| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6014500 | A. BUILDING: _____ B. WING _____ | C 06/21/2022 |

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| ALDEN ESTATES OF NORTHMOOR | 5831 NORTH NORTHWEST HIGHWAY CHICAGO, IL 60631 |

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| S 000 | Initial Comments<br><br>Complaint Investigation 2283437/IL146471 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1210 b)<br>300.1210 d)5)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>following and shall be practiced on a 24-hour, seven-day-a-week basis:<br>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.<br><br>These requirements are not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to assess a resident (R1) who was at high risk for developing a pressure ulcer, and failed to follow physician orders for wound care treatment for (R1 and R2) in the sample of five residents reviewed for pressure ulcer. These facility failures contributed to R1 developing a stage 3 pressure ulcer.<br><br>Findings include:<br><br>1. R1's medical record face sheet documented R1 was admitted 6/12/2019. Diagnosis listed includes, but id not limited to, Parkinson's Disease, Epilepticus seizures related to external causes, not intractable, without status epilepticus, Diaper Dermatitis, Pressure Ulcer of right buttocks stage 4, Anxiety Disorder, Gastro-Esophageal Reflux Disease without Esophagitis, Primary open-angle Glaucoma and unspecified Dementia without behavioral disturbance. R1 was placed on Hospice care on 5/10/22. | S9999 | | |

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| S9999 | Continued From page 2<br><br>On 6/07/22 at 12:53pm, R1 was observed in bed lying on R1's left side. The repositioning schedule posted on the side of the bed showed R1 should be repositioned on R1's back side at 12:00pm. Surveyor showed this to V7, LPN (Licensed Practical Nurse). V7 stated, "The CNA (referring toV4) should have followed the turning schedule." V4, who was standing at R1's bedside, asked R1 if R1 was in pain. R1 replied, "No, I am not in pain".<br><br>During the same observation, R1 was noted with an open pressure ulcer with serosanguinous drainage in the sacrum area that was not identified or assessed until the surveyor insisted on observing the site. V7 (Licensed Practical Nurse) told the surveyor the sacrum wound had been healed. V7 did not know R1 had a pressure ulcer on the sacrum. V7 stated, "I did not know (R1) had a pressure ulcer on the sacrum because I float to different floors." The surveyor then asked V7 to measure the wound and stage the site. R1's sacrum pressure ulcer, measured: length 5cm x 4.5cm width x 1cm depth. V7 then checked the electronic treatment record. V7 cleaned the pressure ulcer with normal saline, applied zinc ointment, and covered with a foam dressing to the sacrum (7x7cm/Centimeter), without notifying V15 (Physician) or V12, (Wound care physician) for an order. R1's treatment order showed there was no order for the sacrum pressure ulcer, and the treatment applied was for the ischium. V7 stated, "That was the only treatment ordered" The surveyor showed V7 the treatment order was for the right ischium.<br><br>On 6/07/22 as at 4:00pm, the facility could not present a treatment order for the sacrum, or the assessment documentation. V2 stated all treatment orders must be ordered by the | S9999 | | |

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| S9999 | Continued From page 3<br>physician.<br><br>On 6/08/22 at 3:16pm, V2 (Director Of Nursing/DON) stated, "I was confused yesterday when you asked me about the treatment order. There should be a dressing order for wound treatment and the nurses are expected to match the dressing with the order. The Wound care physician, or the primary physician should be notified before any dressing is applied." V2 presented a treatment order sheet, dated 6/07/2022 timed 3:59pm for R1, stating that was the order V12 gave yesterday when she contacted V12. V2 stated no wound should be left uncovered unless it was ordered. V2 explained the wound was a newly opened pressure ulcer, and it should have been covered with a protective preventative dressing, followed by a call to the physician.<br><br>On 6/09/22, at 9:26am, surveyor asked V12 (Wound Care Physician) about R1's pressure ulcer. V12 stated, "I saw (R1) two months ago. (R1) had a wound on the buttocks and the wound had healed." V12 further stated, "(V2) called me yesterday about a new wound, and I asked them to apply Medi-honey to the pressure ulcer." V12 stated, "According to (V2), it was not that bad (referring to the pressure ulcer wound), therefore there was no need to send (R1) to E.R (Emergency Room)". V12 stated, "(R1) is now on Hospice comfort care." V12 stated wound care is not to heal the pressure ulcer now, but most of the care now is comfort care because of other co-morbidities. V12 stated, "If (R1) is in pain, there is no need to turn (R1) every two hours, but if possible, we (referring to facility staff) should do it (referring to the repositioning)."<br><br>V12 stated, "Due to malnutrition, these residents | S9999 | | |

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| S9999 | Continued From page 4<br>can have pressure ulcers. (R1) has malnutrition, and can easily get a pressure ulcer. These residents can have fluctuating blood pressure and some of them develop Kennedy ulcers."<br><br>2. R2's medical record face sheet documented Methicillin Resistant Staphylococcus Aureus, Infection As The Cause Of Diseases, Acute Respiratory Failure With Hypoxia,Pneumonia, Unspecified ,Parkinson's Disease, Unspecified Dementia Without Behavioral Disturbance , Type 2 Diabetes Mellitus Without Complications,Chronic Atrial Fibrillation, Pressure Ulcer Of Sacral Region, Stage 3,Dysphagia, Unspecified Falls, Pressure Ulcer, Chronic Cystitis Without Hematuria, Anxiety Disorder, Unspecified Long Term (Current) Use Of Anticoagulants, Benign Prostatic Hyperplasia With Lower Urinary Tract Symptoms, Essential (Primary) Hypertension.<br><br>On 6/07/22 at 11:54am, surveyor observed R2 in a bed wet with urine. Surveyor observed R2 trying to get out of bed. R2 stated to the surveyor "Help". The surveyor called V5, CNA (Certified Nursing Assistant), who identified self as the direct caregiver for R2 to assist R2 with incontinence care. During the incontinence care, R2's wound at the sacrum was noted without a dressing, exposing the wound to the urine and bowel movement noted on the disposable incontinent pad. Wound noted with serosanguinous drainage. Surveyor asked V5 when was the last time R2 had incontinence care. V5 replied V5 had not been able to check on R2 during the shift. Surveyor asked V5 what time did you start your shift? V5 stated her shift is 7am to 3pm. V5 stated the night shift staff did the last incontinence care because V5 had been busy with another resident. | S9999 | | |

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| S9999 | Continued From page 5<br><br>On 6/07/2022 at 12:07pm, V6, RN (Registered Nurse), came into R2's room identifying self as the nurse for R2. V6 stated, "(R2's) wound should not be left uncovered. There should be a treatment dressing over the wound as ordered all the time." V6 stated, "I should have been notified when it (referring to treatment dressing) came off." V6 further stated, "I was not notified by the CNA staff that the dressing was not in place on the wound, so that "boo-boo" (referring to stool) and the urine would not get into the wound which will not help in healing". V6 stated, "We (referring to facility nurses) have to remind the CNAs to let the nurses know when a dressing comes off any wound area."<br><br>The facility Prevention and Treatment of Pressure Injury and Other Skin Alterations, dated 3/02/21, stated the policy is to identify the presence of pressure injury and/or other skin alterations, implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. Listed procedure includes but not limited to at least daily, staff should remain alert for potential changes in the skin condition during resident care<br><br>(B) | S9999 | | |