STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145971	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE COOK REHAB & HEALTHCARE	4101 LAKE COOK ROAD NORTHBROOK, IL 60062

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 -** 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 observation, interview, and record review, the facility failed to ensure that a low pressure air loss matress was in working order and failed to turn and reposition a resident per physician order. This failure contributed to one resident (R2) obtaining two facility-acquired pressure ulcers that became infected and necrotic (dead tissue). Findings include: R2 is an [AGE] year old originally admitted to the facility on [DATE] for long term nursing care and with [DIAGNOSES REDACTED]. On 8/3/20 at 11:50 AM, R2 was observed in her bed fully dressed and lying on her back. R2 was lying atop beige crumpled bedsheets with a dark blue mattress that appeared to be deflated as her body sunk down the center of the bed down to the bed coils. An electronic pump mechanism was attached to the footboard and an indicator light to show the device was functioning was off (not lit) and a dial was set at 150 psi. At 1:15 PM, R2 remained in the same position on her backside atop the deflated mattress. On 8/3/20 at 1:20 PM, V14 (CNA.-Certified Nurses Aide) was walking past R2's room. V14 pointed to R2's room and stated, Yes, she's mine (referring to her resident she was assigned to). Asked if there was another aide working with her, V14 stated, Yes, she's over there on that side (pointing to the other wing); This is my side. On 8/3/20 at 2:40 PM, surveyor entered the R2's room where she appeared to be in the same position on her backside and with the air pump indicator light was not lit. On 8/3/20 at 2:45 PM, V9 (Wound care nurse) provided surveyor a list of facility wounds as requested. V9 stated, Did you want to see wound care because I already did them this morning. Surveyor asked who did wound care, V9 stated, I do. I'm here Monday to Friday. Asked about her wound list provided the the surveyor, V9 stated, I have all these that I do (pointing to her list) and these are the only two that are facility-acquired (pointing to R2). Surveyor asked if nurses do wound care, V9 stated, On the weekends they do. On 8/4/20 at 10:50 AM, V3 (Assistant Director of Nurses) was asked who did wound care in the facility. V3 stated, We have a Wound care nurse (V9) who does it Monday to Friday, and our nurses do the treatments on the weekends. Surveyor asked V3 where nurses documented, V3 stated, It's all in the charts, we don't have electronic records yet so its all on paper. On 8/4/20 at 11:00 AM, V9 showed surveyor her wound surveillance report and was asked about where nurses document what they did. V9 stated, Well I chart on the TAR (Treatment Administration Record) and also in the nurses notes. Surveyor asked if there was any other areas or forms used to document interventions such as turning and repositioning, V9 stated, No just nurses notes and it should be signed off on the TAR. Surveyor asked V9 about the treatment order, V9 stated, Well they are supposed to be turning and repositioning her but I guess they don't document it anywhere. Asked how staff know when to turn and reposition R2 if there is no flow-sheet or documentation showing which position R2 should be in after being turned, V9 stated, I don't know but I will let my director of nurses know. Records in the nurses notes written by V9 (wound nurse) show: 4/23/20: Noted with blanchable redness on left hip applied foam dressing after normal saline wash. MD aware. Skin monitored weekly. 4/24/20: 9A seen by wound doctor with N.O. (new order) noted and carried out. 5/5/20: 8A skin assessment done. Left hip with deteriorating wound, noted with 100% necrotic tissue, approximately 3 x 3.5 x 0. Right hip with blanchable redness. Resident high risk for further skin breakdown related to incontinence to both bowel and bladder, contracted to bilateral lower extremities, unable to shift weights. Nursing note records show no documented entries to show turning or repositioning of R2. TAR's presented to the surveyor show the order Turning and Repositioning at frequent intervals to be blank and with only an FYI to the nurses. On 8/4/20 at 12:30 PM, V9 (Wound Nurse) and V18 (CNA) showed R2's wound treatments to the surveyor. V9 approached R2 and explained to the resident the procedure. V9 observed that the bed was deflated and stated, I did check this earlier and it was working but I see it's still not