STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146013	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkeley Nursing & Rehab Center	6909 West North Avenue Oak Park, IL 60302

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. 40798 Based on observation, interview, and record review, the facility failed to ensure pressure ulcer treatments and/or prevention interventions were implemented and/or completed, as ordered, for 3 of 3 residents (R3, R6, and R8) reviewed for wounds in the sample of 13. The findings include: 1. On 3/22/24 at 9:54 AM, R8 was lying in bed on a regular mattress. No low air loss mattress was in place for R8. R8 said staff turn her when they change her pamper, but was not sure how often she is changed. R8 said she has a wound to her bottom, but doesn't know if there is a dressing. On 3/22/24 at 10:11 AM, R8 said, Tell them to come change me. On 3/22/24 at 10:05 AM, V4, Licensed Practical Nurse (LPN), said R8 has a pressure ulcer to her sacrum and R8's wound care is ordered daily on the night shift, and as needed, if it becomes soiled or removed. V4 said she rounds with the wound care physician each week. V4 assisted R8 to turn to her left side. R8 had a dressing in place to her sacrum which was dated 3/21/24 (the day prior to this investigation). V4 said she needs to change R8's dressing because it is soiled. R8's brief and dressing were both saturated. On 3/22/24 at 10:24 AM, V20, Certified Nursing Assistant (CNA), said R8 has not been changed since she began her shift at 7:00 AM. V20 said residents are supposed to be changed and repositioned every two hours. On 3/22/24 at 1:25 PM, V4 said she rounds with the wound care doctor and them puts the wound treatment orders in for the resident. V4 said she listens to and follows the wound care doctor's instructions from the Wound Evaluation and Management Summary. V4 said the nurse signs off on the Treatment Administration Record (TAR) when the wound care is completed. V4 said R8 is not on a low air loss mattress. V4 said a Group 2 Mattress is a low air loss mattress. V4 said R3 had a left foot wound she got due to her contractures causing her legs to turn inward and rub together. V4 said R3 did not have a special mattress while she was in the facility. R8's Admission Record dated 3/22/24 shows R8's diagnoses include, but are not limited to, right femur fracture, hypertensive heart disease, peripheral vascular disease, and Stage 3 pressure ulcers of the sacrum and left buttock. (continued on next page)

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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(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	R8's Order Summary Report shows and order dated 3/5/24 for R3's sacral wound to be cleaned with Dakin's (wound cleanser) and betadine followed by the application of calcium alginate with silver, and medihoney, then covered with a border dressing every night and as needed. The same Order Summary Report does not include an order for a specialty mattress. R8's current Care Plan (undated) provided by the facility shows R8 is dependent on staff for bed mobility and toileting and is at high risk for further alterations in skin integrity related to impaired mobility and bowel and bladder incontinence. The same care plan also shows R8 has impaired cognitive function/dementia or impaired thought processes. R8's Initial Wound Evaluation and Management Summary dated 2/27/24 shows recommendations for a Group-2 mattress and for R8 to be turned side to side in bed every 1 to 2 hours. 2. R3's Admission Record dated 3/22/24 shows R3's diagnoses include, but are not limited to, cerebral infarction (stroke), hemiplegia and hemiparesis, vascular dementia, and frontal lobe and executive function deficit. R3's Initial Wound Evaluation and Management Summary dated 12/19/23 and R3's Wound Evaluation & Management Summary from 1/5/24 show R3 has a Stage 3 Pressure Wound of the right foot (wound 1) and a Stage 3 Pressure Wound of the right dorsal foot (wound 2). The dressing treatment plan is as follows to Wound 1: Alginate calcium with silver apply once daily, Leptospermum honey apply once daily, wrap with a gauze roll daily and Wound 2: Alginate calcium with silver apply once daily, wrap with a gauze roll daily. Both summaries recommend turning R3 side to side in bed every 1 to 2 hours. R3's Order Summary Report dated 3/22/24 shows orders for R3's right anterior foot to cleanse with normal saline, pat dry, and apply medihoney with a border gauze every night shift from 9/10/23, an order for R3's right lateral foot as follows: cleanse with normal saline, pat dry, apply medihoney with a border gauze in the morning dated 12/17/23, and an order on 12/21/23 for Wound Care Right Foot- cleanse with betadine, apply calcium alginate with medihoney, wrap with gauze roll every night shift. On 12/27/23 there is are orders as follows: Cleanse with normal saline, apply medihoney to the wound bed and cover with dry dressing daily and as needed. Alginate calcium with silver is never ordered for R3's wound care. R3's Treatment Administration Record (TAR) for January 2024 shows R3 did not receive any wound care on 1/1/24, 1/5/24, 1/6/24, and 1/7/24. R3's Care Plan (closed on 1/23/24) provided by the facility shows R3 is dependent on staff for bed mobility. R3's Care Plan did not include any interventions to treat or prevent alterations in R3's skin. The facility's Pressure Ulcer Recommended Treatment Protocols (dated 11/14) shows, All residents with pressure ulcers will be treated with consistent treatment protocols to aid in the healing process. 34117 3. On 3/22/24 at 9:51 AM, R6 was observed lying in bed. A gauze dressing was observed to his sacrum. R6's Wound Physician Progress note dated 3/12/24 documents a stage 4 pressure wound to the sacrum measuring 2.1 cm x 2.0 cm x 0.2cm. Treatment orders include apply calcium alginate with silver and foam dressing daily. Peri-wound treatment apply antifungal and zinc daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Treatment Administration Record (T.A.R.) dated March 2024 shows orders to clean with dakins and betadine, apply calcium alginate with santyl anchor with 4x4 gauze, apply zinc around wound, apply border patch every night shift. A second treatment order wound care: cleanse with 1/4 dakins solution cover with leptospermum honey soaked with calcium alginate, gauze island with border foam daily and apply zinc around peri wound daily at 5:00 AM. The T.A.R. shows two different treatments and both do not show the prescribed treatment as ordered. The T.A.R. shows both treatments are signed off daily.