anything. Surveyor inquired if R1's Medihoney treatment/dressing was documented on the (August 2024 TAR) V11 reviewed R1's EMR (Electronic Medical Records) and responded Nobody sign it or it means it's not there 5 days, the blank one. The Nurses on the floor should be doing this. Surveyor advised that V11 affirmed that she (V11) and V8 were responsible for wound care (in prior statement) V11 replied I (V11) know, but if I cannot do it, I told them (assigned Nurses) that they have to do it. Surveyor inquired about potential harm to a resident if skin integrity impairments are not treated (as ordered) V11 stated Well, it will just deteriorate with the stool and urine there. You need to clean it and put another dressing. On 10/30/24 at 12:59pm, surveyor inquired about staff requirements for resident change in condition re: sacrum Decubitus V14 (Medical Director) stated I would expect that the staging is done properly, the dressing requirements are very clear in the wound care plan, and the offloading mechanisms such as the low air loss mattress is ordered, and as a Physician or in-house Nurse Practitioner, there's a rounding and we treat infection if there's infection. Surveyor inquired about potential harm to a resident if treatments are not administered as ordered V14 responded So there is potential for serious harm, the wound can become infected, and the resident can become septic. Surveyor inquired how osteomyelitis occurs V14 replied It is a progression of any skin or soft tissue infection or trauma, the deeper the wound goes there's muscle and facia. The deeper the wound goes; it can involve the bone and it can be an infection which is osteomyelitis. On 10/30/24 at 1:32pm, V13 (Agency Licensed Practical Nurse) affirmed that she was assigned to R1 on 9/21/24. Surveyor inquired about R1's sacrum skin integrity impairment V13 stated That I'm not too familiar with it because I know that someone is there doing wound care [R1's TAR affirms that wound care was not documented for 5 days]. I'm not sure what kind of wound that (R1) had. V13 affirmed that V15 (CNA/Certified Nursing Assistant) was also assigned to R1 on 9/21/24. On 10/30/24 at 2:15pm, surveyor inquired about R1's sacrum wound, V15 (Certified Nursing Assistant) stated When I changed her, (R1) had like a patch on her butt and we (staff) usually put the zinc on it, it was just red. Surveyor inquired if R1 reported pain V15 replied She might say that she is uncomfortable, so we just turn her side to side. 2. R3's diagnoses include Parkinson's disease and reduced mobility. R3's (9/3/24) risk for skin integrity impairment assessment determined a score of 12 (high risk). R3's (10/3/24) functional assessment affirms resident is dependent on staff for rolling left and right. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's (4/4/24) initial skin alteration record (admission) includes (stage 3) sacrum pressure ulcer. R3's (10/24/24) weekly skin alteration record includes (stage 4) sacrum pressure ulcer [therefore wound declined]. R3's POS includes (4/5/24) turning and repositioning every 2 hours. (4/9/24) air loss mattress check function every shift. (7/23/34) Calcium Alginate apply to sacral daily for stage 4 pressure ulcer after cleansing with NSS (Normal Saline Solution) and cover with dry dressing. R3's care plan includes (4/5/24) high risk for alteration in skin integrity, Interventions: identify potential causative factors and eliminate/resolve when possible. LALM (Low Air Loss Mattress) check for function every shift. On 10/23/24 at 3:44pm, R3 was lying on a LALM, and the setting was on static mode (therefore providing a firm surface). Surveyor inquired about R3's current LALM settings V5 (RN/Registered Nurse) stated Usually it's preset. Surveyor inquired what static mode means V5 responded I'm not familiar with this machine. R3 was noted to be lying on a white flat sheet, a thick blue folded sheet (8 layers), and folded bath blanket (4 layers). V5 counted the layers beneath R3 (as requested) and affirmed that there were 13 excluding the brief (therefore a total of 14 layers placed beneath the buttocks). Surveyor relayed concerns with all the linens placed between R3 and the