Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: ______ B. WING ______	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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
S 000	Initial Comments Complaint investigation: 2297045/IL150846	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Licensure Findings 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)5) 300.3240 a) 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 a) Comprehensive Resident Care Plan. A	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat

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S9999	Continued From page 2	S9999		

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 300.3240 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 regulations were not met evidenced by:

Based on observations, interviews, and record reviews, this facility failed to consistently monitor, assess and implement pressure relieving interventions to prevent the development of a facility acquired pressure ulcer. This affected 1 of 3 residents (R1) reviewed for high-risk skin breakdown and pressure ulcer prevention. This failure resulted in R1 developing a facility acquired unstageable pressure ulcer to left heel.

Findings include:

On 9/17/22 at 10:30am, R1 was observed lying on left side in bed.

On 9/17/22 from 10:30am until 12:35pm, this surveyor monitored R1 every 5 minutes. This surveyor did not observe any staff turn/reposition or provide incontinence care during this timeframe.

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S9999	Continued From page 3 On 9/17/22 from 12:35pm until 1:30pm, this surveyor made continuous observations of R1 at R1's bedside. R1 was observed to be lying on left side in bed. R1 was unable to reposition self. R1's legs are contracted and R1 was able to make brief slight movement with left thigh. R1's upper extremities or head were not observed to make any movement. R1 was observed to have a low air loss mattress with the cord wrapped around the right upper side rail and dangling one inch above the floor at the head of bed; not plugged in to wall outlet. R1 was not observed wearing heel protectors. On 9/17/22 at 1:30pm, V6 CNA (certified nurse aide) and V7 CNA entered R1's room to provide care to R1. R1 was observed to have a bowel movement. When R1 was turned towards the right, the sheet underneath R1 was observed to be saturated and had yellowish discoloration outlining the wet area. On 9/19/22 at from 1:45pm - 2:30pm, this surveyor observed R1 lying in bed with head and upper back leaning towards the right siderail. R1 was observed to have some movement to upper back, but returned to same location on bed. On 9/19/22 at 2:30pm, this surveyor observed V13 (nurse) and CNA provide incontinence care to R1. The sheet underneath R1 was observed to be saturated and had yellowish discoloration outlining the wet area. On 9/19/22 at 9:33am, V2 DON (director of nursing) stated that staff should be checking residents for the need for incontinence care every 2 hours and as needed. V2 stated that residents should be turned every two hours and as needed while in bed. V2 stated that it is important to have	S9999		

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S9999	Continued From page 4	S9999		

the resident's specialty mattress plugged into wall outlet to prevent further skin breakdown and promote wound healing.

On 9/19/22 at 11:57am, V12 (wound care coordinator) stated that R1 has a foam dressing on right heel to protect heel from skin breakdown. V12 stated that R1 is contracted. V12 stated that R1 has a left heel pressure ulcer, facility acquired, initially it was a blister that opened. V12 stated that R1 was admitted with a sacral pressure ulcer that has not healed as of yet. V12 stated that interventions in place for R1 includes: low air loss mattress, protein supplement, turn/repositioning every 2 hours and as needed, contracture pillow between lower legs to prevent pressure issues, wedges, and offloading with heel protectors or pillow to keep feet off bed. V12 stated that R1 is on a total air loss mattress with a topping with bolsters on sides. V12 stated that V12 does not know why R1's air mattress was not plugged in. V12 stated that the nurse should have assessed the air mattress to ensure it was functioning properly. V12 stated that R1 is a heavy wetter, staff should be checking R1 more frequently for incontinence care. V12 stated that residents should be turned every 2 hours and as needed. V12 stated that it is important for staff to implement preventive measures that the wound care team has identified to prevent further skin breakdown. V12 acknowledged it is difficult to state R1's wounds are unavoidable when staff are not implementing preventive measures consistently.

Review of R1's braden score for predicting skin breakdown notes R1 is at severe risk of skin breakdown.

Review of R1's wound physician note, dated

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S9999	Continued From page 5	S9999		

9/13/22, notes R1 with a stage 4 sacral pressure ulcer. R1's wound measures 4.2cm (centimeters) x 3cm x 1.5cm, with 1cm undermining from 9-3 o'clock. Wound with 50% granulation tissue, 25% necrotic tissue, and 25% slough. R1 also has a facility acquired unstageable pressure ulcer to left heel, measuring 5.8cm x 5.8cm x 0.2cm, 100% necrotic tissue. Wound related exam noted musculoskeletal functional status-total care, bowel and bladder incontinence, and weakness of all extremities. Preventive measures: avoid bony prominence under direct pressure, provide stage appropriate mattress, offload heels with heel protectors or pillow, and reposition in bed per facility protocol.

Review of R1's MDS (minimum data set), dated 7/20/22, notes R1 is totally dependent on 2 staff members for bed mobility, transfers, and toileting.

Review of R1's care plan notes R1 with an alteration in skin integrity, pressure ulcers sacrum and left heel. Interventions identified includes: educate resident and/or family regarding pressure ulcer/injury management, elevate heels off bed, pressure reduction foam mattress, pressure redistribution support in bed, turn and reposition every 2 hours and as needed.

Review of this facility's prevention and treatment of pressure injury and other skin alterations policy, dated 03/02/2021, notes to implement preventative measures and appropriate treatment modalities for pressure injuries through individualized resident care plan.

