

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/20/2018
NAME OF PROVIDER OR SUPPLIER ALDEN ESTATES OF NAPERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1525 SOUTH OXFORD LANE NAPERVILLE, IL 60565		
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S 000	Initial Comments Annual Licensure and Certification survey and Complaint Investigation survey # 1874576/ IL104150 F558, F689, F690 and F868 were cited	S 000			
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a)b) 300.1210c) 300.3240a) (LICENSURE 1 OF 1) 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	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/10/18

Illinois Department of Public Health

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S9999	Continued From page 1 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET EVIDENCED BY:	S9999			

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S9999	Continued From page 2 Based on observation, interview and record review, the facility failed to conduct a comprehensive assessment to analyze the development and the progression of the facility acquired pressure injuries. The facility also failed to develop a plan of care based on the identified risk factors and co morbidities of the residents and to consistently implement the plan of care. This resulted in the development of (1) R183's "shearing wound" on the sacrum that progressed to an Unstageable (necrotic) pressure injury. (2) R97 Stage 2 pressure injury progressed to a Stage 4 and (3) R8 development of a sacral Stage 4. This applies to 4 of 8 (R183, R8, R97 and R114) resident reviewed for skin alteration in the sample of 27 residents. The findings include: 1. On July 17, 2018 at 11:44 AM, R183 was in bed lying flat in his back, family members were at bed side. R183 was noted with a gastrostomy feeding and with an indwelling catheter. R183 communicate in non-dominant language (Indian dialect) at 2:37 PM, R183 daughter explained, "We stays with him 24 hours so we can translate for him. They (staff) only come once per shift. We turn the light on but no one will come, we need to wait, most of the time 30 minutes or longer, that's our problem here. They do not have enough helper. He developed a big pressure ulcer while here in the facility. One on each buttocks." On July 18, 2018 at 9:15 AM, R 183 was noted in bed lying on his back, no positioning device	S9999			

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S9999	Continued From page 3 noted. R183 family member (brother in law) stated, "The staff comes only at the end of the shift to empty his catheter bag. We need to call them but most of the time we wait for a long time (30 minutes to an hour) before they come and help him (R183). He developed this big bedsore after he was admitted here. It is hard to get help here, they need more staff. No, they do not come or asked if he needed help. No, they do not turn him that's probably why he developed this black wound in his buttocks and it's getting worst, now it's bigger and it has a very strong rotten odor!" At 11:50 AM, R183 remains in the same position, no off- loading device was noted. The family members at bedside stated there was no staff that came to check and reposition him since 8:00 AM. R183's electronic admission record showed R183 was admitted at the facility on July 2, 2018 with hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting left non dominant side. The Minimum Data Set dated July 9, 2018 showed R183 needing extensive assistance with one staff assist with activities of daily living. R183's electronic skin progress notes presented by V3 (Wound Nurse) dated July 3, 2018 showed R183 was noted with 8.0 cm L (length) X 8.5 cm W (width) X 0.1 cm D (depth) reddened area on his coccyx. This wound is identified and documented as "shear wound". On July 17, 2018 skin progress notes showed that this progressed to an Unstageable pressure injury and with increased size to 12.0 cm L X 10.5 cm W with presence of 75 % slough (tan color).	S9999			

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S9999	Continued From page 4 On July 18, 2018 during wound assessment with V27 (Wound MD) at 12:00 PM, R183 was noted with necrotic area on the sacrum and on the left buttock and an open area on the right buttocks. These wounds has a very strong foul odor and with moderate amount of brownish drainage. V27 explained, "This is the first time I see R183. I was told it started as sheering, now it's Unstageable (black). I am recommending him to go to the hospital for surgery. It has a very foul odor. It smells like it's infected but we won't know that because there's no culture done." On July 20, 2018 at 1:00 PM, V3 explained that the especial mattress was not implemented until July 12, 2013. V3 also stated, that the facility does not evaluate residents for tissue tolerance (specific/individualized repositioning plan). During this week of the survey, the facility was unable to present any documentation that the facility assessed and evaluated R183's root cause for the development R183's pressure injury. The skin plan of care to turn and reposition every two hours was not consistently implemented and the identified risk factors were not address. 2. On July 17, 2018 at 10:40 AM, R97 was noted lying in bed on his back, with an indwelling catheter. R97's gastrostomy feeding was noted to be empty and the feeding pump/machine was beeping. Staff were observed passing by in R97's room but no one stopping by to respond to the alarm. R97 was noted in the same position (on his back) and the alarm going off until 1:00PM after V28 (Certified Nursing Assistant) was notified.	S9999			