LALM V5 replied It should only be one, otherwise this one (LALM) won't work. V5 then proceeded to cover R3 with the blanket and left the room, V5 did not remove any of the sheets and/or blanket beneath R3 at this time. R3's (October 2024) TAR affirms for low air loss mattress checks (blank entries) were noted on 10/5, 10/6, 10/8, 10/19, 10/23, 10/24, 10/25, and 10/27. For Calcium Alginate treatments 9 is documented on 10/6, 10/14, 10/17, 10/20 and 10/28. For turning/repositioning every 2 hours blank spaces were noted on 10/3, 10/5, 10/6, 10/7, 10/8, 10/9, 10/19, 10/20, 10/23, 10/24, 10/25, 10/27 and 10/28. On 10/29/24 at 12:45pm, surveyor inquired why 9 was documented on R3's (October 2024) TAR, V11 (ADON) stated I don't know why they (Nurses) do this number nine. 10/6 (2024) it says done by wound nurse (referring to R3's progress notes). 10/8 says done by wound nurse. 10/14 says done by wound nurse. 10/20 is done by wound nurse. 10/24 will be done by wound nurse. Surveyor inquired if Nurses should be charting wound care for other staff V11 responded No, they have to chart when they are doing it, the dressing and everything. Surveyor inquired what mode the LALM should be in while a resident is lying in bed V11 replied The mattress should just stay in alternating because that is where the cell is alternating, go up and go down the bed, so the patient should be floating in the mattress. Surveyor inquired if several linen layers were placed under R3's buttocks while lying on a LALM is the mattress effective V11 stated No, it has to be one layer only because the air can go to the patients skin. 3. R4's diagnoses include Parkinson's disease, generalized muscle weakness, and protein calorie malnutrition. R4's (10/12/24) Braden determined a score of 11 (high risk). R4's (9/13/24) initial skin alteration record was signed on 9/15/24 (2 days after assessment). Site: Abdomen. Description: Sacral wound stage 4 [the description is incongruent with the site]. Preventive measures: redistribution mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's (10/12/24) re-admission skin alteration record states site: abdomen. Description: sacral wound stage 4. [again, the description is incongruent with the site]. R4's (10/24/24) weekly skin alteration record states sacrum stage 3 [therefore back staged]. R4's (9/13/24) POS states cleanse sacral wound with NS, apply Alginate, cover with dry dressing daily and as needed. R4's (October 2024) TAR affirms sacral treatment was not documented (blank entries) on 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/15, 10/17, 10/18, 10/19, and 10/22. Low air loss mattress checks were initiated on 10/24 (1.5 months after implementation). On 10/23/24 at 3:55pm, inquired if R4 has a wound V6 (RN) stated It's on the back, he (R4) was just turned by the CNA. R4's (10/15/24) BIMS determined a score of 9 (moderate impairment). On 10/23/24 at 3:57pm, surveyor inquired if R4's dressing was changed today R4 replied Uh um nodded his head no and affirmed that it was not. R4 was lying atop of a LALM, surveyor inquired about the current settings on R4's LALM, V6 (RN) stated Unfortunately I (V6) was not told as to what setting he (R4) should be in. Right now, the setting is at 250 (pounds) I wound say however R4 appeared to be about half that weight. Surveyor inquired how much R4 weighs R4 responded 122 pounds. Surveyor requested to inspect R4 at this time. V7 (Certified Nursing Assistant) removed R4's incontinence brief which was dry however a dressing was not present and white cream was noted on the open sacral wound. Surveyor inquired about R4's exposed wound, V6 replied I see a wound on the tailbone, it is an open wound. Surveyor inquired what was on R4's (stage 4) sacrum wound V6 stated Zinc oxide. Surveyor inquired if a dressing was supposed to be on R4's sacrum V6 responded Yes. On 10/28/24 at 10:36am, surveyor inquired why R4's initial wound assessment states stage 4 and the current wound assessment states stage 3, V2 (Director of Nursing) stated Good question. Surveyor inquired about staging wounds, V2 responded When staging from a stage 4 going to a stage 3, if the wound is getting better by the week-by-week