STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145329	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORRIDGE GARDENS	**7001 WEST CULLOM NORRIDGE, IL 60634**

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 and provide treatment to sacral redness to prevent the development of a stage 3 pressure ulcer. This applies to 1 of 1 resident (R1) reviewed for pressure ulcers in a sample of 3. The findings include: Physician order [REDACTED]. On 7/28/20 at 1:20 PM, V16 (LPN-Licensed Practical Nurse) stated she assessed R1 on 5/2/20 when she was readmitted to the facility from a hospital stay. V16 stated she remembered R1's skin condition when assessed on 5/2/20 and R1 had a dressing on her sacral area that was protecting an area of pink skin that seemed irritated from urine. V16 stated the pink area was in the middle of R1's sacrum, was blanchable, very superficial, had no slough, and was not open. V16 stated during the initial assessment of a newly admitted resident, V16 only begins the resident's skin assessment by circling areas of altered skin integrity on the body pictures of the assessment form. V16 stated she also types general notes in the boxes of the form of the skin assessment form. V16 stated the wound care nurse later completes the form by altering the form with detailed measurements and descriptions of the resident's altered skin integrity areas when the wound nurse assesses the resident. Review of R1's clinical record fails to show skin assessments indicating alterations in skin integrity, or treatments related to alterations in skin integrity, completed between 5/2/20 to 5/10/20. The POS, dated 5/1/20-5/31/20, shows no wound treatments for R1 were ordered between 5/2/20 to 5/10/20. The first documented wound treatment order was documented on 5/11/20. R1's readmission Initial Skin Risk Assessment, initiated by V16 on 5/2/20 at the time of admission, was not completed by V4 (Wound Nurse) until 5/11/20 when V4 assessed R1's skin for the first time. Wound assessment, dated 5/11/20 and written by V4, shows R1 had a Stage 3 sacral wound to her right and left buttocks which was open with slough and measured 6.0 cm (centimeters) length, 5.0 cm width, and 0.1 cm depth. The assessment does not indicate whether or not the wound was acquired at the facility, however the date the wound was first observed was documented as 5/2/20. Treatments for the wound included pressure reducing device for chair and bed, turning, repositioning program, nutrition or hydration intervention, pressure ulcer care, and applications of ointments, cleanse with saline, apply [MEDICATION NAME], gauze and cover with foam dressing daily and as needed. On 7/27/20 at 3:29 PM, V4 stated V4 did not assess R1 from 5/2/20 to 5/10/20 because V4 was absent from the facility. V4 stated she checked on R1 when she returned to work because R1 was readmitted to the facility from the hospital. V4 stated she documented on the assessment that the date the wound was first observed was on 5/2/20 because that was the date R1 was admitted . V4 stated she could not confirm that 5/2/20 was the date that R1's pressure ulcer was first observed. V4 stated residents with a Stage 3 pressure ulcer should be referred to the wound physician for assessment and treatment. V4 could not state when R1's Stage 3 wound developed. On 7/28/20 at 3:53 PM, V8 (Nurse Practitioner) stated if she was aware of R1's wound prior to 5/11/20, she would have ordered a wound consult by the facility wound care physician for assessment and treatment. Skin Integrity Care Plan, effective 5/9/20, shows R1 had nutrition intake of 50-70%, was unable to reposition herself, had limited range of motion, was incontinent of bowel and bladder, had no history of pressure ulcers, was cognitively impaired, [DIAGNOSES REDACTED]. Interventions, dated 5/17/20, include dietary referral, provide supplements, calories and vitamins as ordered, inspect skin daily - report any unusual findings in a timely manner, weekly assessment, and wound care consultation as ordered.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and provide nutritional intervention for a resident with a history of significant weight loss, poor nutritional intake, and a newly developed stage 3 pressure ulcer. This applies to 1 of 1 resident (R1) reviewed for nutritional status in a sample of 3. The findings include: Physician order [REDACTED]. POS shows R1's house nutritional frozen pudding was increased to three times daily on 2/20/20. Nutrition note, dated 4/21/20, shows R1 experienced significant weight loss (142.5# (pounds) on 10/23/19 to 127.4# on 4/13/20). The note shows the unintended weight loss was possibly related to reduced oral intake. Nursing notes, dated 4/28/20 and 5/2/20, show R1 was admitted to the hospital on [DATE] and was readmitted to the facility on [DATE]. POS, dated 5/1/20-5/31/20, shows R1's [DIAGNOSES