STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145796	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Balmoral Home	2055 West Balmoral Avenue Chicago, IL 60625

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 0686 Level of Harm - Minimal harm or potential for 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** 41356 Based on review of records, interviews and observations facility failed to follow preventive measures to address sacral pressure ulcer care for 1(R2) out of 3 residents for a total of 3 residents reviewed for skin care. This failure resulted to one resident (R2) sustaining pressure ulcer deterioration. Findings include: R2 is [AGE] years old, initially admitted on [DATE]. R2's medical diagnosis includes Parkinson's disease and muscle weakness. R2 was seen on 04/08/2025 at 12:30 PM, in his room alert and verbally able to response within topic during conversation. R2 replied when asked if he has wounds, Yes, I have on my back. R2 stated that dressing was not change yesterday and today. But was changed a couple of weeks ago. R2 was seen laying on his back. When asked if staff are turning him (R2) on his side? R2 replied, No, they don't turn me on my side. They turn me when they change my dressing on my back. But not daily. R2's feet seen pushing on the footrest without heel protector. Per V6 (Nurse Practitioner Wound) clinical notes dated 03/12/2025, 03/21/2025 and 03/26/2025 R2's sacral pressure ulcer was deteriorating. V6 ordered to place R2 on side lying position every two (2) hours. And to turn and reposition every two (2) hours. R2's Treatment Administration Record (TAR) for March and April 2025 documents that multiple days for full eight (8) hours shift of turning and repositioning every two (2) hours were not signed as being performed. Both facility skin assessments and V6's sacral pressure ulcer assessment documents substantial increase in size. V6 assessment documents, from 0.25 square centimeters on 02/26/2025 to 0.50 square centimeters on 03/12/2025 an increase of 100%. Then further increase in size to 0.80 on 03/26/2025. R2's pressure ulcer was staged as 2 on 12/05/2025 by V16 (Nurse Practitioner Wound) later became stage 3 that indicates wound deterioration. Discrepancy of R2's March and April treatment administration records (TARs) were identified. TAR provided by facility on 04/08/2025 does not document signing of turning and repositioning as ordered by physician for the whole eight-hour shift on multiple days. TAR provided by facility on 04/09/2025 was modified by signing all days that were not signed including physician order for turning and repositioning. R2's wound plan of care document turning and repositioning as part of intervention for pressure ulcer prevention and improvement. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/2025 at 10:55 AM, V7 (Assistant Director of Nursing / Wound Coordinator) stated that included on R2's intervention to treat sacral pressure ulcer is to turn and reposition. And that a pillow is placed on his side to relieve pressure. V7 when asked about purpose of turning and repositioning said, It lift off prolonged pressure. V7 stated that resident who stays for a long time in the same position will get redness or stage one (1) pressure ulcer. V7 said, It is very important to reposition. On 04/09/2025 at 11:58 AM, V2 (Director of Nursing) V2 stated that R2's sacral pressure ulcer reopened on 11/19/2024. V2 stated that there are many factors that may cause worsening of pressure ulcers. Lack of turning and repositioning can cause worsening of pressure ulcer. V2 stated that she cannot explain the modification of R2's treatment administration record. And will take responsibility of documents discrepancies. On 04/09/2025 at 01:00 PM, R2's sacral pressure ulcer was seen with V7. V7 stated that V6 just did the dressing change with R1 sacral pressure ulcer. Pressure ulcer was seen about the size of a penny around half centimeter deep. Appearance of R2's sacral pressure ulcer consistent with stage 3 category. Pressure ulcer staging dated 05/12/2014 CMS attachment training reads and Section M on Minimum Data Set (MDS) assessment: Stage 2 is defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as intact or open/ruptured blister. Stage 3 is defined as full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. On 04/09/2025 at 01:10 PM, V6 (Wound Nurse Practitioner) stated that R2's sacral pressure ulcer decline, as it increased in size on 03/12/2025. V6 stated that R2 needs to be turn and repositioned every two (2) hours and needs to be clean and dry. V6 said, The importance of turning and repositioning to heal a pressure ulcer is like 80% of how to heal pressure ulcers. V6 stated when treating pressure ulcer, the problem is pressure. Therefore, it is important to relieve the pressure. V6 also stated that R2 needs low air loss mattress (LAL) because it helps with the moisture. And currently R2 uses Alternating Pressure (AP) mattress. Preventive measures for sacral pressure ulcer ordered by physician that were not established during review: - Reposition every 2 hours order date 12/01/2024. - Apply heel protector all the time order date 11/05/2024. - Low air loss (LAL) mattress order date 11/2024, R2 was using alternating pressure (AP) mattress. Prevention of Pressure Injury policy not dated reads: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this procedure is providing information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. Under mobility / repositioning, reposition all residents with the risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review or records and interview the facility failed to provide accurate treatment administration record for 1(R2) out of 5 residents for a total of 5 residents reviewed. This failure resulted to inaccurately representing one (1) resident (R2) treatment of pressure ulcer care in the facility. Findings include: R2 is [AGE] years old, initially admitted in the facility on 03/01/2010. R2 medical diagnosis includes Parkinson's disease, bipolar disorder and muscle weakness. On 04/08/2025 at 12:30 PM, R2 was seen in his room alert and verbally able to response within topic during conversation. R2 replied when asked if he has wounds, Yes, I have on my back. R2 stated that dressing was not change yesterday and today. But was changed a couple of weeks ago. R2 was seen laying on his back. When asked if staff are turning him (R2) on his side? R2 replied, No, they don't turn me on my side. They turn me when they change my dressing on my back. But not daily. R2's feet seen pushing on the footrest without heel protector. At the nurse station with V13 (Licensed Practical Nurse) a copy of R2's treatment administration record (TAR) for the month of March and April 2025 a copy was provided. At 01:05 PM went back to nurse station, V2 (Director of Nursing) was requested to provide a copy of R2's physician order sheets included in the chart binder of R2. V2 was informed that earlier a copy of R2's TAR was received from V13. V2 then provided a copy of R2's physician order sheet. At 04/08/2025 at 02:31 PM, an email was sent to V1 (Administrator) and V3 (Assistant Administrator) requesting resident records that includes R2's TAR for the month of March and April 2025. The following day 04/09/2025 at 09:29 AM, facility provided R2's TAR for the month of March and April 2025. Comparing R2's TAR for the month of March and April 2025 provided on 04/08/2025 from R2's TAR for the month of March and April 2025 provided the following day 04/09/2025. Multiple discrepancies were noted as to documentation on treatment services provided. Multiple treatment orders were not signed as being performed including application of abdominal binder, application of heel protector, repositioning of R2 every 2 hours on the original document provided on 04/08/2025. Document provided by facility the following day 04/09/2025, all areas that were not signed was filed up and signed. On 04/09/2025 at 11:58 AM, V2 (Director of Nursing) was made aware R2's two different copies of treatment administration record (TAR) for March and April 2025. After seeing the two (2) documents stated, I can see that many days in the TAR were not signed. I will not say who signed those blank on the TAR. But I will take responsibility. At 02:25 PM, V1 (Administrator) stated that this incident on discrepancies of R2's record will be reviewed and investigated. Per V6 (Nurse Practitioner for Wound) clinical notes dated 03/12/2025, 03/21/2025 and 03/26/2025, document that R2's sacral pressure ulcer was deteriorating. Charting and Documentation policy dated 09/01/2024 reads: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Information documented in the resident medical record includes treatment and services performed. Documentation in the medical record will be objective (not opinionated or speculative, complete, and accurate.