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<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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<td>Annual Licensure and Certification Survey</td>
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<td>Complaint Survey</td>
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<tr>
<td>1981421/IL109908 - F580, F677, F686</td>
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<tr>
<td>1982756/IL111364 - No deficiency</td>
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<td>1983033/IL11673 - No deficiency</td>
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<td>1983501/IL112190 - F689</td>
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<tr>
<td>F 580</td>
<td>Notify of Changes (Injury/Decline/Room, etc.)</td>
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<tr>
<td></td>
<td>CFR(s): 483.10(g)(14)(i)-(iv)(15)</td>
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<td>§483.10(g)(14) Notification of Changes.</td>
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<tr>
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<td>(i) A facility must immediately inform the resident;</td>
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<td>consult with the resident's physician; and notify, consistent with his or her authority, the resident</td>
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<td>representative(s) when there is-</td>
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<td>(A) An accident involving the resident which results in injury and has the potential for requiring</td>
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<td>physician intervention;</td>
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<td>(B) A significant change in the resident's physical,</td>
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<td>mental, or psychosocial status (that is, a</td>
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<td>deterioration in health, mental, or psychosocial</td>
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<td>status in either life-threatening conditions or clinical complications);</td>
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<td>(C) A need to alter treatment significantly (that is, a</td>
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<td>need to discontinue an existing form of treatment due to adverse consequences, or to</td>
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<td>commence a new form of treatment);</td>
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<td>(D) A decision to transfer or discharge the resident from the facility as specified in</td>
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<td>§483.15(c)(1)(ii).</td>
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<td>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that</td>
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<td>all pertinent information specified in §483.15(c)(2) is available and provided upon request to the</td>
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<td>physician.</td>
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<td>(iii) The facility must also promptly notify the</td>
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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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**WENTWORTH REHAB & HCC**

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<thead>
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<tr>
<td>F 580</td>
<td>Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify a physician and family of a detected pressure sore which affected one resident (R354) out of 3 residents reviewed for change of condition notification in a sample of 85. Findings include: R354 was a 62 years old resident admitted to the facility on 1/16/19 with diagnoses of End Stage Renal Disease, Cerebral Infarction, Dependence on Renal Dialysis, Urinary Tract Infection, Type 2 Diabetes Mellitus, Obesity and Difficulty in Walking. R354's initial nursing assessment (1/16/19)</td>
<td>F 580</td>
<td>Wentworth Rehabilitation and Healthcare Center Plan of Correction and Allegation of Compliance F 580 483.10(g)(14)(i)-(iv)(15) Submission of this Plan of Correction by Wentworth Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by</td>
<td>05/22/2019</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CARE IDENTIFICATION NUMBER:**

145429

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

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| Continued From page 2  
completed upon admission documents R354 did not have a pressure sore.  

R354's skin integrity care plan (dated 1/29/19) documents apply barrier cream to areas exposed to moisture/incontinence.  

According to a progress note found in R354's medical record on 2/11/19 at 4:27 pm, R354 was sent to a local area hospital due to lethargy, poor appetite and poor fluid intake. R354's medical record from the receiving hospital dated 2/11/19 at 7:59 pm documents R354 was admitted to the hospital with a sacral decubitus ulcer.  

After being hospitalized for four days, R354 was discharged (2/15/19) from the hospital and readmitted to the facility. R354's initial nursing assessment upon readmission documented skin breakdown on middle crease of R354's buttocks, stage 2. Progress notes in R354's medical record from 2/15/19 - 2/18/19 were reviewed and do not document any assessments or interventions from the wound department for the documented stage 2 pressure ulcer. A complete review of R354's medical record was conducted, including physician order sheets, Care Plan, and assessment. There was no evidence in R354's medical record to show R354 received treatment for the pressure sore between his buttocks.  

