STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden of Waterford	2021 Randi Drive Aurora, IL 60505

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** 48944 Based on observation, interview, and record review the facility failed to follow a physician's treatment order for a resident (R1) with a stage 3 pressure injury to the sacrum. The facility also failed to inform R1's physician of a newly identified pressure injury wound. This applies to 1 of 4 residents reviewed for pressure injuries. The findings include: R1's EMR (Electronic Medical Record) showed R1 had an unhealed chronic stage 3 pressure injury to his sacrum. R1's Braden Scale assessment dated [DATE] showed R1 was at a High Risk for pressure injuries. R1's care plan dated 12/10/2024 showed R1's wound interventions included Treatment as ordered and Wound care consultation as ordered. On 12/10/2024 at 11 AM, R1 was in bed. R1 said last night he had discomfort in his wound area. R1 said he felt as if something was pinching him. On 12/10/2024 at 10:30 AM, V3 (Wound Care Nurse/WCN) was asked to perform wound care to R1's sacral wound. V6 (Hospice Aide) assisted V3 (WCN) with turning R1 in bed for wound care. R1 had an unsecured ABD pad dressing loosely covering his sacrum and buttocks. V3 removed the ABD dressing, and there was a dry 4x4 gauze dressing covering the sacral wound bed. The gauze dressing was adherent to the wound bed and stained with dry serosanguinous drainage, V3 had to moisten the gauze with normal saline to remove the dressing. The peri-wound area was red and irritated, and R1's right buttock had a partially open maroon blister that was bleeding. V3 said it appeared like a popped blood blister. V3 said it was a new DTI (deep tissue injury) pressure wound that measured 4 x 1.5 x 0.5 cm (centimeters). V3 proceeded to clean both wounds and then applied Nystatin (antifungal) cream directly on the sacral wound bed then covered it with a Calcium Alginate dressing. V3 then covered both wounds with an adherent boarded foam dressing. On 12/10/2024 at 1:30 PM, V3 (WCN) said she changed R1's daily sacral wound dressings. V3 said R1's wound was chronic, and would close and reopen. V3 said she had noticed R1's wound bleeding at times and was unsure of the cause. V3 said she does not follow R1's ordered treatment because she feels that the ABD dressing would provide more cushion versus the ordered foam dressing. V3 also said she did not follow the treatment order for the foam dressing because she felt it would not stay on properly. V3 continued to say that she had notified V12 (Wound Physician) of R1's new right buttock wound in the morning and entered a wound care order in R1's EMR. (continued on next page)

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/2024 at 3 PM, V12 (Wound Physician) said he had been treating R1's sacral wound for a long time. V12 said the wound would heal and then reopen. V12 said R1 was at high risk for skin breakdown because of his complex medical conditions and poor oral intake. V12 said that based on R1's medical conditions and end-life care his wounds were determined to be unavoidable. However, he still expected to be notified of any skin alterations immediately to ensure proper wound care would be initiated. V12 confirmed that V3 had not notified him of R1's new right buttock wound once it was identified in the morning. V12 continued to say that he expected his wound care orders to be followed as prescribed. V12 said an ABD dressing was not the same as a foam dressing because a foam dressing provided better protection for R1's wound. V12 also said R1's dressings had to be properly secured to ensure proper covering of the open wound bed to prevent possible complications. R1's WASA Form dated 12/10/2024 (completed during the survey) showed R1 had a new DTI pressure wound to his right buttock. The form said the wound measured 4 x 1.5 x 0 cm with bloody exudate drainage. The form said Noted with Skin Injury to Right buttocks. 25% of the area is open, 75% skin is intact but is dark red/purple. R1's Order Summary Report showed an active treatment order for R1's sacral wound initiated on 11/1/2024 for Maxorb II 4 x 4 Apply to sacral topically every day shift for Skin Condition Clean area with NS, apply calcium ag, cover with dressing, apply mycolog in periwound area. The order did not include V12's order for a foam cover dressing. R1's Order Summary Report also showed another treatment order for his right buttock initiated on 12/10/2024 for Maxorb II Ag 4 x 4.75 Apply to Right buttock topically every day shift for Skin Condition CLEANSE AREA W/NS, APPLY MAXORB, AND COVER WITH FOAM DRESSING. R1's Wound Physician Consultation report dated 12/11/2024 showed R1's sacral wound measured 5.5 x 2.8 x 0.2 cm with moderate serosanguinous exudate and the peri-wound was denuded. The report also showed a current treatment order initiated on 10/30/2024 to cleanse the wound with normal saline then apply topically a calcium alginate dressing and apply Mycolog to the peri-wound area and cover with a foam dressing daily. The report continued to show R1's new right buttock wound was also assessed. The report said the pressure injury was a stage 3, measuring 3.6 x 2 x 0.2 cm with moderate serosanguinous drainage. The report showed V12's (Wound Physician) treatment order was to cleanse the wound with normal saline then apply a calcium alginate dressing and apply Mycolog to the peri-wound area and cover with a foam dressing daily. The facility's document titled Job Description Titled: Wound Care Coordinator dated 11/2021, said Essential Functions A. Must ensure that all nursing procedures and protocols are followed in accordance with established policies .E. Administer or assist with wound treatments as ordered by the physician. F. Review treatment orders for completeness of information and accuracy of transcription of the physician's order .M. Update the family/responsible party and attending physician for any changes on wound assessments .P. Consult with other nurses, management, and other related health professionals to assist in assessing, planning and delivering and evaluating patient care .