B

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S9999	Continued From page 6	S9999		

Continued From page 6

2 of 2 Licensure Findings

300.1210b)
300.1210d)6)

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These regulations were not met as evidenced by:

Based on observation, interviews, and record review, this facility failed to develop and implement a plan to keep a staff dependent resident from an avoidable fall incident. This failure affected 1 of 3 residents (R1) reviewed for falls. This failure resulted in R1 falling out of bed, sustained a laceration to right cheek, and required transport to the hospital for further

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S9999	Continued From page 7 evaluation and treatment. Findings include: On 9/17/22 at 10:30am, R1 was observed lying on left side in bed. R1 was not observed to be in a low bed. On 9/17/22 from 10:30am until 12:35pm, this surveyor monitored R1 every 5 minutes. This surveyor did not observe any staff turn/reposition or provide incontinence care during this timeframe. On 9/17/22 from 12:35pm until 1:30pm, this surveyor made continuous observations of R1 at R1's bedside. R1 was observed to lying on left side in bed. R1 was unable to reposition self. R1's legs are contracted and R1 was able to make brief slight movement with left thigh x 2 during this observation. R1's upper extremities, torso, or head were not observed to make any movement. On 9/19/22 at from 1:45pm - 2:30pm, this surveyor observed R1 lying in bed with head and upper back leaning towards the right side rail. R1 was observed to have some movement to upper back, but returned to same location on bed. On 9/17/22 at 2:15pm, V4 (wound care nurse) stated that R1's low air mattress alternates pressure every 15 minutes. On 9/19/22 at 11:57am, V12 (wound care coordinator) stated that V12 was informed on 8/26/22 that R1 had fallen. V12 stated that V12 assessed R1 after fall for any skin issues. V12 stated that it does not make sense how R1 could have fallen. V12 stated that R1's oxygen	S9999		

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S9999	Continued From page 8	S9999		

concentrator is positioned on the left side of bed near head of bed. V12 stated that R1 is able to make slight movements. V12 stated that if R1 weighed less and was able to make more than slight movement, it would be possible to have the air mattress' alternating pressure slide R1 close to edge of bed and potentially fall from bed.

On 9/19/22 at 1:00pm, V3 ADON (assistant director of nursing) stated that V3 was notified R1 had fallen. V3 stated that V3 spoke with V10 (nurse), V10 stated that he was alerted by another staff member that R1 was on the floor. V3 denied interviewing V7 CNA (certified nurse aide) regarding this incident. V3 stated that when V10 reached R1's room, R1 was in bed. V3 stated that V10 did head to toe assessment, R1 had a facial laceration. V3 stated that V3 instructed V10 to call physician and R1's family. V3 stated that V3 is the back up to V8 (restorative nurse/falls coordinator). V3 stated that the interdisciplinary team was involved informally to come up with intervention as a team to prevent further falls. V3 stated that initially V3 thought R1 had a seizure, requested evaluation for seizures in emergency room. V3 stated that the hospital did not evaluate for seizure activity. V3 stated that when R1 returned to this facility, V3 requested physician order keppra level; level was normal and seizure activity was unlikely cause of fall. When questioned how R1 fell when R1 was last seen 10 minutes prior lying in center of bed and air mattress' alternating pressure setting changes pressure every 15 minutes, V3 is unable to provide an answer.

On 9/19/22 at 1:15pm, V7 CNA (certified nurse aide) stated that V7 was assigned to R1 on 8/26/22. V7 stated that V7 turned R1 onto right side facing the door. V7 stated that at 11:20am,

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S9999	Continued From page 9	S9999		

V7 saw V10 (nurse) giving R1 medicine, informed V10 she was going to break. V7 stated that probably V10 repositioned R1 again. V7 stated that upon returning from break, V7 was feeding another resident when V7 was informed R1 had fallen out of bed. V7 stated that V7 does not know how R1 could have fallen out of bed. V7 stated that R1 moves around in bed. V7 stated that R1 is not able to move arms or legs, R1 is able to move trunk.

On 9/19/22 at 1:27pm, V10 (nurse) stated that V10 was notified by the Covid-19 testing team that R1 was on floor. V10 stated that they did medication pass and suctioned R1, when he left, R1's body was positioned in the middle of bed. V10 stated that R1's head of bed was raised, body midline, and knees pointing towards window. V10 denied repositioning/turning R1 when V10 was providing care to R1.

Review of R1's fall documentation, dated 8/26/22, 1cm (centimeter) laceration under right eye. R1 was observed on the floor between her bed and window. R1 was on her left side facing the window and contracted. R1 was wearing a gown with the tie secured, R1 was barefoot and had a brief on that was clean and dry. Bed was in the lowest position with air mattress inflated. There was no clutter in her room and the lighting was adequate. R1 was last observed 10 minutes prior to incident and was in the middle of the bed.

Review of R1's medical record, dated 8/26 at 12:40pm, V10 (nurse) noted: R1 fell off the bed and sustained a 1cm laceration to the lower right eye. Physician notified, R1 ordered to be sent to the hospital for further evaluation.

Review of R1's hospital medical record, dated

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S9999	Continued From page 10 8/26/22, notes R1 presented to the hospital after an unwitnessed fall. R1 is contracted, unable to ambulate. Unknown how R1 fell. Small laceration noted to R1's right cheek. Per this facility's documentation, R1 in a persistent vegetative state. Review of R1's falls care plan notes R1 is at risk for falls related to seizure disorder. Interventions identified: on 10/28/21-use low bed. B	S9999		