assessment of the wound nurse. Surveyor inquired if back staging of wounds is appropriate V2 replied Don't we indicate if its progressing or getting better? Surveyor inquired if V2 was familiar with staging wounds V2 stated No. [The National Pressure Ulcer Advisory Panel advises against reverse staging of pressure ulcers, or bedsores, because it doesn't accurately reflect the healing process]. On 10/29/24 at 1:07pm, surveyor inquired why R4's initial sacral wound assessment (dated 9/13/24) was documented/signed on 9/15 (3 days after admission). V11 (ADON) stated (R4) was admitted on the 12th and the assessment was done the next day. When you do it on the day it will give you the day that you did the assessment. If I do the assessment today, I have to sign the assessment for today. Surveyor inquired about concerns with R4's (9/13/24) initial wound assessment, V11 responded The site says abdomen how can you put abdomen when the site is sacrum. 4. R2's diagnoses include dementia, type II diabetes mellitus, protein calorie malnutrition, and generalized muscle weakness. R2's (10/12/24) risk for skin integrity impairment assessment determined a score of 10 (high risk). (continued on next page)

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	145767	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paul House & Health Cr Ctr	3800 North California Avenue Chicago, IL 60618

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's (10/12/24) initial skin alteration record (admission) includes left buttock stage 4 pressure ulcer and sacrum MASD. R2's (10/24/24) weekly skin alteration record includes sacrum stage 4 [incongruent with the initial assessment] and buttocks MASD [incongruent with the initial assessment]. On 10/29/24 at 12:28pm, V11 (ADON) affirmed that (V8/Wound Care Nurse) documented R2's (10/12/24) and (10/24/24) wound assessments. Surveyor inquired why R2's (10/12/24) initial wound assessment includes left buttock stage 4 (black/eschar tissue) however the (10/24/24) assessment (conducted 12 days later) states buttocks MASD, V11 stated (R2) cannot have MASD because (R2) is not eating. That cannot be, you cannot come back and change that to MASD. Stage 4 cannot go back to MASD. The documentation was not entered properly. R2's (10/23/24) POS states cleanse sacral 1/2 strength Dakins, pat dry, apply metrocream, cover with dry dressing daily. R2's (October 2024) TAR affirms the sacral treatment was not documented (blank entry) on 10/26/24. The (7/2023) low air loss mattress policy states the purpose is to provide features of a mattress support system that provides a flow of air to assist in managing the heat and humidity of the skin. Low air loss mattresses will be utilized for residents with stage III and IV pressure ulcers of the trunk as well as residents with multiple stage II pressure ulcers. The low air loss mattress will be checked on a regular basis to ensure that all cells of the mattress are functioning appropriately. Any resident on a low air loss mattress will have a single non-fitted sheet which may be used for assistance with repositioning. The management of wounds policy (revised 12/31/23) states it is the policy of this facility to manage tissue load and improve tissue tolerance to pressure, friction, and shearing forces. This will be accomplished through the use of appropriate positioning practices, positioning devices, and support services. It is the policy of this facility to treat the wound according to the guidelines of the Agency for Healthcare Research and Quality (AHRQ), National Pressure Ulcer Advisory Panel, and current standards of clinical practice. According to the AHRQ, Care of the ulcer itself involves debridement of necrotic tissue, cleansing of the wound at initial examination and at each dressing change, and using a dressing that keeps the ulcer bed continuously moist but the surrounding intact skin dry. The following policies and procedures will be utilized: wound cleansing policy and procedure and wound dressing policy and procedure.