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	IL6014328	A. BUILDING: _____ B. WING _____	05/18/2023

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DIMENSIONS LIVING PROSPECT HTS	700 EAST EUCLID AVENUE PROSPECT HEIGHTS, IL 60070

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)5) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. These Requirements were Not Met as evidenced by: Based on observation, interview, and record review, the facility failed to implement interventions according to resident's plan of care in preventing the development of a pressure ulcer for one (R13) of two residents in the sample of 21 reviewed for pressure ulcers. This failure resulted in R13's intact skin developing moisture associated skin damage on the left buttock which progressed to a Stage 4 pressure ulcer.	S9999		

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S9999	Continued From page 2 Findings include: R13 is an 84-year-old female, admitted in the facility on 09/30/22 with diagnoses of Pressure Ulcer of Sacral, Stage 4, Neurocognitive Disorder with Lewy Bodies and Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. R13's POS (Physician Order Sheet) dated 04/14/23 recorded: Left buttock: Apply skin prep to surrounding skin. Cleanse with normal saline. Pat dry. Hypochlorous Acid Solution 0.05% and cover with gauze island with border dressing once daily one time a day for Stage 4 pressure wound of the left buttock. R13's Wound Notes documented the following: 08/19/22 - Non pressure wound of the Left Buttock full thickness Etiology: Moisture Associated Skin Damage (MASD) Wound size - 2.5 x 3.0 x 0.1 cm (centimeters) Recommendations: Return to bed after every meal to limit sitting time and facilitate wound healing. 10/06/22 - Unstageable (due to necrosis) of the left buttock full thickness Etiology: Pressure Wound size - 3.0 x 4.0 x not measurable cm. Wound progress: Deteriorated. Additional Wound Detail: Wound originally due to moisture associated skin damage. Deteriorated and found to have MRSA (Methicillin-resistant Staphylococcus aureus). Now Unstageable. Recommendation: Keep patient out of chair until wound improves. 11/18/22 - Stage 4 pressure wound of the left	S9999		

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buttock full thickness
Etiology: pressure
Wound size - 3.0 x 3.3 x 2.0 cm.
Recommendation: Keep patient out of chair until wound improves.

On 05/15/23 at 11:00 AM, R13 was observed sitting in her wheelchair in the dining room. R13 is alert, verbal but unable to state if she has wound on the lower back when asked. She was observed in the dining room until 1:50 PM when she was put back into bed. At 4:50 PM until 6:00 PM, she was again observed up in her wheelchair in the dining room, eating dinner.

On 05/17/23 at 12:49 PM, R13 was observed in the dining room sitting in her wheelchair. V8 (Certified Nurse Assistant/CNA) was asked regarding R13. V8 stated, "I am her regular CNA. She has pressure ulcer on the left buttock and on the sacrum. She is usually up in the wheelchair at 7:30 AM until 10:00 AM, then to bed. She stayed in bed for two hours. She is up again at 11:30 AM for lunch and put to bed around 1-1:30 PM. This is her routine. She is wearing incontinent brief and uses the toilet. I check her for incontinence every two to two and a half. At 1:17 PM, R13 was brought to the bathroom by V8 for incontinence care. R13's incontinent brief was observed moderately soaked with urine. V8 stated that she changed her (R13) brief at 10 AM. V8 used disposable wipes to clean R13's peri area and buttocks then put on her brief. V8 did not apply any skin protective cream on R13's peri area and buttocks prior to securing her (R13) brief. Subsequently, she (R13) was transferred back to bed.

On 05/17/23 at 1:25 PM, wound care was observed on R13 provided by V6 (Registered

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Nurse, RN). Her (R13) pressure ulcer on the left buttock is like the size of a dime, wound bed appeared red to purplish in color, with measurements of 1.4 cm x 2 cm x 1.3 cm. According to V6, "She acquired her left buttock pressure ulcer in the facility on 08/19/22, started as MASD due to her being wet often. She needs to be checked and changed three to four times in the morning, like every two hours. Her MASD became Stage 4. Interventions in preventing pressure ulcer are repositioning; frequent toileting; wheelchair cushion; incontinence care every two hours. She should be sitting up for meals and put to bed after meals."

On 05/17/23 at 9:48 AM, V3 (Acting Director of Nursing) was interviewed regarding R13 and pressure ulcer on the left buttock. V3 verbalized, "She has a pressure ulcer on the left buttock, Stage 4, facility acquired, was identified on 08/19/2022, as non-pressure wound due to MASD. On 10/06/22, the left buttock MASD became Unstageable due to necrosis. On 11/18/22, the Unstageable left buttock pressure ulcer became Stage 4. It started as MASD caused by wet diaper or not applying moisture skin barrier. Staff has to check residents for incontinence care at least every two hours, more often. Change incontinent brief when needed. She always sits in the wheelchair, eats breakfast in the dining room, if she is on therapy, therapy takes her. She eats lunch in the dining room. She needs repositioning; offload wounds."

V11 (Wound Doctor) was interviewed on 05/17/23 at 02:17 PM regarding R13. V11 stated, "It was an acquired pressure ulcer on the left buttock, started as MASD, now its Stage 4. Cause is moisture from incontinence. In providing incontinence care, clean resident in a timely

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manner, follow whatever protocol in place, turn in a timely manner. Apply protective barrier cream which could be a part of incontinence care. Keep her out of chair since wound is improving."

