

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0044149		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/16/2026	
NAME OF PROVIDER OR SUPPLIER GREEK AMERICAN REHAB CARE CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 220 N FIRST STREET , WHEELING, Illinois, 60090			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			01/23/2026	
	Annual Health Survey						
S9999	Final Observations		S9999			02/02/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210d)2)3)5)						
	300.1220b)3)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						
	d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure preventive measures were in place to prevent developing of new skin impairment and deterioration of current pressure ulcer, and failed to follow physician orders in wound management. These failures affect one (R144) resident in the sample of 31 reviewed for Pressure Ulcer/Wound Care Management and resulted in R144 developing a Stage 3 Sacral Pressure ulcer, with R144's wound needing debridement.		S9999				

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S9999	Continued from page 2 Findings include: R144 was re-admitted on 2/25/24, with diagnoses listed in part but not limited to Alzheimer's disease, Dementia, History of falling, Pressure ulcer of sacral region stage 3. Active physician order sheet indicated: Bilateral heel suspension boots for offloading every shift. Low air loss mattress. Use one flat sheet only every shift. Moisture barrier for incontinence care as needed every shift for skin prophylaxis. (specialized) cushion when resident is up in chair to protect skin integrity. Sacrum- clean with normal saline solution, apply Medi honey, cover with island dressing every day shift and as needed for MASD (Moisture Associated Skin Damage). The order of Medi honey did not indicate if it is gel, paste, or cream. Braden scale for predicting pressure sore risk, dated 12/2/25, indicated at high risk. Comprehensive care plan, dated 1/13/26, indicated R144 has stage 3 pressure ulcer to sacrum. On 1/14/26 revised by V28, Care plan Coordinator, R144 has actual impairment to skin integrity related to fragile skin, incontinence, and impaired mobility. 1/13/25 noted with stage 3 pressure ulcer of the sacrum. See care plan for pressure ulcer. No care plan developed for prevention of skin impairment. R144's progress note, dated 12/31/25, indicated, "upon assessment (R144) noted with MASD to the sacrum, wound measures 1.5cm x 1.0cm x 0.1cm with small serous exudate. Cleansed with normal saline solution, applied Medi honey and covered with island gauze." R144's Wound care physician assessment note, dated 1/13/26, indicated: "I have been asked to consult on this 91-year-old long term care who had MASD and today was found to have a stage 3 sacral pressure ulcer. Wound assessment indicated: Sacral is an acute stage 3 pressure injury ulcer acquired on 1/13/26 and has received a status of not healed. Initial encounter measurements are 0.7m x 0.6cm x 0.1cm. There is a small amount of serous drainage noted. Wound bed has 76-100% adherent yellow slough. Selective debridement with a total area debrided of 0.42sq cm was performed. Dermis and epidermis were removed along with devitalized tissue: biofilm and necrotic/eschar." On 1/13/26 at 11:00AM, V4, WCN (Wound Care Nurse), said R144 has an acquired stage 3 pressure ulcer on sacral area.		S9999				

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S9999	Continued from page 3 On 1/14/26 at 9:58AM, V4, WCN, and V22, CNA (Certified Nurse Assistant), were preparing R144 for wound care. R144 was lying on an inflated mattress, not a low air loss mattress, as indicated in physician order sheet (POS). V4 said the mattress is a (specialized) mattress. The mattress is inflated, hard, and firm on the lower part, and soft, with an irregular indentation on upper part of the mattress. No bilateral heel suspension boots as indicated in POS. V22 repositioned R144 on his right side. V4 removed the dressing on sacral area. Observed minimal serous sanguineous drainage. V4 said R44 has a Stage 3 pressure ulcer with 25% yellow slough and 75% granulation tissue. V4 cleansed wound with normal saline solution (NSS) and apply Medi honey gel to sacrum and covered with bordered gauze dressing. On 1/14/26 at 11:00AM, review of R144's medical records showed the following: Physician order of low air loss mattress and bilateral heel boot were not implemented as ordered. No skin care plan was developed for prevention of skin impairment. No care plan was developed when R144 was identified with MASD on 12/31/25. Care plan was not initiated until after the MASD deteriorated to a Stage 3 pressure ulcer. No weekly wound monitoring and documentation was done from 12/31/25 when MASD was identified. On 1/14/26 at 11:00 AM, V4 stated she only develops skin care plans and does weekly skin assessment/monitoring for stage 2 and above pressure ulcers. V4 added V28, Care plan coordinator, initiates the skin care plan if she missed it. V4 said she informed the IDT (Interdisciplinary Team) during morning meeting when R144 was identified with MASD. On 1/14/26 at 12:44PM, V28, Care plan Coordinator, said he was not aware R144 had MASD on 12/31/25. V28 said any changes in skin condition such as MASD on sacral area must be addressed in care plan to develop new interventions to enhance healing and prevent deterioration. On 1/14/26 at 10:30AM, V2, DON, said they only develop individualized care plan for actual pressure ulcers not other skin impairment such as MASD (Moisture Associated Skin Disorder) or skin tear. V2 was informed of R144's physician order of low air loss mattress and bilateral		S9999				

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S9999	Continued from page 4 heel suspension boots not being implemented. V2 said they don't have policy on following physician order. On 1/15/26 at 10:35AM, V2, DON, retracted her statement given 1/14/26. She said they develop individualized care plans for residents with MASD. Facility unable to provide policy on following physician order. Facility's policy on Skin condition monitoring reviewed 2/5/25 indicated: Policy: Nurse will complete comprehensive skin assessment on admission/re-admission, quarterly, annually or for significant change. A weekly skin condition check is completed by a nurse in conjunction with the resident's shower/bath schedule. All documentation related to the skin condition assessments and check will be documented. Procedure: 1. Skin condition check will be done by the nurse assigned to the resident on shower day. At a minimum of once a week. 2. Observe entire body for any broken areas, rashes, bruises, dry flaky skin, redness, irritation, wounds, etc. document findings in the skin progress notes. 3. Wounds will be measured weekly by the wound care nurse or an outside provider such as a wound physician. 4. Any new open wound areas, skin breaks or skin discoloration must be communicated to the resident/responsible party and physician by the assigned nurse. 11. All resident with wounds and residents at high risk of a wound are reviewed and discussed in weekly NAR meeting. Facility's policy on Care plan reviewed 8/19/25 indicated: Procedure: The care plan will be formulated in terms of problems, goals, and interventions. MDS, CAA and comprehensive assessments will be reviewed to identify possible problems, goals and interventions.	S9999					

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S9999	Continued from page 5 Significant change in condition/readmission: within 7 days of completion of the resident assessment, a care plan will be reviewed and updated by IDT. Care plan will be updated in the computer. When a new approach is added to the care plan, the day it is initiated will be placed at the beginning and electronically signed. (B)			S9999			