According to progress notes (2/18/19), R354 was again sent to a local area hospital on 2/18/19 at 7:00 PM due to a change in status. While in the hospital a culture of the wound between R354's buttocks was taken and sent to the laboratory for analysis (2/18/19). The result of the wound culture returned positive for MRSA and Candida Albicans. |

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| the facility of the truth of any facts set forth in this allegation by the Survey Agency.  
Corrective Actions taken for those residents alleged to have been affected are:  

• R354 no longer reside at the facility  
Actions taken to identify other resident that may have the potential to be affected are:  

• An audit was conducted of all residents related to notification of family and primary care provider of a change in condition resulting from a pressure ulcer.  
• An audit was conducted that all residents with pressure ulcer for appropriate treatment orders.  
• No other facility residents affected.  

The measures the facility will take to ensure the problem will be corrected and will not reoccur.  

• Nurses were in-serviced on the facility's changes in condition policy.  
• Nurses were in-serviced on the facility's prevention and treatment of pressure injury and other skin alterations policy.  

Quality Assurance plans to monitor facility performance to make sure corrections are achieved.  

• A QA Tool was initiated to monitor |

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05/22/2019

**NAME OF PROVIDER OR SUPPLIER**

WENTWORTH REHAB & HCC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

201 WEST 69TH STREET

CHICAGO, IL 60621

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**DATE OF COMPLETION**

If continuation sheet Page 3 of 22
Continued From page 3

On 5/21/19 at 10:49 am, V20 (Wound Care Coordinator) was asked to provide treatment administration record related to R354’s wounds. V20 stated there isn’t one because R354 did not have a wound and no treatment was provided. V20 stated R354 had no wounds of any kind while in the facility. V20 stated R354 had old skin issues like scar tissue but never a pressure sore. V20 also stated the facility was applying barrier cream (zinc oxide) during R354’s care to prevent a wound. When asked about the physician order dated 2/18/19 for zinc oxide, V20 stated the order for zinc oxide is a generic order that residents get as a preventative measure and not an actual wound treatment. V20 also stated zinc oxide is a house stock that the facility carries and is ordered often.

On 5/22/19 at 3:58 PM, V20 stated that on 2/11/19 R354 was discharged to a local hospital and did not have a wound. When asked if she performed a wound assessment or treated R354 for the stage 2 ulcer noted on readmission on 2/15/19, V20 stated, "no" she did not because it was a weekend and she works during the week only. V20 stated the only treatment R354 received was zinc oxide, which is a routine preventive measure for residents at risk for developing pressure ulcers.

On 5/21/19 at 10:33 am, V19 (Director of Nursing) stated if during care an area of concern is identified, the certified nursing assistant (CNA) notifies the floor nurse, who then assesses the resident and then the physician and family are notified. V19 also stated if a resident is admitted or readmitted to the facility, a skin assessment is performed by the admitting nurse. If the nurse residents identified with a change in condition resulting from a pressure ulcer to prevent the delay in treatment, notification family and notification of primary care provider this will be initiated by the Director of Nursing or designee.

- The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up.
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<td>F 580</td>
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<td>Continued From page 4 has a concern with skin integrity, the doctor is notified and orders treatment are obtained and implemented.</td>
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<td>On 5/21/19 at 2:12 PM, V34 (family member) stated she was never notified by the facility that R354 had a pressure ulcer. V34 also stated she found out from local hospital about R354's pressure ulcer.</td>
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<td>On 5/21/19 at 3:40 PM, V18 (Physician) stated if a pressure sore is identified by the facility, V18 or V18's nurse practitioner are notified by phone or in person since the nurse practitioner is at the facility five days per week. V18 also stated if he is not available then V18's group is notified of a new pressure sore, then orders are placed for treatment. On 5/22/19 at 1:24 pm, V18 stated it is highly unlikely a pressure sore would be identified and not treated. When asked if V18 was aware R354 had a pressure sore, V18 stated, &quot;I can't answer because if a wound was identified then wound service would see the resident and place an order for treatment. In addition, I (V18) or the nurse practitioner would be notified.&quot;</td>
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<td>The facility's &quot;Prevention and Treatment of Pressure Injury and other skin Alterations&quot; policy (dated 06/2018) states:</td>
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<td>3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.</td>
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<td>6. Complete a Comprehensive Pressure Injury Assessment for identified pressure injuries</td>
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<td>The facility's &quot;Change of Condition (Resident)&quot; policy (dated 02/17) states:</td>
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### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Wentworth Rehab & HCC  
**Address:** 201 West 69th Street, Chicago, IL 60621

