STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146065	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbington Vlge Nrsg & Rhb Ctr	31 West Central Roselle, IL 60172

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** Based on interview and record review, the facility failed to document changes in skin condition, failed to ensure a physician assessed a new wound. The facility also failed to develop and implement care plan interventions for a resident who was admitted with pressure wounds to both heels, was identified with risk factors for further pressure wound development, and who developed sacral pressure wounds. This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 5. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease, moderate protein calorie malnutrition, gout, bilateral heel wounds, low back pain, and dysphagia. R1 was discharged from the facility on January 1, 2026. R1's MDS (Minimum Data Set) dated December 11, 2025, showed R1 was severely cognitively impaired and dependent on staff assistance with all ADLs (Activities of Daily Living) including eating, bed mobility, toileting, dressing, bathing and transfer. R1's progress note, dated December 30, 2025, at 11:06 PM, showed R1's physician ordered R1 transferred to the hospital due to abnormal lab results. R1 was transferred to the local hospital on December 31, 2025, at 00:46 AM and was admitted to the hospital with a diagnosis of pneumonia. R1's tissue tolerance assessment dated [DATE], completed by V7 (Registered Nurse/RN) showed R1 needed repositioning more often than every 2 hours. R1's skin condition assessment dated [DATE], showed R1 had a pressure ulcer on his right heel. The assessment also showed, in the interventions section, R1 had pressure relief device in chair, turning and repositioning program, nutrition and hydration interventions and dressing changes all identified as ongoing interventions in the past 7 days. The skin condition assessment showed to initiate care plan. R1's care plan initiated on December 8, 2025, showed there was no care plan in place to address pressure ulcer prevention such as need for turning and repositioning program, due to R1's immobility, incontinence or behavior of being aggressive when touched. The care plan did not include devices staff could use such as a positioning wedge or pillows, to encourage turning and repositioning or a schedule for repositioning for staff to follow. There was no care plan in place to address off loading of resident's heels while in bed. The nutrition care plan did not include strategies for feeding R1 or include what staff should do if R1 refused to eat. R1's daily shower skin check sheets were provided by the facility. R1 had skin check sheets dated December 5, 12, 16, 19, and 23, 2025. On the skin check sheets dated December 5, the skin check indicated R1's skin was intact with the presence of a bruise but no location of where the bruise was. The skin check sheet dated December 16 indicated R1 skin was intact with presence of rash and bruise with no location of where the rash and the bruise were located. The skin check sheets dated December 12, 16 and 23 did not have any documentation including whether or not skin was intact regarding R1's skin. V2 (Director of Nursing) was unable to provide any follow up documentation or interventions that were provided regarding the skin concerns identified. R1's observation note dated December 23, 2025, at 11:51 PM, by V8 (RN) showed R1 developed pressure ulcers on both sides of his (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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(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	sacrum. The observation note showed the skin on the sacrum was reddened with 2 open circular areas with approximate measurements of 3.0 cm (centimeters) x 3.0 cm on the right and left sides of the sacrum, and red tissue in the wound bed. The observation showed V8 cleansed the wound with normal saline and applied A & D ointment and border foam gauze.On January 16, 2026, at 3:23 PM, V6 (Certified Nursing Assistant/CNA) stated she was R1's CNA on the day of R1's admission. V6 stated she recalled R1 had some redness on the skin on the low back and recalled he had wounds on both heels. V6 stated R1 would yell a lot and tell staff to leave him alone. V6 stated R1 did not like to be changed and R1 used to get out of bed into a wheelchair when first admitted and then just stopped getting out of bed. V6 stated she could not recall exactly when R1 stopped getting out of bed.On January 16, 2026, at 3:33 PM, V8 stated V9 (CNA) had alerted him to the presence of the new wounds on R1's sacral area. On January 16, 2026, at 3:36 PM, V9 (CNA) stated on December 23, 2025, was the first time he was assigned to take care of R1 when he noticed the redness and open areas on R1's sacrum and reported the condition to V8. V9 stated R1 needed 2 caregivers' assistance to reposition R1 because he would yell a lot and would swing his arms at staff during care. V9 stated R1 did not like to eat and would refuse to open his mouth at meal times. V9 stated there was no repositioning schedule for R1 that he was aware of and remembered R1 was tall and skinny and did not get out of the bed. On January 16, 2026, at 4:10 PM, V5 (Wound Nurse Practitioner) stated R1 was admitted with pressure wounds on both heels. V5 stated he first assessed R1 on December 5, 2025, and told nursing staff in addition to R1 already having pressure wounds, R1 was at risk to develop additional pressure wounds due to R1's poor nutritional status, immobility, and incontinence. V5 stated he ordered vascular studies for both legs and instructed nursing staff to follow the Facility Pressure Injury Prevention Protocol. V5 stated on the first visit with R1 there was no low air loss mattress on R1's bed. V5 stated R1 was underweight, had protein calorie malnutrition and could become aggressive when touched. V5 stated the last visit for R1 was on December 19, 2025, prior to the identification of sacral area pressure wounds and V5 did not assess the new wounds. Review of R1's physician and physician extender progress notes from December 24 through discharge showed neither the wound physician extender nor medical physician /physician extender assessed R1's sacral wound. On January 20, 2026, at 11:30 AM, V2 (Director of Nursing) stated when a resident is admitted with a pressure wound the expectation is the resident will have a care plan in place to prevent further pressure wound development and a care plan to promote wound healing. V2 stated the expectation is for residents with existing pressure wounds or at risk for developing pressure wounds be repositioned every 2 hours. V2 was unable to provide documentation that R1 was repositioned every 2 hours or provide a plan to meet R1's need for repositioning, prior to R1's development of sacral pressure wounds. The facility's policy titled Skin Alteration and Assessment Policy dated July 2022, showed, It is the policy of this facility to ensure that the facility will assess, treat the skin impairment for residents based on the observation during admission, and/or change in skin condition.2. During shower or while providing ADL care .CNA has to fill out the daily shower sheet form with their findings.3. The assigned nurse will initiate the treatment and /or interventions .11. Resident will be seen by the Wound MD during weekly wound rounds or as needed.15. QA nurse will update the care plan.