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S9999	Continued From page 5 At 1:05 PM, V28 said, "We were in his room to clean him around 10:00 AM." V28 identified R97 as confused and totally dependent on staff with all of his activities of daily living and unable to reposition self. V28 verified that R97 was lying on his back and said, "As far as I know he does not have any pressure ulcer." The facility pressure injury log showed R97 has a Stage 4 on the sacrum. R97'S Minimum Data Set dated July 2, 2018 showed R97 was admitted at the facility on June 12, 2018 with diagnoses to include hypertension, urinary tract infection, malignant neoplasm of prostate and Cerebrovascular Accident. R97 was identified needing extensive assistance with two plus staff assist with transfers and positioning. On July 18, 2018 at 9:20 AM, R97 was in the room sleeping on his bed, lying on his back. No positioning device was noted. At 11:08 AM, V27 (Wound Doctor) was in the hallway. V27 stated, "This is the second time I saw him. I was told that upon admission he had had a Stage 2 pressure ulcer on his sacrum that deteriorated (R97's initial nursing assessment showed that this Stage 2 was 3.5 cm X 6.0 cm X 0.1 cm). . He was sent at the hospital and his wounds were debrided. R97's pressure sore is now Stage 4 with visible muscles. Well, in order to heal the wound they need to off load the area and reposition the patient at least every two hours. No, the wound is on his buttocks so they are not supposed to position him on his back. They should only be re positioning him from side to side." On July 19, 2018 at 9:40 AM, the Therapist were observed assisting R97 to sit at the edge of the	S9999			

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S9999	Continued From page 6 bed. While sitting at the edge of the bed with V29 (Physical Therapy Assistant) supporting R97, V31 (Nurse) was observed applying a dressing on R97's left shoulder wound. V31 claimed, "It's an old wound. I initially saw it Monday (July 16, 2018). There was no documentation found in R97's electronic records or presented as requested, that the doctor or family were notified, no treatment order was obtained and carried out. During treatment observation on July 19, 2018 at 10:22 AM with V3 (Wound Nurse) and V28 (Certified Nursing Assistant), R97's dressing was noted saturated with brownish drainage. V3 measured and described R97 wound as follows: Sacral area, Stage 4, muscles are visible. The wound was measured at 15 cm in length X 14 cm width x 4.5 cm depth with undermining from 7 o'clock through 4 o'clock deepest at 12 o'clock with 4 cm. With yellow slough at the center of the wound and the left shoulder blade wound measured at 3.0 cm x 7.3 cm. The most current skin care plan dated June 13, 2018 shows R97 has excoriation to buttocks. The interventions listed to avoid lying on back, position body with pillows/support devices and turn and reposition every two hours were not implemented on July17, 2018. There was no comprehensive assessment conducted by the facility to analyze the root cause of R97's pressure injury deterioration and to revise R97's plan of care based on his identified risk factors and co morbidities. On July 19, 2018 at 10:08 AM, R97 said, "I got 2 sores on my behind (buttocks) because instead of lifting me up, they drag me across the bed. Now, I have a new sore on my left shoulder. It	S9999			

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S9999	Continued From page 7 would be easier for them to just drag me across the bed. It hurts when they do that (drag). " 3. R8's Face Sheet documents the following pertinent diagnosis: multiple sclerosis, irritable bowel syndrome, osteoarthritis and osteoporosis. On 7/17/18 at 11:35 AM R8 was sitting in a wheelchair with bilateral heel boots on in the dining room. On 7/17/2018 at 1:52PM R8 was sitting in a wheelchair in the room with a mechanical lift pad underneath R8. On 07/18/18 at 9:08 AM while laying in bed R8 said staff keep me up in my wheelchair and do not help me reposition and when they lay me down they reposition me only once. They should do it more often. R8 said her pressure sore is not doing good. On 7/17/2018 at 3:30PM, R8 was asleep in bed. V8(Certified Nursing Assistant) said he is assigned to care for R8 today and does not know how long R8 has been laying down, but R8 was in bed upon the start of my shift which was 2 PM. On 07/19/18 09:01 AM V7(Restorative Nurse Supervisor) wheeled R8 to the room and V7 exited the room. R8 said" I push my self to the bathroom and wait for response from my call cord, I have accidents sometimes because I wait too long and that is not good for my butt sore or me. On 7/19/18 at 9:01 V11(Certified Nursing Assistant) was in the room. V11 said R8 was up in the wheelchair at the start of my shift which was 6 am this morning, the night staff got R8 up and put her in the wheelchair. V11 said R8 has not been toileted today. At this time R8 received	S9999			

