STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510079	A. BUILDING: _____ B. WING _____	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE GLEN ELLYN	60 N NICOLL WAY GLEN ELLYN, IL 60137

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A 000	Initial Comment Annual Licensure Survey	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Level 2 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) 12) The person requires treatment of stage 3 or stage 4 decubitus ulcers or exfoliative dermatitis; or 13) The person requires 5 or more skilled nursing visits per week for conditions other than those listed in subsection (c)(12) for a period of 3 consecutive weeks or more except when the course of treatment is expected to extend beyond a 3 week period for rehabilitative purposes and is certified as temporary by a physician. (Section 75(c) of the Act) This requirement is not met as evidenced by:	A2000		

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A2000	Continued From page 1 Based on interview and record review the facility failed to have staff with appropriate skills and failed to provide a level of service required to for one resident (R2) who was admitted with puncture wounds. This failure caused harm to R2 and creates a substantial probability of harm to other residents who present with wounds. Findings include: Review of medical record documents that R2 is 74 years old with diagnosis Including Parkinson's, depression, and anxiety disorder with an admission date of 7/11/24. E2 (DON) stated on 10/4/24 at 2:45pm that she (E2) had assessed R2 at a skilled nursing facility on 7/10/24. R2's assessment is documented in a nursing progress note dated 7/10/24 and reads 'noted with open wound to medial abdomen and under her right armpit. Medial abdomen wound with exudate per wound care nurse. R2 is being followed by a wound care doctor (at this skilled living facility). R2 presented maximum assist with transfers and requires contact guard with balanced support from RN. She was unable to take a step forward during the assessment.' Also documented on 7/11/24 under observation, R2 informed the nurse that she had a fall approximately 2 weeks ago which she sustained 2 wounds. One under her right armpit and abdominal area. Wound to armpit 1 x 2 x 0.5. Abdominal wound two left side umbilicus 2.5 x 3.5 x 1.5 cm. E2 stated on 10/4/24 at 11:30 AM that R2 had become entangled and impaled with her transfer rail at home for approximately 5 hours with resulting wounds. This occurred around 9/20/24.	A2000		

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A2000	Continued From page 2 Facility home health documentation dated 7/12/24 states the abdominal wound has slough in wound bed. Progress note dated 7/11/24 documents R2 was prescribed 300 milligrams Clindamycin three times a day for puncture wound of abdominal wall. There is insufficient wound assessment including comprehensive appearance, frequency of dressings, and monitoring of the abdominal and armpit wounds. Facility incident and accident reported dated 7/15/24 (four days after admission) states R2 had a fall sustaining a raised area to the back of the head. R2 was taken to the ED for evaluation. This incident and accident report documents the hospital diagnosis as Wound Infection and states R2 was 'receiving oral antibiotics and wound care three times a week by home health supplemented by NP visits 2 times a week; in total was being seen five days a week for her wound care.' The results of R4's abdominal CT scan states "new left anterior abdominal wall cutaneous wound with surrounding skin thickening, subcutaneous fat stranding, and local 4 cm fluid collection extending to and superficial to the rectus abdominis muscles. Non specific hyper attenuating material within the wound. Correlate with clinical exam." R2 was readmitted on 7/19/24. No further wound progress notes per facility until 7/24/24 when a new treatment order was written for three times a week. There is no progress note related to this wound until two days later on 7/26/24 which documents R2 returned on stretcher, two person assist. Hospital stated the wound was cleaned, repacked and 4 x 4 is applied. Soiled 4 x 4s are to be replaced on a daily basis. It is unclear when	A2000		

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A2000	Continued From page 3	A2000		

and why R2 was sent to the hospital but most likely it was for the abdominal wound care.

Nursing note dated 7/28/24 states R2 developed a low grade temp. Order was given for Tylenol every 4 hours. Progress note dated 8/4/24 states R2 'is confused, stating she feels locked up in a strange room and wants help to get upstairs to her old apartment. Running low grade temp and Tylenol given. Home health nurse provided wound care and only replaced dressings that were soiled. The wound care nurse (NP) is coming on 8/5/24 for a complete dressing change. More absorbent dressings are needed and ordered'.
E2 stated the home health agency nurse was to simply change the 4 x 4s on top of the wound 3 times a week. Nurse practitioner wound documentation states the initial assessment of R2 was done on 7/29/24. This assessment states "the wound appears severe." The wound nurse (NP) to change the wound packing once a week.

E2 was unable to provide documentation of R2's comprehensive wound assessment and appearance during R2's 25 day stay at the facility.

There is conflicting information as to how often R2's wound dressing was being changed. Medical record documentation identified 3 times a week and sometimes five times a week. A puncture wound of this size and depth required skilled comprehensive nursing and management (by NP) more than one time a week. This wound also required frequent monitoring and accurate documentation, neither of which was performed. Additionally, the complexity of this wound was beyond assisted living care. R2 should not have been admitted and facility should not have readmitted her.

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A2000	Continued From page 4 Nursing note dated 8/4/24 states facility nurse noticed the left lower abdomen dressing to be very soiled and with odor: monitor during the night. Progress note dated 8/5/24 states 'RN made aware of change in condition; noted non healing wound diagnosed by nurse practitioner: pressure ulcer of unspecified site, stage 4. R2 noted to be a febrile and complaining of nausea. R2 was sent to the ER for evaluation. R2 was admitted with diagnosis of fever, Abscess and Cellulitis. MD would like R2 to start on IV antibiotics. R 2 did not return to facility.	A2000		