inflating so perhaps it could be the tubing. I already called the company to replace it and they said it will be replaced sometime today. Surveyor asked V9 to explain the air mattress pump functions, V9 stated, The dial has to be inflated to 125 psi setting suited for (R2's) weight and the green light should be lit showing normal pressure. Asked the importance of the correct pump setting, V9 stated, Well it can't be over inflated or else it doesn't work properly but for some reason it's still not working anyway. V9 proceeded with the treatment demonstration and with V18 (CNA) turned R2 to her side. V9 first removed a layer of incontinence pad described to the surveyor as a hip-hugger. V9 removed the hip hugger to reveal another incontinence pad, and then the bandage on her pressure sores. V9 removed the right hip dressing to show a tennis ball-sized wound. Surveyor asked V9 to describe the wound, V9 stated, It was just blanchable redness at first probably around April and the next time I say it it was already necrotic. Right now it appears to have a lot of slough and old necrotic tissue about 5 by 6 centimeters. It was just blanchable redness at first and she scratched it and it just like happened over night and was necrotic the next morning. V18 then turned R2 to her other side to show her left hip pressure ulcer that appeared to be a golf ball-sized hole. V9 stated, The left hip wound is undermining at around 10:00 o'clock and 12:00 o'clock (describing the location of the undermining tissue of the wound). Surveyor asked how deep the wound was, V9 stated, It's about 3 centimeters deep. Surveyor asked V9 to describe the undergarments R2 had on, V9 stated, After we do the treatments, she has a wound dressing (bandage) on her wounds, she has a diaper because she's incontinent, then there's a hip hugger (incontinence briefs with foam padding on each side of the hips). V9 stated, Those are the hip huggers we put on her to keep her from scratching herself. Surveyor asked if the facility tried other means to keep R2 from scratching, V9 stated, No, it's just a behavior she has. Asked if they tried other methods to address R2's itching and V9 stated, No. At the conclusion of the wound treatments, surveyor asked again about R2's wounds. V9 stated, Both the wounds to her left and right hip is facility-acquired meaning she got them when she was here. Yes, they are considered avoidable and she should not have gotten them. Surveyor asked about turning and repositioning and to show how nurses document that it's being done, V9 stated, Well the nurses are supposed to turn (R2) at least every two hours but we don't put it anywhere. Physician order [REDACTED]. The same physician order [REDACTED]. TAR's(Treatment Administration Record) were transcribed from the doctor's order as Turn and Reposition at frequent intervals and with a hand-written FYI next to the order but had no initials or signatures by nurses to document that the frequent turning was accomplished. On 8/4/20 at 1:20 PM, V14 (CNA-Certified Nurses Aide) was asked about R2. V14 stated, Yes she is my resident again. I usually have her and I took care of her yesterday too. Surveyor asked when the last time she went in to see R2, V14 stated, I saw her earlier when I changed her (referring to her incontinence briefs). Asked the time she went in to change her, V14 stated, I don't know maybe early in the morning. Asked when else she saw R2, V14 stated, Well I peek in and watch her and she was okay why is there something wrong. Asked if she goes and turns R2, V14 stated, Oh yes we do that too, I did that earlier when I changed her. Asked if anyone helped in turning R2, V14 stated, No I did it myself but sometimes I ask someone to help but everyone's always busy so I just do it. Asked how often R2 needed to be repositioned while in bed, V14 stated, I don't know, until they (nurses) tell me. All OBRA quarterly assessments (MDS-Minimum Data Set) dated 1/8/2020, 4/6/2020, 6/23/2020, and 7/10/2020 show R2 to be totally dependent of full staff performance for bed mobility requiring 2 staff to turn and reposition while in bed. All four of R2's MDS quarterly assessments show R2 at risk for developing pressure ulcers but do not include any turning and repositioning program in all the four MDS's. Interview with V15 (Wound Doctor) on 8/4/20 at 1:30 PM, states, I've been seeing R2 since the beginning of the year. I see her every Friday when I do my wound rounds at the facility. She should be on a low air loss mattress

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.