REDACTED]. The POS shows R1 was on droplet isolation for COVID-9, received a pureed diet with honey-thickened liquids, and required feeding assistance and small teaspoon amounts of solid/liquids at a slow rate during meals. The POS shows R1 was ordered a calorie count on 5/2/20 for three days and R1 received two liters of intravenous fluids on 5/6/20 and 5/8/20 due to a [DIAGNOSES REDACTED]. The POS shows R1 was receiving swallowing therapy for moderate to severe oral and suspected pharyngeal stage dysphagia. Nursing notes, dated 5/3/20, show R1 ate only 25% of meals and was dependent on staff for feeding. Nursing note, dated 5/6, shows R1's nurse practitioner was informed R1 was not eating well (50% of meals) and R1 received two liters of intravenous fluids for dehydration. Nurses notes show R1 received intravenous fluids again on 5/8/20 due to dehydration. Wound documentation, dated 5/11/20, show R1 had a newly diagnosed stage 3 sacral pressure ulcer. Nursing notes, dated 5/15/20, show, Please do the dietary consultation for the resident. She has trouble eating and swallowing. Review of R1's clinical record fails to show any nutrition assessment, nutrition documentation, from 5/2/10 to 5/27/20. The clinical record fails to show dietary response to the physician order [REDACTED].# on 4/13/20 to 116.4# on 5/19/20). The note shows R1's unintended weight loss was related to reduced oral intake. Recommended interventions include the addition of two of R1's previously ordered oral supplements prior to her hospitalization on [DATE], and the addition of liquid protein 30 milliliters twice daily. On 7/27/20 at 4:40 PM, V9 stated she was not notified R1 had an order for [REDACTED]. V9 stated R1 was clearly not meeting her nutritional needs orally. V9 stated she has access to the wound rounds computer program and has access to the list of all residents who have pressure ulcers at the facility. On 7/27/20 at 12:11 PM, V15 (Diet Technician) stated she was not aware R1 was placed on intravenous fluids after readmission to the hospital. V15 stated a resident should be seen within 24-72 hours of returning from the hospital. V15 stated she was unsure why no one saw R1 when she returned to the facility and that either V15 or V9 should have seen R1 within 24-72 hours of her readmission on 5/2/20. V15 stated usually nursing gives V15 the results of a calorie count and V15 gives the results to V9. Resident clinical monitoring document, dated 4/1/20 to 7/28/20, show the following weights were recorded at the facility for R1: 130 lbs (pounds) 4/1/20 130 lbs 4/8/20 127.4 lbs 4/13/20 The weight report fails to provide an admission weight when R1 returned from the hospital on [DATE]. 116.4 lbs 5/19/2020 Facility Nutrition Assessment policy/procedure, dated 2016, shows, Dietary personnel including director of food and nutrition services, diet techs and diet clerks provide initial nutrition assessments . The healthcare community and the dietitian work together in determining level of nutrition risk. Medical conditions which may place clients at nutrition risk include: Enteral or [MEDICATION NAME] tube-feeding, Pressure injury, [MEDICAL TREATMENT], Significant Weight Loss. Facility Nutrition Assessment Timeline policy/procedure, dated 2019, shows, When a client is admitted to the community, the client is visited by a representative from the Food Service Department within 72 hours . The diet technician and the registered dietitian work collaboratively to coordinate nutrition care for the client . The dietitian provides in-depth nutrition assessments for clients whose medical condition may place them at nutritional risk. Medical conditions which may place

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) clients at nutrition risk include: Enteral or [MEDICATION NAME] tube feeding, pressure injury, [MEDICAL TREATMENT], significant weight loss. To comply with the Resident Assessment Instrument (RAI) timeline, nutrition assessments are completed no later than the fourteenth calendar day of the client's admission . Facility Calorie Count policy/procedure, dated 2018, shows, A calorie count may be initiated as needed for nutrition evaluation or for clients who may be at risk for weight loss. Notation of the type and amount of food consumed in a 3-day period is made in an electronic calorie count program or on a paper form. The dietitian evaluates the 3-day calorie count information in light of the client's overall nutrition status and based on this information makes nutrition recommendations if indicated. In the event that a calorie count is deemed impractical, the dietitian may use information pertaining to the client's food intake from the 23-hour report or from information recorded in progress notes. All these sources of information are considered valid in determining the client's nutrition status and making nutrition recommendations.