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 32819 Based upon record review and interview the facility failed to ensure that competent nursing staff are available to meet the needs for four of four residents (R1, R2, R3, R4) reviewed for wound care. The facility failed to ensure that the Wound Care Nurse is certified, failed to ensure that wound assessments are accurate, failed to stage wounds correctly, failed to ensure that all Nursing staff are aware of LALM (Low Air Loss Mattress) use requirements, failed to in-service all Nursing staff for LALM use, failed to follow physician orders, failed to ensure that treatment administration is documented on the TAR (Treatment Administration Record), failed to administer treatments as ordered, and failed to follow policy procedures. Findings include: 1. R1 was transferred from the facility to the hospital on 9/21/24. On 10/28/24 at 1:05pm, surveyor inquired about R1's (facility acquired) skin integrity impairment, V2 (Director of Nursing) presented R1's (2/23/34) initial skin alteration record and (3/21/24) weekly skin alteration record and stated 2/23 is when the MASD (Moisture Associated Skin Damage) started and 3/21 is when the MASD got resolved. Then, the 9/16 (2024) MASD was identified next. R1's (9/16/24) initial skin alteration record affirms sacrum MASD was documented however R1's (9/21/24) hospital history and physical (5 days later) states patient has large sacral decubitus [therefore incongruent with R1's facility assessment]. R1's (9/16/24) POS (Physician Order Sheets) include Medihoney apply to sacrum daily for excoriating/MASD. Cover with foam dressing however R1's (9/21/24) ER (emergency room) progress notes state pressure ulcer noted to (R1) sacrum dressed with white substance and dressing on arrival [Medihoney which was prescribed - is not a white substance]. On 10/28/24, surveyor requested credentials for the facility Wound Care Nurse. At 12:05pm, V1 (Administrator) stated that the facility employs two wound care Nurses (V8, V10) however only presented V10's (Wound Care Nurse) wound care certification. Surveyor inquired when V10 was hired V1 responded (V10) started last Monday so that would be on October 21st [7 days prior]. On 10/28/24 at 12:47pm, V1 stated that (V8/Wound Care Nurse) Does not have wound care certification and subsequently affirmed in writing that V8 does not possess the WCC (Wound Care Certified) certification. This employee (V8) was hired on September 18, 2023 (over 1 year ago). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 12:11pm, surveyor inquired who's responsible for wound care at the facility V11 (ADON/Assistant Director of Nursing) stated I troubleshoot for the facility just to do the dressing when the wound care is not here and affirmed that when V8 (Wound Care Nurse) is not working she (V11) provides wound care. Surveyor inquired when V8 works at the facility V11 responded Friday, Saturday, Sunday and Monday. Surveyor inquired if V11 is wound care certified V11 replied No, I'm not. Surveyor inquired about R1's skin integrity impairment (prior to 9/21/24) hospital transfer V11 stated (R1) has excoriation. Surveyor inquired what blank spaces on the TAR indicates, V11 responded That they didn't do anything. Surveyor inquired if R1's Medihoney treatment/dressing was documented on the (August 2024 TAR) V11 reviewed R1's EMR (Electronic Medical Records) and responded Nobody sign it or it means it's not there, 5 days, the blank one. The Nurses on the floor should be doing this. Surveyor advised that V11 affirmed that she (V11) and V8 were responsible for wound care (in prior statement) V11 replied I know, but if I cannot do it, I told them (assigned Nurses) that they have to do it. 2. On 10/23/24 at 3:44pm, R3 was lying on a (Low Air Loss Mattress) LALM, and the setting was on static mode (therefore providing a firm surface). Surveyor inquired about R3's current LALM settings, V5 (RN/Registered Nurse) stated Usually it's preset. Surveyor inquired what static mode means, V5 responded I'm not familiar with this machine. R3 was noted to be lying on a white flat sheet, a thick blue folded sheet (8 layers), and folded bath blanket (4 layers). V5 counted the layers beneath R3 (as requested) and affirmed that there were 13 excluding the brief (therefore a total of 14 layers placed beneath the buttocks). Surveyor