#### Summary Statement of Deficiencies

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<tr>
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<tr>
<td>F 580</td>
<td>Continued From page 5</td>
<td>F 580</td>
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<tr>
<td>F 584</td>
<td>Safe/Clean/Comfortable/Homelike Environment</td>
<td>F 584</td>
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<tr>
<td>SS=E</td>
<td>CFR(s): 483.10(i)(1)-(7)</td>
<td>5/24/19</td>
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**§483.10(i) Safe Environment.**

The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide:

- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
  - (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
  - (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

- §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

- §483.10(i)(3) Clean bed and bath linens that are in good condition;

- §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);
### F 584

Continued From page 6

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide a clean and sanitary environment for 10 residents (R2, R80, R87, R77, R140, R29, R41, R119, R188, R60) of 85 residents reviewed for environment.

Findings include:

On 5/19/19 during the initial facility tour, observed the following concerns:

At 10:58 AM, observed in R2, R80, and R87's shared bathroom, hanging from the wall grab bar at the toilet, one unlabeled/undated urinal. The urinal was not contained in a sanitary manner.

At 11:00 AM, observed at R77's bedside an enteral feeding pump on an IV (intravenous) pole. The pump, its' attached electrical cord and pole were heavily soiled with multiple areas of dried, hardened, tan fluids. Observed a 60cc (cubic centimeter) piston syringe placed in its plastic solution container with approximately 150cc of clear fluid. The unlabeled/undated solution container was stored on R77's dresser next to a television.

Wentworth Rehabilitation and Healthcare Center
Plan of Correction and Allegation of Compliance

F 584
483.10(i)(1)-(7)
Safe/Clean/Comfortable/Homelike Environment

Submission of this Plan of Correction by Wentworth Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the Survey Agency.

Corrective Actions taken for those residents alleged to have been affected:

- R2, R80, and R87 urinals were
At 11:05 AM, observed on R140's night stand, an unlabeled/undated 60cc piston syringe placed in its plastic solution container.

At 11:15 AM, observed at R29's doorway an isolation cart with signage indicating R29 was on contact isolation precautions. Observed in R29's bathroom a urinary drainage collection bag hanging from the grab bar at the toilet. The urinary drainage tubing and connecting catheter port were in contact with the floor, next to the toilet. During interview with V3 (Assistant Director of Nursing/ADON) at 11:18 AM in R29's room, V3 viewed R29's urinary collection bag tubing and catheter port lying on the bathroom floor next to the toilet. V3 stated "Oh no, that's not good; it's (the urinary equipment) touching the floor. I will dispose of that right away." V3 donned gloves, gathered the contaminated equipment and disposed it in R29's isolation trash container.

At 11:25 AM, observed at R41’s bedside an enteral feeding pump on an IV (intravenous) pole. The pump and IV pole were heavily soiled with multiple areas of dried, tan fluids. Observed R41’s call light cord lying on the bed, also heavily soiled with dried, hardened tan and brown fluids and debris.

At 11:26 AM, observed R119’s call light cord lying on the bed, the cord was heavily soiled with thick, dried tan and brown fluids and debris. During interview with V3 and V15 Licensed Practical Nurse (LPN) at 11:40 AM in R41 and R119’s room, both V3 and V15 observed R41 and R119’s soiled call light cords and R41’s soiled feeding pump/pole. V3 agreed the soiled equipment was unacceptable and said the items would be labeled and contained in a sanitary manner.

- R77 and R41 Feeding pump, electrical cord, and pole were cleaned.
- R77 and R140 Solution container was discarded.
- R29 Urinary Collection Equipment was discarded.
- R41 and R119 Call Light cords were cleaned.
- R188 and R60 over-the-bed tables were cleaned.

Actions taken to identify other resident that may have the potential to be affected are:

- Patient rooms were checked, no other cleanliness concerns were noted.
- No other facility residents affected

The measures the facility will take to ensure the problem will be corrected and will not reoccur.

- Employees have been in-serviced on Equipment Change Schedule Policy.

Quality Assurance plans to monitor facility performance to make sure corrections are achieved.

