STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145684	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF HOMEWOOD	940 MAPLE AVENUE HOMEWOOD, IL 60430

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow physician orders [REDACTED]. Findings include: R7 was admitted to facility with [DIAGNOSES REDACTED]. R7 medical practitioner wound progress notes dated [DATE] documents an unstageable pressure wound to sacral/coccyx/left buttocks measuring in length 4.5cm, width 8 cm, and depth unable to be determined with small amount of serous drainage with 100% tan eschar. R7's progress notes dated [DATE] documents R7 alert and responsive x2. Extensive assist with ADLS given per staff. Call light in reach. Safety maintained. Vital signs stable. Patient had increased dark reddish brown drainage from sacrum wound temp 99.2. NP notified and request for labs made due to drainage and low grade temperature. Received order for NP to see patient tomorrow and she will evaluate for further labs. R7 progress note and medical record do not document any record of R7 being seen by medical Practitioner after [DATE]. R7's next progress note document a note by social service on [DATE] followed by progress note on [DATE] that resident was not breathing on her own, CPR initiated and 911 called. On [DATE] at 3:56 PM, V2 (unit manager) said she would expect all staff to follow through with any physician orders. V2 said she was unable to find any documentation of R7 being seen by any medical practitioner after [DATE].
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 follow their wound preventions practices by not developing effective wound care prevention interventions to reduce or prevent the development of pressure sores for 3 of 6 (R7, R1, and R2) residents reviewed for pressure sore prevention practices. Findings include: R7's admission screen dated 5/31/19 documents under skin bruising to bilateral forearms with no other skin issues present. Braden score was 16 on admission which determines at risk score. R7's progress notes with created date of 6/11/19 and effective date 6/2/19 documents skin assessment completed, skin warm and dry to touch and noted intact. R7's Braden scale dated 6/10/19 documents a score of 16 which equals at risk score. R7's progress note dated 6/11/19 document unstageable pressure ulcer to Left buttocks/coccyx measuring 6.2x6.2x0cm. Small amount of drainage 80% necrotic and 20% pink granulation. Attached wound edges and periwound intact. Turned and repositioned. Heels noted soft and boggy. Heel protector boots in place. Redistributing mattress to be provided to prevent further breakdown. R7 medical practitioner wound progress notes dated 6/12/19 documents an unstageable pressure wound to sacral/coccyx/left buttocks measuring in length 4.5cm, width 8 cm, and depth unable to be determined with small amount of serous drainage with 100% tan eschar. On 9/18/20 at 11:40 Pm, V18 (wound NP) said it is very rare for a resident to develop an unstageable wound within 24 hours. Resident will typically show some type of alteration in skin before wound develops into an unstageable wound. If/when staff are assessing the skin they could of tried to put in new interventions to prevent the wound from worsening to an unstageable wound but depends on patient. Unstageable wounds can vary in color and can sometimes be missed if not assessed appropriately. V18 said any visits would be documented in medical record for residents. On 9/17/20 at 1:27Pm, V 12 (wound nurse) said residents will have body audits daily for first 7 days and then weekly if no alterations completed by floor nurse on treatment record. If resident does develop a pressure sore they would have daily body audit by floor nurse or wound nurse. V12 said she did not see any of those body audits for R7. If resident was assessed to be high risk with no open wounds we may implement a low air loss mattress but depends on patient. On 9/18/20 at 3:56 PM, V2 (unit manager) provided therapy notes to show R7 was receiving daily therapy but she was unable to provide any other documentation of R7 being up and out of bed or being turned or repositioned. R7's treatment administration record dated 6/1/19- 6/30/19 does not document any body audits or weekly skin assessments. R7's Medication Administration Record [REDACTED]. R7's progress note dated 6/4/19 documents by medical doctor, R7 examined while lying in bed. R7 is often lethargic and sleeping and has poor appetite with no nausea or vomiting. R7's progress notes dated 6/5/19 documents R7 lying in bed and complaints of left lower extremity pain. R7 progress notes dated 6/6/19 documents R7 is high risk for developing contractures, pressure ulcers, and poor healing or fall if not receiving adequate therapy and pain control. R7's progress notes dated 6/10/19 documents R7 has complaints of left knee achy pain with bending. R7's progress notes dated 6/16/19 documents R7 alert and responsive x2. Extensive assist with ADLS given per staff. Call light in reach. Safety maintained. Vital signs stable. Patient had increased dark reddish brown drainage from