STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BIRCHWOOD PLAZA	1426 WEST BIRCHWOOD CHICAGO, IL 60626

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a dignified dining experience for 17 (R15, R17, R21, R22, R35, R66, R70, R72, R88, R110, R112, R113, R117, R176, R177, R178 and R376) of 17 residents in a sample of 68, reviewed for dignity and resident rights. Findings include: R112 is a [AGE] year old with a [DIAGNOSES REDACTED]. On 3/2/2020 at 12:12 pm, R112 was observed sitting in a chair in R112's room. V8 (Certified Nursing Assistant, CNA) delivered R112's lunch tray. On 3/2/2020 at 12:14 pm, V6 (CNA) was observed entering R112's room, standing next to a seated R112 and began feeding the pureed lunch meal while standing over R112. After V6 fed R112 several bites of food, R112 refused to continue eating the food. Subsequently, V6 exited R112's room, and both V5 (Registered Nurse, RN) and V6 returned to R112's room. V5 stated that she would order R112 a substitute tray for lunch. On 3/2/2020 at 12:30 pm, V5 (RN) was observed delivering R112's substitute lunch tray and again was observed feeding R112, while standing over the resident who was sitting in a chair. V5 continued to stand, while feeding R112 the remainder of the lunch meal. During a subsequent observation on 3/3/2020 at 12:13 pm, V6 (CNA) was observed standing while feeding R112 her pureed lunch meal. On 3/3/2020 at 12:16 pm, R112 asked V6, Would you like a chair? V6 said that she would sit down; and was observed to move a chair next to R112, who was sitting in chair. V6 was then observed at eye-level with R112, during the feeding. On 3/3/3030 at 2:34 pm, V6 (CNA) stated that to feed a resident, she should get a chair and sit down next to the resident. V6 stated that she should not be standing and feeding a resident seated in a chair. On 3/3/2020 at 2:39 pm, V5 (RN) stated that when she feeds a resident who is sitting, she sits next to the resident to talk and engage with the resident at the same eye level. V5 confirmed that she and V6 should have been sitting while feeding R112. On 3/4/2020 at 2:30 pm, V3 (Director of Nursing) stated that a dignified way of feeding a resident is to be sitting at the same eye level of the resident. Facility policy, Promoting/Maintaining Resident Dignity and dated August 2013, documents, in part, Policy: It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. Facility policy, Assistance with Meals and dated October 2009, documents, in part, 3. Residents requiring full assistance: . c. Residents who cannot feed themselves with be fed with attention to safety and comfort. On 3/2/2020 at 11:32 am, lunch trays were delivered to the 2nd floor. V10 (CNA-Certified Nurse Assistant) indicated that this was the 1st cart which contained lunch trays for the residents seated towards the back of the dining room. There was a blue curtain that separated the back half of the dining room from the front half. V10 indicated that the front half would be served from the 2nd cart which is delivered at 12:00pm. The following residents were already seated at their tables in the front half of the dining room with clothing protectors in place waiting for their lunch trays to arrive: R15, R21, R22, R35, R66, R70, R72, R88, R110, R113, R117, R176, R177 and R178. At 11:39 am, R66 was moved to the back of the room. V11 (Activity Aide) stated out loud, Oh, she has foods on the first cart? That's awesome! This statement was made in front of the residents that would have their trays delivered at 12:00pm. At 11:41 am, R376 opened the curtain to exit the back of the dining room and enter the front of the dining room. V11 stated, once again loud enough for the residents seated in the front half to hear, We have to keep the curtain closed because we don't want these people to see everyone eating. R15, R21, R22, R35, R70, R72, R88, R110, R113, R117, R176, R177 and R178 waited for their lunch trays without snacks, drinks or diversional activities provided. The residents could smell the food, hear the spoons/forks and dishes as they were moved and hear the staff as they talked to the residents about the food. At 11:46 am, the curtain divider was opened and the residents in the front half were able to view the residents eating. R22 stated, See, now they're full and we're not. On 3/2/2020 at 11:53 am, R113 asked when the food was coming. V11 stated, Not yet, seven more minutes. You know that. At 11:54 am, a visitor entered the room with a bag full of bananas. R35, R113, R117 and R176 asked for bananas. V11 stated, Not right now and took the bananas away and indicated that she would give them back after lunch. On 