- A QA Tool was developed for overall cleanliness of patient rooms. The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145429

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 05/22/2019

**NAME OF PROVIDER OR SUPPLIER**
WENTWORTH REHAB & HCC

**STREET ADDRESS, CITY, STATE, ZIP CODE**
201 WEST 69TH STREET
CHICAGO, IL 60621

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<tr>
<td>F 584</td>
<td>Continued From page 8 cleaned. At 12:55 PM, observed R188's rolling over-the-bed table in which the tabletop was covered with multiple areas of dried fluid spills. On 5/20/19 at 1:59 PM, observed R60's rolling over-the-bed table in which the tabletop was heavily covered with multiple areas of dried fluid spills and bits of food. Requested Environmental Cleanliness policies, received and reviewed the facility's &quot;Equipment Change Schedule Policy&quot; (dated 10/2018). Policy states under &quot;Procedure: 5. IV Poles and Feeding Pumps: a. Clean IV poles and feeding pumps weekly and pm (as necessary). On 05/19/19 between 10:51 to 11:10am, R85's clothes were observed all over the floor in his room. R58, R78, R83, R126, R173 and R181's room were also noted with clothes stored on the bare floor and side tables. Clothes in transparent plastic bags were also observed stored on the bare floor. When this was brought to V11's (3rd floor Clinical Director) attention, V11 stated, &quot;This will be taken care of.&quot;</td>
<td>F 584</td>
<td></td>
<td>5/24/19</td>
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<tr>
<td>F 677 SS=E</td>
<td>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care to resident's needing assistance with ADL's</td>
<td>F 677</td>
<td>Wentworth Rehabilitation and Healthcare Center Plan of Correction and Allegation of</td>
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**NAME OF PROVIDER OR SUPPLIER**

WENTHORCH REHAB & HCC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

201 WEST 69TH STREET

CHICAGO, IL 60621

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 677</td>
<td>Continued From page 9 (Activities of Daily Living). This affects 4 residents (R20, R30, R176, R182) in the sample reviewed for ADL's. Findings include: 05/19/19 10:40 AM R176 was observed visibly wet while laying in bed. R176 stated, &quot;I need help. I'm wet.&quot; R176 was noted with smell of urine. R176's bed was also soaked with urine. 05/19/19 11:05 AM, R30 was observed with long finger nails. When asked about R30's long finger nails, V10 (Certified Nurses Aide/CNA) stated, &quot;R30's nails are supposed to be trimmed down by the CNA's.&quot; V10 explained that this wasn't her regular floor and that she was pulled to the floor to help out. Review of the plan of care for R30, initiated 6/26/2018, lists interventions that include but are not limited to, clipping finger nails as needed for focus on risk for self-harm. R30's ADL plan of care states R30 has impaired ADL skills. 05/19/19 11:42 AM, R20 was observed in the dining room with eyes closed. R20 was observed with overgrown facial hair and hair disheveled On 05/21/19, R20's MDS (Minimum Data Set) section G ADL's (Activities of Daily Living) dated 05/10/2019 was reviewed. R20 was coded 3/3 for personal hygiene, which indicated R20 needs extensive assistance with (two person physical assist) personal hygiene. On 05/21/19 at 1:58 PM, R176's MDS (Minimum Data Set) section G ADL's (Activities of Daily Living) dated 05/03/2019 was reviewed. R176</td>
<td>F 677 Compliance 483.24(a)(2) ADL Care Provided for Dependent Residents Submission of this Plan of Correction by Wentworth Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the Survey Agency. Corrective Actions taken for those residents alleged to have been affected: • Incontinence care was provide for R176. • R30 fingernails were clipped. • R20 and R182 facial hair trimmed Actions taken to identify other resident that may have the potential to be affected are: • Incontinent checks performed on other patients. • Fingernails and facial hair was checked on other patients. • No other facility residents affected The measures the facility will take to ensure the problem will be corrected and will not reoccur.</td>
<td>05/22/2019</td>
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**NAME OF PROVIDER OR SUPPLIER**