sacrum wound temp 99.2. NP notified and request for labs made due to drainage and low grade temperature. Received order for NP to see patient tomorrow and she will evaluate for further labs. R7 progress note and medical record do not document any record of R7 being seen by medical Practitioner after 6/16/19. Facility Skin practice guide dated 01/2013 documents under prevention interventions reposition frequently in bed and chair, elevate heels, complete thorough skin observations. Under admission skin evaluation documents a weekly skin evaluation is completed by the licensed nurse for those identified as at risk for skin breakdown that do not have pressure ulcer. Daily skin evaluations are completed by the licensed nurse for those patients with pressure ulcers. Documentation of skin evaluation is completed on the treatment administration record. R2 was admitted on [DATE] from the hospital. Progress notes dated 2/1/2020 documents: R2's buttock was redden. R2's right buttock was open, pink with no drainage present. R2's Braden assessment dated [DATE] documents: R2 was a twelve which indicated high risk for developing pressures ulcers. R2's minimum data sets (MDS) section M dated 2/8/2020 documents: R2 was at risk for developing pressure ulcers. Progress note dated 7/31/2020: R1 was admitted from the hospital with a [DIAGNOSES REDACTED]. R1 had eighteen staples in place with dressing. R1 was on isolation for [MEDICAL CONDITIONS] ([MEDICAL CONDITION]) which is inflammation of the colon caused by bacteria resulting in diarrhea. R1's MDS dated [DATE] documents: R1 required extensive assistance with one person physical assist with bed mobility. Section M documents: R1 is at risk for developing pressure ulcers/injuries. R1's Braden Scale for predicting pressure sore dated 7/30/2020 documents a score of seventeen which indicated at risk for development of a pressure ulcer. Admission/Re-Admission Evaluation dated 7/31/2020 documents: R1 had Ulcerative [MEDICAL CONDITION] and diarrhea present. R1's coccyx, groin and left heel was red. Progress note dated 8/2/2020: R1 had redness noted to the sacrum. Progress note dated 8/3/2020: R1's sacrum was noted reddened and opened. Progress note dated 8/3/2020: R1 has a pressure ulcer that was unstageable to sacrum measuring (0.5cm x 0.5cm) with moisture. Wound base hundred percent yellow with no drainage noted. Weekly Skin report documents: R1 has an in-house acquired pressure ulcer to the sacrum with an onset date on 8/3/2020. Medical Practitioner Wound Progress dated 8/4/2020 documents: R1 had moisture associated [MEDICAL CONDITION] Groin & Coccyx area. Encourage turn/repositioning per facility protocol. R1 had a stage one to the left heel. Skin note dated 8/13/2020 documents: R1 was seen on wound rounds: coccyx pressure now stage three (2cm x 2cm) with moisture. R1 still has redness to buttocks Weekly Skin report dated 8/13/2020 documents: R1's Braden score is eleven. R1 has a stage three pressure ulcer to the coccyx: Treatment: ointment.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145684	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF HOMEWOOD	940 MAPLE AVENUE HOMEWOOD, IL 60430

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	(continued... from page 1) Nutrition/Weight note dated 8/15/2020 documents: R1 weighs 131.4 pounds, down 13.8 pounds since admission 7/30, likely due to fluid weight losses and ongoing loose stools, which are complicated by ulcerative [MEDICAL CONDITION]. Progress note dated 8/17/2020 documents: R1 returned from an appointment with a low blood pressure and using accessory muscles to breathe. R1 was sent to emergency room for evaluation. R1 was admitted [MEDICAL CONDITION]. Hospital paperwork dated 8/20/2020 documents: R1 has a sacral wound with moisture associated skin damage, dressing dry and intact. Discharge medication: ointment as need for soothing. Hospital paperwork: Infectious disease progress note dated 8/21/2020: R1 reported that he had been having occasional diarrhea over the past two weeks. Facility's Admission/Re-Admission Evaluation dated 8/22/2020 documents: R1's rectal area was red area related to diarrhea. Progress noted date 8/23/2020 documents: R1 seen by wound care team and skin assessment completed. R1 was noted with skin warm and dry to touch with skin intact, redness to peri area related to incontinence, barrier ointment to be applied by staff for preventative measures. No other concerns for wound care at this time. Pt was turned and repositioned. Admit/Readmit note dated 8/26/2020: documents: R1 has skin breakdown around anus. R1 was not able to move his lower extremities bilaterally during examination. Progress noted dated 8/30/2020 documents: R1 has redness to buttock with blackened and opened area noticed. . Wound care team made aware. Barrier cream applied. Skin and wound evaluation dated 8/30/2020 documents: R1 has a new facility acquired unstageable pressure ulcer to the sacrum due to slough and or eschar with drainage. Wound Measurements Area: 66.5 centimeter (cm), length 10.5cm and width 9.3cm.R1 has a facility acquired unstageable pressure