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S9999	Continued From page 8 requested pain medicine and went to participate in an activity without being toileted. On 7/19/18 at 10:38 AM V11(CNA) and V12(CNA) took R8 to the room and placed R8 in bed. After the transfer V12 exited the room and V11 changed R8's incontinent brief which was heavily soiled. R8 had a pressure dressing to the sacrum area. V11 said R8's incontinent brief should be changed every 2 hours, because R8 urinates a lot in the morning. It was again confirmed by V11 that R8 has not been toileted today; hence R8 has been up in the wheelchair for more than 4 and a 1/2 hours. V3(Wound Care Nurse) entered the room to change the dressing for R8's stage 4 re-opened sacral wound. V3 said it just re-opened last week. V3 said possible causes for the wound to re-open are mobility issues, nutrition and incontinence. V3 said the wound care doctor examined R8 on 7/18/2018. Wound Care Evaluation Form dated 7/18/2018 written by the physician documents the following pertinent data, " has incontinence, reposition every 2 hours and as needed and provide bowel and bladder management. The wound description is stage 4 sacral re-opened pressure sore measuring 0.8 cm in length by 0.5cm in width by 0.3 cm in depth with excoriation to the peri-wound. Wound Care Assessment Data was reviewed. The assessment dated 3/9/2016 document a re-admission of R8 with the stage 4 sacral wound and the assessment dated 8/1/2017 documents the stage 4 sacral wound healed. Wound Care Evaluation Form dated 7/9/2018 documents the re-opening of the sacral wound.	S9999			

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S9999	Continued From page 9 Care Plan for Alteration in Skin Integrity initiated on 6/13/2018 states to keep skin clean and dry and turn and re-position every 2 hours as needed. Care Plan for bladder/bowel incontinence initiated on 9/7/2011 says staff to check and change in every 2 hours daily. On 7/20/2018 at 10:50AM, V27(Wound Care Physician) said sitting in incontinence for extended periods of time is not recommended for residents who are high risk for pressure ulcer development. It could potentially cause a re-opening and the facility should be re-positioning and off-loading R38. 4. The Admission Record dated July 17, 2018 documents R114 admitted on June 21, 2018 diagnoses to include Pressure Ulcers. R114's Brief Interview of Mental Status dated July 9, 2018 documents R114 as cognitively intact. On July 17, 2018 at 12:04 PM R114 sat in a wheelchair with an undated wrapped gauze dressing to the right lower extremity and foot. R114 stated she was admitted to the facility for treatment of several ulcers. R114 stated dressing changes are not done consistently every day as ordered. The Wound Care Evaluation Note dated June 25, 2018 documents R114 with Pressure Ulcers to the coccyx, right and left gluteal folds. The Wound Assessment Form dated July 3, 2018 documents R114 with venous wounds to the right anterior shin, right plantar heel, right lateral foot, right anterior lower leg and right fifth toe. R114's June 2018 Treatment Administration Record (TAR) does not document completed	S9999			

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S9999	Continued From page 10 treatments for Santyl ointment to right lower extremity ulcers and for Medihoney to right and left gluteal fold and sacral pressure ulcer on June 27, 2018. R114's July 2018 TAR does not document completed treatments for Medihoney to the right anterior leg ulcer on July, 10, 12, or 14, 2018. R114's July 2018 TAR does not document completed treatments for Medihoney to the right heel ulcer on July, 10, 12, 14, or 15, 2018. R114's July 2018 TAR does not document completed treatments for Santyl and Medihoney to the right and left gluteal fold ulcers on July, 6, 12, and 14-16, 2018. R114's July 2018 TAR does not document completed treatments for Hydro Blue Foam to the right lateral foot ulcer on July, 12 and 14, 2018. R114's July 2018 TAR does not document completed treatments for Santyl to the right ishium ulcer on July, 10, 12, 14-16, 2018. On July 19, 2018 at 2:27 PM, V3 (Wound Nurse) stated all treatments are documented and signed on the Treatment Administration Record at the time the treatment is completed. The Care Plan dated June 23, 2018 documents R114 with alterations in skin integrity due to multiple wounds with interventions to include provide treatments as ordered. The Medication Administration: General Guidelines dated March 2018 documents to record on each residents TAR immediately following administration of medications.	S9999		