**WENTWORTH REHAB & HCC**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

201 WEST 69TH STREET
CHICAGO, IL 60621

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</tr>
</thead>
<tbody>
<tr>
<td>F 677</td>
<td>Continued From page 10 was coded 3/2 for personal hygiene, which indicated R176 needs extensive assistance with (one person physical assist) personal hygiene. Review of the plan of care for ADL's initiated on 03/29/2012 states R176 is reliant on staff supervision to complete ADL's and interventions include assisting R176 with completion of personal hygiene task as needed. 05/19/19 at 10:45 AM R182 was observed with overgrown facial hair. While in the Symptom Management Group, R182 stated, &quot;I will like to get this off.&quot; On 05/21/19, R182's MDS (Minimum Data Set) section G ADL's (Activities of Daily Living) dated 05/03/2019 was reviewed. R182 was coded 1/1 for personal hygiene, which indicated R182 needs supervision and set up help for personal hygiene. Interventions include assisting R182 with completion of personal hygiene task as needed. Review of plan of care for ADL's initiated on 01/01/2012 stated R182 requires supervision with ADL's assistance due to behavior issues. The facility policy presented titled &quot;Shaving the Resident&quot; dated 05/10 documents that the purpose is to remove facial hair and improve the resident's appearance and morale. The facility &quot;Job Description for Certified Nursing Assistant&quot; listed the essential functions that include but not limited to providing assistance with ADL's (Activities of Daily Living) to specific number of residents and/or as directed by the staff nurse. Making rounds to assure customers are safe and comfortable.</td>
<td>F 677</td>
<td>• Employees have been in-serviced on ADL care. Quality Assurance plans to monitor facility performance to make sure corrections are achieved. • A QA Tool was developed for ADL care. The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up.</td>
<td>5/24/19</td>
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<tr>
<td>F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer</td>
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</tbody>
</table>
Continued From page 11

CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity

§483.25(b)(1) Pressure ulcers.

Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to treat a pressure sore after identifying it and failed to notify a physician regarding a pressure sore for one resident (R354) out of 4 residents reviewed for pressure sores in a sample of 85.

Findings include:

R354 was a 62 years old resident admitted to the facility on 1/16/19 with diagnoses of End Stage Renal Disease, Cerebral Infarction, Dependence on Renal Dialysis, Urinary Tract Infection, Type 2 Diabetes Mellitus, Obesity and Difficulty in Walking.

R354’s initial nursing assessment (1/16/19) completed upon admission documents R354 did not have a pressure sore.

R354’s skin integrity care plan (dated 1/29/19)

Wentworth Rehabilitation and Healthcare Center
Plan of Correction and Allegation of Compliance

F 686 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE ULCERS

Submission of this Plan of Correction by Wentworth Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the Survey Agency.

Corrective Actions taken for those
Continued From page 12
documents apply barrier cream to areas exposed
to moisture/incontinence.

According to a progress note found in R354’s
medical record on 2/11/19 at 4:27 pm, R354 was
sent to a local area hospital due to lethargy, poor
appetite and poor fluid intake. R354’s medical
record from the receiving hospital dated 2/11/19
at 7:59 pm documents R354 was admitted to the
hospital with a sacral decubitus ulcer.

After being hospitalized for four days, R354 was
discharged (2/15/19) from the hospital and
readmitted to the facility. R354’s initial nursing
assessment upon readmission documented skin
breakdown on middle crease of R354’s buttocks,
stage 2. Progress notes in R354’s medical
record from 2/15/19 - 2/18/19 were reviewed and
do not document any assessments or
interventions from the wound department for the
documented stage 2 pressure ulcer. A complete
review of R354’s medical record was conducted,
including physician order sheets, Care Plan, and
assessment. There was no evidence in R354’s
medical record to show R354 received treatment
for the pressure sore between his buttocks.

According to progress notes (2/18/19), R354 was
again sent to a local area hospital on 2/18/19 at
7:00 PM due to a change in status. While in the
hospital a culture of the wound between R354’s
buttocks was taken and sent to the laboratory for
analysis (2/18/19). The result of the wound
culture returned positive for MRSA and Candida
Albicans.

On 5/21/19 at 10:49 am, V20 (Wound Care
Coordinator) was asked to provide treatment
administration record related to R354’s wounds.

residents alleged to have been affected are:

* R354 no longer reside at the facility

Actions taken to identify other resident
that may have the potential to be affected
are:

* An audit was conducted of all
residents’ skin.
* No other facility residents affected.