3/3/2020 at 11:07 am, V11 was saying out loud, (R22) is 2nd cart. Your lunch comes on the 2nd cart. You no longer get your food on 1st cart. You eat at 12. And to R178, V11 stated, Go over there. Your food comes 2nd cart. At 11:05 am, R17 entered the dining room and V11 stated, (R17) is 1st cart. R66 stated, I wish I was 1st cart. R22 was heard stating, I wish I could get into a car and drive to Lake Michigan and drink some water. R113 stated, They think we don't know that they're eating over there. But we have noses. We can smell the food. R66 was asked if she was okay with being served from the 2nd cart. R66 stated, Would you be okay? We have no choice. From 11:53 am to 11:57 am, R113 watched the clock and counted the minutes for when the food would arrive. V11 stated, You know, sometimes it arrives three to four minutes late. On 3/3/2020, the second cart was not transported to the 2nd floor until 12:05 pm. On 3/3/2020, V3 (DON-Director of Nursing) and V12 (RN) indicated that the 2nd cart was for residents that required assistance with eating. This surveyor observed and noted that this was not the process. On 3/4/2020 at 12:07 pm, R21 was the only resident who's lunch tray was on the 2nd cart and required feeding assistance from staff. R15, R17, R22, R35, R66, R70, R72, R88, R110, R113, R117, R176, R177 and R178 were able to feed themselves and did not require staff assistance. On 3/4/2020 at 1:36 pm, V13 (Food Service Supervisor) indicated that the 1st cart is sent to 2nd floor by 11:20 am or 11:25am. V13 stated, These trays are for the early feeders or people that require help or need to be fed. V13 indicated that the 2nd cart has trays for people that can feed themselves and don't require supervision. This is opposite what V3 and V12 stated the process for delivery of lunch trays was. V13 stated, That gets sent up by 12:00pm. I don't choose to do the seatings. Nursing dictates to us who is in which seating. It would not be difficult to serve everyone at the same time. The kitchen has no problem feeding 12 more people their trays. It doesn't take much more time. On 3/4/2020 at 1:43 pm, V3 (DON) stated, 1st cart and 2nd cart, my understanding is that they need to prepare the first cart first so that it's warm when it comes up. Honestly I don't know. The facility's Meal Times form documents that lunch is served to all units at 12:00pm. The MDS (Minimum Data Set) for R15, R17, R35, R66, R72, R88, R110, R113, R117, R176, R177 and R178 document that they require set up help only for meals. Only R21, R22 and R70 require physical assistance from staff according to their MDS assessments. A facility policy dated 10/2017 and titled, Meal Tray Service documents: The second cart/service is delivered and served typically 10 minutes later to Dining room [ROOM NUMBER], to ensure each resident receives a meal served in a dignified and appetizing manner.
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.** Based on observation, interview and record review, the facility failed to accurately assess and measure a pressure sore, failed to follow current standards of infection control practices when performing a wound care treatment, failed to provide notification of a decline in the condition of a pressure sore and failed to ensure that an air mattress was used according to manufacturer recommendations. These deficient practices affected one resident (R101) of four residents reviewed for

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

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) pressure sores in a sample of 68. Findings include: R101's Wound or Pressure Ulcer Identification and Progress Record documents that on 2/6/2020 R101 had a Stage 1, facility acquired pressure sore on the right sacrum. It was documented that Medseptic cream was to be applied three times a day. On 2/11/2020, V12 (RN-Registered Nurse) documented that R101's sacral wound was a Stage 2 and measured: length - 3.5 centimeters (cm) and width - 2.5 cm. It was documented that the skin was intact with a blister and redness surrounding the skin. V12 did not notify hospice services staff regarding R101's assessed worsening of the sacral wound, from a Stage 1 to a Stage 2. There was no change in treatment orders. On 2/18/2020, R101's wound assessment documented a downgrade in R101's pressure sore from a Stage 2 to a Stage 1. On 3/1/2020, V12 documented that R101's pressure sore was a Stage 3 and measured: length - 0.8 cm, width - 1 cm, depth - 0.1 cm. On 3/2/2020, V17 (Hospice Nurse) documented R101's Right Buttock pressure sore as a Stage 1 without a depth measurement. On 3/3/2020, V12 measured R101's wound