relayed concerns with all the linens placed between R3 and the LALM, V5 replied It should only be one, otherwise this one (LALM) won't work. V5 then proceeded to cover R3 with the blanket and left the room, V5 did not remove any of the sheets and/or blanket beneath R3 at this time. R3's (October 2024) TAR affirms for low air loss mattress checks (blank entries) were noted on 10/5, 10/6, 10/8, 10/19, 10/23, 10/24, 10/25, and 10/27. For Calcium Alginate treatments 9 (see progress note) is documented on 10/6, 10/14, 10/17, 10/20 and 10/28. For turning/ repositioning every 2 hours blank spaces were noted on 10/3, 10/5, 10/6, 10/7, 10/8, 10/9, 10/19, 10/20, 10/23, 10/24, 10/25, 10/27 and 10/28. On 10/29/24 at 12:45pm, surveyor inquired why 9 was documented on R3's (October 2024) TAR, V11 (ADON) stated I don't know why they (Nurses) do this number nine. 10/6 (2024) it says done by wound nurse (referring to R3's progress notes). 10/8 says done by wound nurse. 10/14 says done by wound nurse. 10/20 is done by wound nurse. 10/24 will be done by wound nurse. Surveyor inquired if Nurses should be charting wound care for other staff, V11 responded No, they have to chart when they are doing it, the dressing and everything. Surveyor inquired what mode the LALM should be in while a resident is lying in bed V11 replied The mattress should just stay in alternating because that is where the cell is alternating, go up and go down the bed, so the patient should be floating in the mattress. Surveyor inquired if several linen layers were placed under R3's buttocks while lying on a LALM, is the mattress effective. V11 stated No, it has to be one layer only because the air can go to the patients skin. Surveyor inquired if in-services for LALM were provided to staff, V11 stated Oh yeah, every day when I make rounds I say only 1 linen, 1 linen because you know it should be one sheet only. We do in-services quarterly for like an air mattress because we have a agency aide or something like that. If I have in-service, I have a guest binder for them (Agency Staff). Surveyor requested the LALM in-services at this time. The (9/20/24) Air Mattress in-service sign in sheet was endorsed by 7 staff and the (10/11/24) Air Loss Mattress in-service sign in sheet was endorsed by 8 staff therefore a total of 15 staff [additional Air Loss Mattress in-services were conducted - after surveyor inquiry]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24, V1 (Administrator) presented the employee roster and affirmed that a total 66 Nurses and CNAs are employed by the facility (excluding agency staff). 3. R4's (9/13/24) initial skin alteration record was signed on 9/15/24 (2 days after assessment). Site: Abdomen. Description: Sacral wound stage 4 [the description is incongruent with the site]. Preventive measures: redistribution mattress. R4's (9/13/24) POS states cleanse sacral wound with NS, apply Alginate, cover with dry dressing daily and as needed. R4's (October 2024) TAR affirms sacral treatment was not documented (blank entries) on 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/15, 10/17, 10/18, 10/19, and 10/22. Low air loss mattress checks were initiated on 10/24 (1.5 months after implementation). On 10/23/24 at 3:55pm, inquired if R4 has a wound V6 (RN) stated It's on the back, he (R4) was just turned by the CNA. R4's (10/15/24) BIMS determined a score of 9 (moderate impairment). On 10/23/24 at 3:57pm, surveyor inquired if R4's dressing was changed today R4 replied Uh um nodded his head no and affirmed it was not. R4 was lying atop of a LALM, surveyor inquired about the current settings on R4's LALM, V6 (RN) stated Unfortunately I (V6) was not told as to what setting (R4) should be in. Right now, the setting is at 250 (pounds) I wound say however R4 appeared to be about half that weight. Surveyor inquired how much R4 weighs, R4 responded 122 pounds. Surveyor requested to inspect R4 at this time. V7 (Certified Nursing Assistant) removed R4's incontinence brief which was dry however a dressing was not present and white cream was noted on the open sacral wound. Surveyor inquired about R4's exposed wound, V6 replied I see a wound on the tailbone, it is an open