The measures the facility will take to
ensure the problem will be corrected and
will not reoccur.

* Nurses were in-serviced on the
facility’s changes in condition policy.
* Nurses were in-serviced on the
facility’s prevention and treatment of
pressure injury and other skin alterations
policy.

Quality Assurance plans to monitor facility
performance to make sure corrections are
achieved.

* A QA Tool was initiated to monitor
residents identified with a change in
condition resulting from a pressure ulcer
to prevent the delay in treatment,
notification family and notification of
primary care provider this will be initiated
by the Director of Nursing or designee.
* The results of the monitoring
completed under this Plan of Correction
are submitted to the QAPI Committee for
review and further follow-up.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</table>
| F 686        | Continued From page 13  
V20 stated there isn't one because R354 did not have a wound and no treatment was provided.  
V20 stated R354 had no wounds of any kind while in the facility. V20 stated R354 had old skin issues like scar tissue but never a pressure sore. V20 also stated the facility was applying barrier cream (zinc oxide) during R354's care to prevent a wound. When asked about the physician order dated 2/18/19 for zinc oxide, V20 stated the order for zinc oxide is a generic order that residents get as a preventative measure and not an actual wound treatment, V20 also stated zinc oxide is a house stock that the facility carries and is ordered often.  
On 5/22/19 at 3:58 PM, V20 stated that on 2/11/19 R354 was discharged to a local hospital and did not have a wound. When asked if she performed a wound assessment or treated R354 for the stage 2 ulcer noted on readmission on 2/15/19, V20 stated, "no" she did not because it was a weekend and she works during the week only. V20 stated the only treatment R354 received was zinc oxide, which is a routine preventive measure for residents at risk for developing pressure ulcers.  
On 5/21/19 at 10:33 am, V19 (Director of Nursing) stated if during care an area of concern is identified, the certified nursing assistant (CNA) notifies the floor nurse, who then assesses the resident and then the physician and family are notified. V19 also stated if a resident is admitted or readmitted to the facility, a skin assessment is performed by the admitting nurse. If the nurse has a concern with skin integrity, the doctor is notified and orders treatment are obtained and implemented. | F 686 | | 05/22/2019 |
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| F 686             | Continued From page 14  
On 5/21/19 at 2:12 PM, V34 (family member) stated she was never notified by the facility that R354 had a pressure ulcer. V34 also stated she found out from local hospital about R354's pressure ulcer.  
On 5/21/19 at 3:40 PM, V18 (Physician) stated if a pressure sore is identified by the facility, V18 or V18's nurse practitioner are notified by phone or in person since the nurse practitioner is at the facility five days per week. V18 also stated if he is not available then V18's group is notified of a new pressure sore, then orders are placed for treatment. On 5/22/19 at 1:24 pm, V18 stated it is highly unlikely a pressure sore would be identified and not treated. When asked if V18 was aware R354 had a pressure sore, V18 stated, "I can’t answer because if a wound was identified then wound service would see the resident and place an order for treatment. In addition, I (V18) or the nurse practitioner would be notified."  
The facility's "Prevention and Treatment of Pressure Injury and other skin Alterations" policy (dated 06/2018) states:  
3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.  
6. Complete a Comprehensive Pressure Injury Assessment for identified pressure injuries  
The facility's "Change of Condition (Resident)" policy (dated 02/17) states:  
To ensure that the resident's physician/physician on call/NP and responsible party is kept informed regarding the resident's change of condition. The | F 686 | | | |
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<tr>
<td>F 686</td>
<td>Continued From page 15 attending physician or physician on call/NP and responsible party will be notified with changes in a resident's condition.</td>
<td>F 686</td>
<td>Wentworth Rehabilitation and Healthcare Center Plan of Correction and Allegation of Compliance</td>
<td></td>
</tr>
<tr>
<td>F 689 SS=D</td>
<td>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that direct care staff followed facility protocol regarding close supervision of a resident with a recent history of a fall with injury, failed to follow the facility’s Fall protocol regarding fall investigations and monitoring of common day rooms on the Memory Care unit. This deficient practice affected one resident (R40) of three residents reviewed for falls in a sample of 85. Findings include: R40 resides on the Memory Care unit. R40's Admission Record documents, in part, the following medical diagnoses: Dementia, Abnormalities of Gait and Mobility, Lack of Coordination and Syncope/Collapse. R40's Fall Risk Assessment and Fall Care Plan document that R40 is a High Risk for falls.</td>
<td>F 689</td>
<td>5/24/19</td>
<td>Wentworth Rehabilitation and Healthcare Center Submission of this Plan of Correction by Wentworth Rehabilitation and Healthcare Center is not a legal admission that a deficiency exists or that this statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the Survey Agency. Corrective Actions taken for those</td>
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<td>689</td>
<td>Continued From page 16</td>
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The facility's Incident log documents that R40 had a fall on 5/13/19 at 8:24am. There is a second entry that is crossed out that documents R40 had a second fall on 5/13/19 at 9:30pm.