ulcer to the right ischial tuberosity due to slough and or eschar. Wound Measurements Area: 1.6cm, length 1.1cm and width 1.8cm. Medical Practitioner Wound Progress Note dated 9/1/2020 documents: R1 was seen for chronic unstageable sacrum right ischial tuberosity. Present since admission. Treatment ointment cover with boarded gauze dressing. Wound#1: Sacrum: Type: Pressure: Measurements: Length 10.49cm, width 9.3cm and depth unable to determine. Wound#2: Right Ischial: Type: Pressure: Measurements: Length 1.07cm. Width 1.81cm and depth unable to determine. On 9/17/2020 at 2:41pm, V7 (Wound Nurse) said, R1 had a stool infection with diarrhea. When I assessed R1on 8/3/2020, the wound was small, round but I could not see the wound base. I did the rounds with V18 (Wound Nurse Practitioner) on 8/4/2020 and maybe she saw something else thats why she charted moisture associated [MEDICAL CONDITION] to R1's groin and coccyx. My assessment on 8/13/2020, R1 had a stage three, we were applying a debridement ointment and it was working. I did not need to change the treatment. We needed to reinforce turning and position. I saw R1 on 8/30/2020, took pictures of R1's wounds but I can't show them to the Surveyor. I don't know what happen to R1 between 8/23/2020 and 8/30/2020. On 9/17/2020 at 3:04pm, V15 (Nurse), I was R1's nurse on 8/30/2020, I was informed by the aide that R1 had redness and blacken area on the sacrum. R1's sacrum was red with black in the center. I cleaned R1's sacrum, updated the wound care team and the supervisor who no longer works here. I didn't complete a skin alteration form. On 9/17/2020 at 3:36pm, V17 (Nurse) said, I was R1's nurse on 8/3/2020. I was informed that R1 had redness, excoriation on his sacrum. I assessed R1's sacrum and noted an opened area the size of a dime. R1 incontinent of bowel and bladder. R1 had a stool infection with diarrhea. R1 was admitted from the hospital after having hip surgery from a fall. R1 came to the facility for physical and occupational therapy. On 9/18/2020 at 9:47am, V12 (Treatment Nurse) said, I provide R2 with his treatments daily. R2 was a complex case. I must have gotten busy and forgot to sign out the treatment on the treatment administrative record (TAR). R2's left ear was a facility acquired wound. On 9/18/2020 at 10:32am, V18 (Nurse Practitioner) said, R2 break down on the left ear was from equipment. When I started seeing R2 in March, R2 had an unstageable to the left ear. All residents need to be turned and repositioned as frequent as possible. Based on the facility protocol a resident should be moved frequently and at least every two hours. On 9/18/2020 at 11:25am, V18 (Wound Nurse Practitioner) said, R1 had lot diarrhea due to an infection. R1 skin was moist, red and shiny. I ordered an ointment/paste three times a day and as needed as a protectant for R1 sacrum. The paste cannot be aggressively removed when cleaning the resident, it will take off the skin. The ointment acts as a debridement agent when another medication is added, and it is covered with boarder dressing. The two medication/creams closed inside of a dressing will be activated by the resident's body heat an acts as a debridement agent but without the dressing it is just a protectant barrier. On 9/18/2020 at 11:39am, V18 (Wound Nurse Practitioner) said, I can't tell you what happen between 8/23/2020 and 8/30/2020 for R1. Staff should have seen something. The assessment tool use for predicting pressure sore should be used to see if a resident will develop a skin break down. On 9/18/2020 at 1:03pm, V19 (Nurse) said, skin assessments are done daily and documented on the TAR. A resident should be repositioned every two hours but can be repositioned as needed. If a resident is being repositioned or up to the chair it should be documented. It they are a bed ridden resident it is our responsibility to reposition the resident. On 9/18/2020 at 2:30pm, V23 (Nurse) said, R1 was admitted with a surgical wound after having hip surgery for [REDACTED]. R1 did not have any skin break down to the buttock. R1 received [MEDICAL TREATMENT] in his room due to [MEDICAL CONDITION]. No task for turning and reposition was noted in R1's electronic health record. Medical Practitioner Wound Progress Notes dated 2/5/2020 documents: R2 was admitted to the facility with acute stage two pressure ulcer to the left buttock and acute stage pressure ulcer to coccyx. R2 healing is guarded due to multiple comorbidities despite preventive measures. R2's pressure ulcers are close together and may combine into one. Wound one: Pink left buttock pressure ulcer measuring: Length 5.3 centimeters (cm), width 2.6 cm and depth 0.1 cm Wound two: Pink coccyx pressure ulcer measuring: Length 1.8cm, width 0.4 and depth 0.1. Recommending to upgrade to air mattress and encourage turning and repositioning. Medical Practitioner Wound Progress Notes dated 3/19/2020 documents: R2 has a chronic unstageable pressure injury to the right ear and coccyx. Deep tissue injury to left and right heel. Wound one: Location: Right heel, pressure, purple eschar, deep tissue injury measuring: