STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUTHERAN HOME FOR THE AGED	**800 WEST OAKTON STREET ARLINGTON HTS, IL 60004**

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 assess R1's pressure ulcer on a weekly basis and provide treatment based on that assessment. The facility also failed to consult with the wound care physician as ordered. This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in a sample of 5. The findings include: R1 was admitted to the facility for rehabilitation on 7/19/20 with [DIAGNOSES REDACTED]. R1's Admission Progress notes dated 7/19/20 state, DTI (Deep Tissue Injury) to coccyx and stage 2 to right buttocks . R1's Skin evaluation Form dated 7/20/20 states, DTI 2 x 1 cm. Small superficial opening to right buttocks 1 x 1 cm. R1's Skin Evaluation Form dated 7/21/20 states, DTI to coccyx, 2x1 cm. The wound is described as a full thickness wound, pressure injury and the treatment ordered is {Foam Dressing}. There is no mention of the Stage II pressure ulcer on the Right Buttocks on 7/21/20. This assessment was done by V9 (RN-Wound Care Nurse). R1's Skin Evaluation Form dated 7/24/20 states, No new skin issues noted. DTI left buttocks, stage 2 on right sacrum . There are no measurements and no other description of the wounds. R1's Skin Evaluation Form dated 7/31/20 states, Skin check done. No new skin issues noted. There are no measurements and no descriptions of the wounds. R1's Skin Evaluation Form dated 8/7/20 states, DTI to coccyx with slough and necrotic tissue. The wound measurements are 4 x 3 x 0.5 cm. On 8/26/20 V9(RN- Wound Care) stated, (R1) had a DTI on admission. It was purplish in color, on her buttocks. She was never seen by the V10 (wound doctor). He is here weekly on Thursdays and when they asked me to have him see her, he was already gone for the day so he was supposed to see her the next week. On 7/21/20 they asked me to see her. I see all pressure wounds. I did not see a reason for her to see V10 at that time. The area was not open, she had a low air loss mattress and a foam dressing for protection. The attending physician then asked to have her seen by the wound doctor on 8/8/20. I see the residents weekly and the nurse's do the dressing changes daily. I went on vacation and the floor nurse's should have taken over and done the assessments. She was found with slough and necrotic tissue on 8/7. The nurse's rely on the nurse practitioner (NP) for orders. Santyl ([MEDICATION NAME] medication) was ordered on 8/10. Her treatment was only changed once and that was on the 8/10. The nurses should document in the Skin Condition section (in the electronic chart) every week when they do the assessment. There should be measurements every week. On 8/26/20 at 2:15PM, V6(R1's Primary Physician) stated, {R1} came into the facility with a stage 2 on her coccyx and she was referred to wound care- I was not aware that she had not been seen by wound care. On 8/27/20 at 8:30 AM V2 (Director of Nursing) stated that sometimes the nurses document their wound assessments on the Treatment Administration Record (TAR) when they do the treatments. V2 stated that on 7/31 (in the TAR) the nurse documented, same so she had to have measured and assessed the wound and it was the same as the last assessment. The Treatment Administration Record (TAR) from 7/20/20 - 8/10/20 shows daily entries under the treatment order as follows: 7/20- Redness, 7/21- No signs and symptoms of infection, 7/22- Clean Minimal Drainage, 7/23-Minimal Drainage, 7/24- No signs and symptoms of infection, 7/25- Dry, 7/26- Healing, 7/27- Healing, Moderate drainage, 7/28- Moderate drainage, 7/29- (Blank), 7/30- Redness, 7/31-Remains open, moderate drainage, 8/1- Moderate slough {devitalized tissue}, 8/2-8/7- Redness, 8/8-Done, Got worse, MD notified, 8/9- Minimal Drainage, 8/10- Moderate Drainage The TAR also shows entries under the order to Evaluate all wounds weekly on shower days. Once each week. The entry dated 7/24 states, see skin condition and the entry dated 7/31 states, Same. R1's Nurse's Notes(NN) date 8/7/20 state, DTI on sacrum , size appears increased, wound bed moist with slough and eschar.{devitalized tissue} Protective foam dressing applied. NN dated 8/8/20 state, Consult with {V10} ordered due to worsening DTI on sacrum . NN dated 8/10/20 (3 days after the wound was assessed) state, Seen by NP. Wound examined. New treatment orders received . R1's physician's orders [REDACTED].{V10} dated 7/19/20. The facility policy entitled Skin-Integrity- Pressure Ulcers/Pressure Injury dated 12/4/2018 states, Prevention of pressure ulcers/pressure injury will be through assessment, care plans, evaluation and monitoring of the resident in accordance with best practice standards.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.