On 5/22/19 at 9:53am, V3 (Assistant Director of Nursing/ADON) indicated that R40's second incident was not concluded to be a fall because R40 was not found on the floor. R40's Fall Risk Assessment dated 5/13/19 at 9:35pm documented: Reason for assessment: e. Post Fall. This indicates that R40's second incident was concluded to be due to a fall. It is documented in R40's Progress Notes that R40 suffered a laceration on the forehead and was sent to a local hospital for treatment.

On 5/22/19 at 3:08pm, V3 confirmed that a complete fall investigation with root cause analysis was not initiated after R40's first fall on 5/13/19. V3 confirmed that a fall investigation should be performed after every fall as facility protocol. V3 submitted witness statements for R40's fall on 5/13/19. On one witness statement, the date of 5/13/19 was written over a date of 5/22/19. This was confirmed with V2 (Assistant Administrator).

On 5/19/19, V25 (Dementia Coordinator) left the day room R40 was sitting in unattended from 11:40am to 11:43am. V24 (Licensed Practical Nurse/LPN) entered the room at 11:44am and left immediately. The day room was left unattended from 11:44am to 11:46am. V24 confirmed that the day room she just exited had low functioning residents that required extensive assistance.

On 5/19/19 at 12:45pm, V25 left the day room residents alleged to have been affected:

- V25, V24, V31, and V32 were re-educated on proper supervision/monitoring of day rooms.

Actions taken to identify other resident that may have the potential to be affected are:

- Observations of supervision/monitoring of day rooms was performed with no non-compliance noted.
- No other facility residents affected

The measures the facility will take to ensure the problem will be corrected and will not reoccur.

- Employees have been in-serviced on Fall Protocol.
- Employees have been in-serviced on Supervision/Monitoring of day rooms.

Quality Assurance plans to monitor facility performance to make sure corrections are achieved.

- A QA Tool was developed for monitoring the supervision of day rooms and fall protocol. The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up.
<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
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</table>
| F 689 | Continued From page 17 | R40 was sitting in unmonitored from 12:45pm to 12:51pm. V24 re-entered the room at 12:52pm and left at 12:54pm. The day room was again left unattended from 12:55pm to 1:00pm. On 05/20/19 at 11:19am, V31 (Dementia Activity Personnel) left the day room where R40 was seated unattended from 11:19am to 11:20am. Residents were overheard yelling, "Sit down before you fall. Don't you get up." This surveyor entered the day room at 11:20am and noted R40 standing up next to the couch. V31 re-entered the day room briefly to tell R40 to not stand up, told R40 she was going to fall and assisted R40 to the couch. V31 again left the day room unattended from 11:20am to 11:21am. On 5/20/19, V32 (LPN) left the day room where R40 was seated unattended from 11:44am to 11:47am. V32 re-entered the room briefly and left it unattended from 11:47am to 11:48am. On 5/22/19 at 9:53am, V3 stated, "When (R40's) in the day room, she needs to be monitored more closely. She's going to move around and we need staff to move around with her." V3 indicated that R40 was transferred to a local hospital and upon return, the following was implemented: close monitoring (for R40) on the unit, make sure to assist her when she ambulates and monitor her close in common areas. R40's Fall Care Plan does not document the updated interventions. V3 indicated that it should be reflected in R40's Care Plan. On 5/20/19 at 12:40pm, V25 stated, "The expectation is that the day rooms are always monitored." V25 indicated that there is no policy
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<td>F 689</td>
<td>Continued From page 18 regarding monitoring of the day rooms but that it is a facility protocol that is followed.</td>
<td>F 689</td>
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<td>A facility Fall protocol regarding fall investigations was requested on 5/22/19 at 10:00am and 3:34pm. The protocol was not submitted as requested.</td>
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<td>A facility policy dated 2/2019 and titled, &quot;FALL MANAGEMENT PROGRAM&quot; documents: POLICY: While preventing all resident falls is not possible, it is the facility’s policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment.</td>
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<tr>
<td>F 880</td>
<td>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</td>
<td>F 880</td>
<td></td>
<td>5/24/19</td>
</tr>
<tr>
<td>SS=E</td>
<td>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</td>
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<td>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</td>
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<td>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