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S9999	Continued From page 11 (B) (2 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	S9999			

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S9999	Continued From page 12 of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	S9999			

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(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) COMPLETE DATE
S9999	Continued From page 13 or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on interview and record review the facility failed to effectively manage abnormal laboratory results for a resident receiving anti-coagulants. This applies to 1 of 6 residents (R114) reviewed for anti-coagulant use in a sample of 27. This failure resulted in R114 being hospitalized with a diagnosis of Gastrointestinal Hemorrhage. Findings include: The Admission Record documents R114 admitted to the facility on June 21, 2018 with diagnoses to include Deep Vein Thrombosis of the right leg. R114's Order Summary Report dated June 1, 2018 through July 31, 2018 documents R114 receiving two blood thinners, Warfarin Sodium, 9 milligrams, (mg) beginning on June 22, 2018 and Enoxaparin Sodium, 40 mg every 12 hours, beginning on June 21, 2018. The Lab Results Report dated June 25, 2018 document R114 with an elevated Prothrombin Time of 39.8 seconds (normal range 20.2-30.8) and an elevated International Normalized Ratio (INR) of 3.77 (normal range 2.0-3.0). This lab report documents these elevated levels were reported to the facility on June 25, 2018 at 12:51 PM and does not indicate the physician was	S9999			

Illinois Department of Public Health

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S9999	Continued From page 14 notified. R114's Progress Notes dated June 25-26, 2018 do not document the physician was notified of the elevated levels. On July 19, 2018 1:43 PM V22 (Nurse) stated on June 28, 2018 R114 had blood in her stool at approximately 9 PM which V22 described as melena (dark tarry stools containing decomposing blood). V22 informed V23 (Physician) who provided orders to hold the blood thinners and to complete stat lab work. V22 stated, "I called the lab and they didn't show up. They called at 1 AM and they said they couldn't make it until 3 am because they didn't have staff. They didn't come until late, way after 3 am." V22 stated she did not inform V23 this lab work could not be completed stat. V22 stated on June 29, 2018 at approximately 7 AM R114 had a large amount of blood in her stool again and was sent to the hospital. The Lab Results Report dated June 29, 2018 document this lab work which was ordered stat on June 28, 2018 completed at 6 AM. The results document R114 with an elevated Prothrombin Time of 65.3 seconds (normal range 20.2-30.8) and an elevated INR of 6.21 (normal range 2.0-3.0). In addition this report documents R114's Red Blood Cell Count was 2.17 cells per cubic millimeter (normal 4.2-5.4), Hemoglobin 6.5 grams per deciliter (normal 12-16) and Hematocrit was 21.5 percent (normal 37-47). R114's Hospital History and Physical dated June 29, 2018 documents R114 with Gastrointestinal Bleed. On July 19, 2018 at 2:05 PM, V2 (Director of Nursing) stated anti-coagulant medications (blood thinners) are to be monitored per physician	S9999			

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S9999	Continued From page 15 orders and any abnormal results are called to physician for any recommended orders such as medication changes or further lab. V2 stated stat labs are to be completed in 4 hours and if that cannot occur the physician is to be notified. V2 stated, R114's abnormal laboratory results should have been called to V23 and V2 confirmed there is no evidence these abnormal results were called to V23. V2 stated physician notification is documented in the progress notes. On July 20, 2018 at 9:15 am V23 stated if he had been informed of R114's elevated lab from June 25, 2018 he would have adjusted the anti-coagulant dosing and ordered monitoring. V23 stated gastrointestinal testing was completed during V23's hospitalization with no significant findings. V23 confirmed the cause of the bleeding was from the anti-coagulants and stated, "Yes, it was preventable." V23 stated they should have notified a physician. The facility policy Coumadin (Warfarin) Monitoring Guidelines dated May 2017 documents all residents receiving Coumadin therapy will receive monitoring per physician orders. This policy further documents upon receipt of the results the physician will be notified. (B)	S9999			