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) because she came in with a stage 3 pressure ulcer. If you tell me that mattress was not functioning since yesterday, that should have been changed immediately. I hope they did. Surveyor asked V15 if he considered R2's wounds to be avoidable, V15 stated, Her wound is avoidable. If she is capable of healing her other wounds I would have to agree with you and say her wounds are avoidable. Surveyor asked whether he ordered turning and repositioning for R2, V15 stated, Turning and repositioning at a minimum of 2 hours or less I always order for someone at risk for pressure injuries. I also agree that she should not have obtained these other two wounds if she was being turned and repositioned at least every two hours to off-load any pressure on her skin. Surveyor asked about microclimates of wounds, V15 stated, Microclimates are contributing factors such as linens, covers, padding impact wound healing. Excessive-padding, linens, coverings can be a problem and there shouldn't be that much padding on her. There should be minimal coverings over her wounds. I wasn't aware that there was that many layers of padding because when I come in to see her wounds, the staff already have her wounds ready for me to see. I'll be there (facility) this Friday so I'll address this with the staff. Asked about about necrotic wounds, V15 stated, Wound necrosis cannot happen over night. If she (R2) was scratching herself, she could not caused necrosis of her wound right away as the nurse told you. That would be incorrect. If she was scratching her wounds, the staff should have seen this before hand and also regularly off-loaded the pressure. Her skin doesn't just become necrotic. This is why it is important to turn and reposition a patient to take the pressure off otherwise the wound will die (necrosis) due to pressure not being relieved on the body part or bony prominence. Surveyor asked about his orders, V15 stated, If I say turn and reposition every two hours at a minimum, that should not be written as a FYI as it is an order not a recommendation.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based upon observation, interview, and record review, the facility failed to follow their established policy and procedures for infection control and prevention by failing to ensure that staff wear full personal protective equipment before entering the facility, and failure to ensure staff fully cover their nose and mouth while wearing masks in an effort to prevent the spread of infectious microorganisms, including COVID 19. These failures have the potential to affect all 77 residents. Findings include: On 8/3/20 at 11:30 AM, surveyor entered the facility and was provided a form to fill out pertaining to any exposure to Covid. Surveyor was given a temperature check and oxygen saturation test. V16 (Regional Director of Clinical Operations) asked surveyor to keep mask on and to enter the bathroom to wash hands and then to don (put on) a fabric gown before entering facility. During this process, V5 (Certified Nursing Assistant, CNA) was observed entering the facility taking her own temperature, but did not take her oxygen saturation nor put on a gown as the surveyor was required to do before entering the facility. On 8/3/20 at 11:50 AM, V7 (Restorative Nurse) entered the building, but did not put on a new gown prior to entering the building. Surveyor asked V7 who stated, I was outside getting something from my car but I'm supposed to put on a new gown before I come back inside the facility. Asked the purpose of putting on a gown, V7 stated, Well it's for infection control, sorry, I should be washing my hands first and putting on a gown. On 8/3/20 at 12:10 PM, surveyor observed V11 (Dietary Aide) serving lunch behind the tray line in the kitchen wearing her mask below her nose as she served the food onto each tray. Staff then took each tray V11 served on the tray and brought them out to each resident seated in the main dining area. Surveyor asked about her mask, V11 stated, My mask go sometimes down my nose. I know, I know I have to wear over nose. On 8/3/20 at 12:25 PM, surveyor walked through the double doors of the Covid-19 PUI (Patient Under Investigation) unit. There were no signs to the PUI unit to instruct or warn anyone entering to wear full personal protection equipment. Upon entering the unit, V4 (CNA) sat on the right side of the hallway. V4 wore a personal protective gown while seated in a chair with a facemask that was lowered below her chin as she watched television on her personal