145429

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING __________

B. WING __________

**(X3) DATE SURVEY COMPLETED:**

05/22/2019

**NAME OF PROVIDER OR SUPPLIER:**

WENTWORTH REHAB & HCC

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

201 WEST 68TH STREET

CHICAGO, IL 60621

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<td>F 880</td>
<td>Continued From page 19 conducted according to §483.70(e) and following accepted national standards; $483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. $483.80(a)(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility. $483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</td>
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<td>F 880</td>
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F 880  Continued From page 20
infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its
IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record
review, the facility failed to follow standard
infection control practices with regards to proper
storage of a clean linen cart on the second floor
skilled unit. This failure has the potential to affect
all 55 resident's residing on this unit.

Findings include:

On 5/19/19 at 11: 26 AM, observed in R41, R119,
and R136's shared bathroom a clean linen cart
with briefs, gowns and sheets stored on the
shelves of the cart. The linen cart was uncovered,
with the shelved items exposed and pushed
against the toilet (making contact with the toilet).

On 5/19/19 at 11:40 AM, interview was conducted
with V3 (Director of Nursing/DON) and V15
(Licensed Practical Nurse/LPN) in R41, R119 and
R136's room. Both V3 and V15 observed the
uncovered linen cart stored against the toilet in
the resident's bathroom. V3 stated, "That cart
shouldn't be there" and pulled the cart out of the
bathroom. V3 stated to V15 to remove all of the
items stored on the cart and return to laundry for
washing.

Review of facility policy "Clean Linen Distribution
and Nursing Unit Storage" (revised 6/2018) states
"B. Procedure ... 7. Nursing will be responsible
for maintaining linen storage closets and carts ...
to assure linen is protected against

Wentworth Rehabilitation and Healthcare
Center
Plan of Correction and Allegation of
Compliance
F 880
483.80(a)(1)(2)(4)(e)(f) Infection
Prevention & Control

Submission of this Plan of Correction by
Wentworth Rehabilitation and Healthcare
Center is not a legal admission that a
deficiency exists or that this statement of
deficiencies was correctly cited. In
addition, preparation and submission of
this POC does not constitute an
admission or agreement of any kind by
the facility of the truth of any facts set
forth in this allegation by the Survey
Agency.

Corrective Actions taken for those
residents alleged to have been affected:

- R41, R119, and R136 linen cart was
  disinfected, and linen cleaned.

Actions taken to identify other resident
that may have the potential to be affected are:

- Observations of other linen carts
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| F 880             | Continued From page 21 contamination. 8. Nursing and Housekeeping will assure that linen is not being stored or hoarded in resident rooms. | F 880         | conducted, all were in the proper storage area.  
  • No other facility residents affected.  
  The measures the facility will take to ensure the problem will be corrected and will not reoccur.  
  • Employees have been in-serviced on proper storage on linen carts.  
  Quality Assurance plans to monitor facility performance to make sure corrections are achieved.  
  • A QA Tool was developed for proper storage of linen carts. The results of the monitoring completed under this Plan of Correction are submitted to the QAPI Committee for review and further follow-up. | 05/22/2019 |