with this surveyor present. V12 stated, Length - 1.5 cm, width - 2.0 cm, depth - 0.3 cm. It's a Stage 2. V12 indicated that she is not wound care certified. On 3/5/2020 at 9:09 am, V17 stated, (R101's) wound is managed by Hospice. They get orders for the wound care from myself and the certified wound care nurse that we have on staff. I assess once a week. I measure, take pictures and send it to the team manager and wound care nurse. I am not wound care certified. Stage 1 is non blancheable redness. Stage 2 is classified as an opening in the skin without depth. On 3/2/2020, I staged (R101's) wound at a Stage 2 because there was no depth to it. Stage 3 is when there is depth. No one from facility called me to say that pressure ulcer worsened or changed. No one has called me to get a change in treatment. I would have changed the treatment orders. They should be calling Hospice primarily and not the primary physician. I cannot give wound care orders unless I see the patient. It is also not documented in R101's progress notes that V17 was notified regarding the worsening of the wound. V17 indicated that now, with this knowledge,she would have to come see R101 either today or tomorrow. R101's Wound or Pressure Ulcer Identification and Progress Records dated 2/11/2020 to 3/3/2020 documented stages of R101's pressure sore that were inconsistent with the description that V17 provided. On 3/3/2020 at 10:07 am, V12 performed wound care on R101's sacral wound. Initially, V12 only measured the length and width of the wound. V12 was asked what the depth of the wound was. V12 viewed it and stated, About 0.2 cm. V12 then used a non sterile paper tape measure, to measure the depth of the wound. The tape measure was observed to came in contact with the wound, as V12 attempted to measure. V12 stated, 0.2 centimeters and threw the tape measure in a plastic bag on top of her used gloves and soiled gauze, that were used to cleanse R101's wound. V12 retrieved the tape measure from the soiled items in the plastic bag and re-measured the depth of R101's wound. Again, the tape measure came in contact with the wound as she measured the depth and stated, 0.3 centimeters. V12 indicated that she normally uses an non sterile tongue depressor to measure the depth of wounds. It was noted at 10:30 am that R101's air mattress was not turned on. V10 (CNA-Certified Nurse Assistant) and V18 (CNA) checked and found that the machine was not plugged in. V10 stated, I don't know how long that's been like that. It was also noted that R101's air mattress had multiple linens: Fitted sheet and thick cloth incontinence pad. V10 and V18 indicated that all air mattresses are padded with a fitted sheet and thick incontinence pad. On 3/5/2020 at 11:13 am, V3 (DON-Director of Nursing) stated, We should put a fitted sheet, flat sheet folded in fourths and thick incontinence pad. V3 also indicated that if the resident is on Hospice then the Hospice service manages the wound orders and not the primary physician. R101's Care Plan for skin integrity documents: 12/20/19: Monitor the effectiveness of the treatment and refer to MD (Medical Doctor) as needed. Manufacturer specifications for the facility air mattresses reads: Bed Linens: This device incorporates a waterproof cover that is moisture vapor permeable; therefore it is recommended to limit bed linens to one sheet in order to maximize the system's performance. NOTE: Only breathable incontinent pads are recommended for use with this device. A facility policy dated January 2019 and titled, SKIN CARE POLICY documents: 4. Nursing staff will notify the attending physician of any unusual skin change developments. 5. Nursing staff will notify the attending physician for wounds that have significant changes and obtain order changes as necessary. 8. Pressure relieving Mattress, chair cushions and repositioning techniques will be used for any residents assessed at high risk for skin breakdown.
F 0912 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** Based on observation and record review, the facility failed to provide 80 square feet and 100 square feet per resident bedrooms. Findings include: Observations of the following multiple resident rooms do not provide 80 square feet per resident: 111, 113, 114, 115, 116, 118,121, 122, 211, 212, 214, 215, 217, 311, 313, 315, 317 and 325. Observations of the follow single resident room does not provide 100 square feet per resident: 210. On 3/2/2020 at 10:41 am, during the facility entrance conference, V7 (Administrative Consultant) stated that there have been no changes to the facility floor plan or the rooms listed for the room waiver.