Length 4.63cm, width 5.55cm and depth unable to determine: Wound two: Left Heel, pressure, purplish, deep tissue injury measuring: Length: 4.3 cm, width 3.8 and depth unable to determine: Wound three: Right ear, pressure, yellow tan and black eschar measuring: Length 1.62cm, width 1.19cm and depth unable to be determined. Wound four: Coccyx, unstageable, pressure ulcer measuring: Length 8.92cm and width 4.68cm. Treatment: Encourage turn and repositioning. R1 care plan dated 7/31/2020 documents R1 required assistance for transferring from one position to another. R2 care plan dated 2/2/2020 document R2 was a risk for skin alterations related to comorbidities and requires assistance for transferring from one position to another. Facility Task for April 2020 documents R2 was toilet and bed mobility sign out with blanks/ not documented on April 1st and the 4th. R2's Treatment Administration Record dated 4/1/2020-4/30/2020 documents treatments for the left ear and sacrum/buttock not signed out or blank for April 2nd, 5th and 6th. Facility Skin practice guide dated 01/2013 documents under prevention interventions reposition frequently in bed and chair, elevate heels, complete thorough skin observations. Under admission skin evaluation documents a weekly skin evaluation is completed by the licensed nurse for those identified as at risk for skin breakdown that do not have pressure ulcer. Daily skin evaluations are completed by the licensed nurse for those patient with pressure ulcers. Documentation of skin evaluation is completed on the treatment administration record.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their transmission based precautions and Covid-19 policy by cohorting asymptomatic and symptomatic residents for 2 of 2 residents (R3, R15), and failed to don PPE (Personal Protective Equipment) when entering contact/droplet isolation rooms for 3 of 5 residents (R12, R13, and R14) all reviewed for infection control practices. Findings include: R3 admitted to facility with [DIAGNOSES REDACTED]. R3 census list documents R3 was in a room on the 6th floor nursing unit from 2/21/20 until 5/3/20. R3's progress notes dated 4/28/20 document R3 was swabbed for covid19 and airborne isolation in place. R3's physician order [REDACTED]. R3's progress note dated 4/29/20 document changes in oxygen saturations, low grade temperatures of 99.6 and presence of cough. R3's covid test reported 5/3/20 documents covid 19 detected. R15's census documents R15 was moved to the same room as R3 on 4/30/2020. R15's physician orders [REDACTED]. R15's progress note dated 4/30/20 do not document any signs of cough, shortness of breath or fever. Facility census report dated 4/30/20 through 5/3/20 document R3 and R15 were residing in the same room. On 9/18/20 at 12:10pm V2(unit manager) said, residents that were positive or symptomatic would be placed on isolation. The roommate would either stay with resident or be placed for monitoring for signs and symptoms. V2 unsure why R3 was given another roommate while symptomatic. Facility covid 19 monitoring and measures plan dated 3/2020 documents to place any patient identified in facility with a temperature greater than 99, 72 hours prior to identification of last known exposure and the identified patient roommate in airborne isolation; cohort residents with like organisms when shared rooms are required. During the survey on 9/16/20 at 9:56 Am, V24 (CNA) observed in R13's room assisting with care needs with no gown on in the room. At 10:00 AM, V24 (CNA) entered R14's room to answer call light. No gown or gloves donned prior to entering. During the survey on 9/17/20 at 5:15 Pm, V 26 (CNA) delivered dinner tray to R12's room without donning gown or gloves. At 5:16Pm, V 26 (CNA) delivered dinner trays to R13 and R14 without donning gown or gloves. On 9/16/20 at 958 AM, V24 (CNA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145684	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF HOMEWOOD	**940 MAPLE AVENUE HOMEWOOD, IL 60430**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) said staff are to wear gown, gloves, mask and eye protection when entering isolation rooms. On 9/17/20 at 5:25Pm, V26 (CNA) said staff are to wear gown, gloves, mask and eye protection when entering isolation rooms. Isolation rooms are identified with red label on door and isolation bin outside the door. On 9/18/20 at 12:10pm, V2(unit manager) said staff should be wearing mask, eyewear, gown, and gloves when caring for resident on airborne precautions. When staff are passing trays to residents on airborne precautions they should be wearing mask, eyewear, gown, and gloves. R12's physician order [REDACTED]. R13's physician order [REDACTED]. R14's physician order [REDACTED]. Facility policy titled transmission based precautions and covid 19 dated 7/1/2020 document that airborne precautions are transmission based precautions that utilize a combination of droplet and airborne precautions. The same level of precaution are utilized whether the patient is on special covid19 unit or in a private room. N95 mask, eye protection, gown and gloves.