cellphone. Asked if she was the nurse, V4 stated, No I'm a CNA I'm watching the resident. V4 pointed to R3 who was seated in a chair without a mask and with tray table placed in front of the resident. Surveyor asked about V4's face mask, V4 stated, Yes, I should be wearing it but I was just listening to something on my phone. V4 then placed her mask over her face to cover her nose and mouth. Surveyor asked V4 about a mask for the resident (R3) she was supposed to monitor, V4 stated, I'll get him one. Surveyor remained in the unit as lunch was served from a enclosed metal rolling tray cart. V4 took each food tray and went in to each room to serve the tray to each resident. V4 went in and out of each isolation room and did not gown and garb a gown, nor change her gloves while serving different residents in the unit. Surveyor asked V4 what she was supposed to do when serving the residents in isolation, V4 stated, I'm wearing my gown and mask, I wasn't told to take them off each time. Interview with V8 (LPN-Licensed Practical Nurse) at 12:45 PM, stated, I'm the nurse for the PUI unit. I have 7 patients on contact droplet isolation. Before you enter those double doors, you should be putting on a gown and removing the gown when you exit the unit. We have to wear full PPE (Personal Protective Equipment) with a gown, mask, faceshield, and gloves. The PUI unit is treated the same as the Covid unit. Surveyor asked about the procedure for entering each resident isolation room on the PUI unit, V8 stated, You have to gown and garb, wear your face mask and gloves, but you have to remove your PPE's when you leave each isolation room and don new PPE. On 8/3/20 at 2:40 PM, V10 (Activity aide) was seated in the dining room writing notes in a book with no mask on while residents were present in the dining room. Surveyor approached V10, who then placed her mask over her nose and mouth. V10 stated, I'm sorry I'm supposed to be wearing a mask. On 8/4/20 at 8:45 AM, V12 (Therapist) came in through the double doors and did not wear a gown as required by anyone entering the facility. On 8/4/20 at 2:20 PM, V17 (Registered Nurse, RN) was seated in the nursing station with no mask while seated immediately outside the Covid unit. Surveyor asked V17 about mask wearing and V17 immediately placed her mask on and stated, Well I don't have Covid and I can't wear a mask long because I have shortness of breath. V16 (Regional Director for Clinical Operations) who was also at the nursing station during the exchange between surveyor and nurse stated, V16 stated,Yes I witnessed that. We are still in the process of our plan of correction and I will address this with that nurse (V16). If she is short of breath as she says than I will have her work on another floor and/or she will need to get clearance about her health status with her physician. On 8/5/20 at 11:00 AM, V16 (Regional Director for Clinical Operations) reiterated, Everyone must don a gown upon entering the facility and remove the gown when they exit the facility unless they bring a change of clothes to the building. V2 (director of nurses) added, We have spoken to all the staff you observed not following infection control measures and they have all been re-inserviced (re-educated) on proper mask-wearing at all times. If you go back to the PUI unit, we have a new sign that is more visible and will warn anyone before entering the unit. Facility policy, dated 3/27/20, titled Standards and Guidelines: SG Covid -19 Exposure control plan states, It is the standard of this facility to protect our residents, staff and others who may be in our facility from harm during emergency events. To accomplish this, we have developed procedures for specific hazards which build on the cross-cutting strategies in our continuity of operations plan . The facility will identify, address, and communicate to residents, visitors and staff, signs and symptoms of COVID-19 and preventative measures to prevent the spread of this respiratory disease. Screening. Educate. Post signage: at visitor/vendor entrances. Surveillance. Housekeeping. Kitchen Sanitation. Family/Resident communication. Staffing: Staff to be screened prior to each shift. Implementation of mitigation strategies: The following situations will be allowed pending a negative screening has been completed, negative temperature (<99.6) and have demonstrated appropriate hand hygiene and are wearing appropriate PPE when in patient care areas. Promote easy and correct use of personal protective equipment (PPE) by: Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room.