wound. Surveyor inquired what was on R4's (stage 4) sacrum wound, V6 stated Zinc oxide. Surveyor inquired if a dressing was supposed to be on R4's sacrum, V6 responded Yes. On 10/28/24 at 10:36am, surveyor inquired why R4's initial wound assessment states stage 4 and the current wound assessment states stage 3 (therefore back staging the wound), V2 (Director of Nursing) stated Good question. Surveyor inquired about staging wounds V2 responded When staging from a stage 4 going to a stage 3, if the wound is getting better by the week-by-week assessment of the wound nurse. Surveyor inquired if back staging of wounds is appropriate, V2 replied Don't we indicate if its progressing or getting better? Surveyor inquired if V2 was familiar with staging wounds V2 stated No. [The National Pressure Ulcer Advisory Panel advises against reverse staging of pressure ulcers, or bedsores, because it doesn't accurately reflect the healing process]. On 10/29/24 at 1:07pm, surveyor inquired why R4's initial sacral wound assessment (dated 9/13/24) was documented/signed on 9/15 (3 days after admission). V11 (Assistant Director of Nursing) stated (R4) was admitted on the 12th and the assessment was done the next day. When you do it on the day it will give you the day that you did the assessment. If I do the assessment today, I have to sign the assessment for today. Surveyor inquired about concerns with R4's (9/13/24) initial wound assessment, V11 responded The site says abdomen how can you put abdomen when the site is sacrum. 4. R2's (10/12/24) initial skin alteration record (admission) includes left buttock stage 4 pressure ulcer and sacrum MASD. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's (10/24/24) current skin alteration record includes sacrum stage 4 (left buttock was stated on the initial assessment) and buttocks MASD (sacrum MASD was stated on the initial assessment). On 10/29/24 at 12:28pm, V11 (ADON) affirmed that (V8/Wound Care Nurse) documented R2's (10/12/24) and (10/24/24) wound assessments. Surveyor inquired why R2's (10/12/24) initial wound assessment includes left buttock stage 4 (black/eschar tissue) however the (10/24/24) assessment (conducted 12 days later) states buttocks MASD. V11 stated She (R2) cannot have MASD because she (R2) is not eating. That cannot be, you cannot come back and change that to MASD. Stage 4 cannot go back to MASD. The documentation was not entered properly. R2's (10/23/24) POS states cleanse sacral 1/2 strength Dakins, pat dry, apply metrocream, cover with dry dressing daily. R2's (October 2024) TAR affirms the sacral treatment was not documented (blank entry) on 10/26/24. The management of wounds policy (revised 12/31/23) states it is the policy of this facility to manage tissue load and improve tissue tolerance to pressure, friction, and shearing forces. This will be accomplished through the use of appropriate positioning practices, positioning devices, and support services. It is the policy of this facility to treat the wound according to the guidelines of the Agency for Healthcare Research and Quality (AHRQ), National Pressure Ulcer Advisory Panel, and current standards of clinical practice. According to the AHRQ, Care of the ulcer itself involves debridement of necrotic tissue, cleansing of the wound at initial examination and at each dressing change, and using a dressing that keeps the ulcer bed continuously moist but the surrounding intact skin dry. The following policies and procedures will be utilized: wound cleansing policy and procedure and wound dressing policy and procedure. The (7/2023) low air loss mattress policy states the purpose is to provide features of a mattress support system that provides a flow of air to assist in managing the heat and humidity of the skin. Low air loss mattresses will be utilized for residents with stage III and IV pressure ulcers of the trunk as well as residents with multiple stage II pressure ulcers. The low air loss mattress will be checked on a regular basis to ensure that all cells of the mattress are functioning appropriately. Any resident on a low air loss mattress will have a single non-fitted sheet which may be used for assistance with repositioning.