Weekly wound round documentation dated 05/11/23 recorded R13's left buttock Stage 4 pressure ulcer measures 1.5 x 1.3 x 1.4 cm, undermining/tunneling at 2.5 cm at 1 o'clock 5. Progression/Interventions: 6a. Additional information: Keep patient out of chair until wound improves; offload wound; turn side to side in bed every 1-2 hours if able.

R13's care plan related to current medical/physical status. Pressure ulcer on sacrum on admission.
08/19/22 - pressure ulcer on left buttock
Interventions/Tasks:
Offload the buttocks, put her back to bed after meals on her sides as much as possible (02/06/23).
Incontinence care with incontinent brief changes-apply skin protective cream to peri area and buttocks after toileting (02/06/23).

Facility's policy titled "Pressure Ulcer/Skin Integrity" revision date 4/2022 documented in part but not limited to the following:
Policy:
Based on the comprehensive assessment of a resident, (name of group communities) will ensure:
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
A resident with pressure ulcers receives necessary treatment and services, consistent with

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S9999	Continued From page 6 professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6) 300.1810f) 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.	S9999		

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S9999	Continued From page 7 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. 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: 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. 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. Section 300.1810 Resident Record Requirements f) An ongoing resident record including progression toward and regression from	S9999		

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S9999	Continued From page 8 established resident goals shall be maintained. These Requirements were Not Met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their policy and procedures for fall prevention by not consistently assessing risks for falls, not ensuring fall interventions were implemented, not implementing effective fall interventions for residents experiencing multiple falls, and not providing adequate supervision for high risk fall residents who required increased supervision. This failure applied to two (R122 and R274) of four residents reviewed for falls and resulted in R274 sustaining a left femur fracture. Findings include: 1. R274 is a 93-year-old male who originally admitted on 1/27/23 and currently resides in the facility. R274 has multiple diagnoses including but not limited to the following: left femur fracture, respiratory failure, CHF, COPD, need for assistance with personal care, unsteadiness on feet, difficulty in walking, and HTN. Per hospital discharge records dated 1/27/23, R274 was admitted to the skilled nursing side of the facility from assisted living due to weakness and gait abnormalities secondary to COVID-19 pneumonia. Per facility incident report dated 2/10/23 states in part but not limited to the following: Assisted living nurse reported that resident was found in front of his former room in assisted living lying on the floor. Writer immediately went to check on	S9999		

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resident, noted resident lying on left side. Assisted to wheelchair with two staff. Asked resident what happened, "I was trying to get my keys to open the door and I lost my balance." Noted skin tear on left knee and verbalized pain on the left hip. Resident sent out to hospital with the paramedics. Mobility: ambulatory with assistance. Summarize the post-fall findings: Resident lost his balance while opening his assisted living room. Left the skilled unit without notifying staff. New fall prevention interventions to be implemented as a result of the assessment: notify staff if needing to leave the unit.

Per hospital records with admission date of 2/10/23 show R274 was admitted with a left hip fracture.

On 5/15/23 at 10:15AM, it was observed that R274's room is down the hall, multiple rooms away from the nursing station.

On 05/17/23 at 10:23AM, V6 (Registered Nurse/RN) was interviewed regarding R274's functional status and care. V6 said R274 was a previous resident of our assisted living side and came here for therapy. R274 is currently in a wheelchair and can move independently in his wheelchair. He needs assistance with ambulating and transferring because he is unsteady. He does attempt to get up unassisted especially when he needs to go to the bathroom. We try and keep him in a common area because he needs increased supervision. He has periods of confusion, and sometimes he's hard to understand.

It is to be noted that R274 had a fall on 4/12/23 and 4/28/23 in his room.

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S9999	Continued From page 10 At 2:59PM, V3 (Director of Nursing/DON) was interviewed regarding R274 fall on 2/10/23. V3 said R274 ambulated with his walker to his old apartment on the assisted living side of the facility. The nurse covering the assisted living side found him on the floor outside of his old apartment. He walked off the unit without informing anyone or anyone noticing him. R274 is confused and forgetful and did need increased supervision at the time of his fall. The intervention put in place at this time was for R274 to notify the staff when leaving the unit. Attempted to interview V19 (former employee) and V20 (Certified Nursing Assistant/CNA) on multiple occasions but was unable to get a hold of during course of survey. R274's care plan with initiation date of 1/27/23 states, in part but not limited to the following: Focus: Actual/at risk/ and/or potential for complications with or falls r/t current medical/physical status. Has medications/diagnoses that can affect fall risk. Patient with unsteady gait. Goals: Will be free of serious injuries r/t falls through next review date. Will have reduced risk for falls with stated interventions through next review date. Interventions: Frequent checks and toilet him if needed, encourage fluids, encourage him to stay in common area if not sleeping date initiated 4/28/23. Check for unmet needs: pain, toileting, hunger, thirst, temperature- date initiated 2/10/23. Reinforce need to use call light to request assistance- date initiated 2/10/23. Frequent checks in the afternoon, offer different seating positions, encourage fluid intake during all interactions- date initiated 4/13/23.	S9999		

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S9999	Continued From page 11 R274 MDS (Minimum Data Set) dated 2/10/23 states, in part but not limited to the following: Staff assessment for mental status: short term memory indicated a memory problem. Activities of daily living assistance: limited assistance with transferring and walking in corridor. Facility policy titled Accidents/Falls with revision date of 10/2022 states, in part but not limited to the following: Policy: the facility strives to promote safety, dignity, and overall quality of life for its residents by providing an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents. Procedure: 3. An immediate/initial care plan for fall risk will be developed for any newly admitted residents whose assessment indicated that the resident was at risk for falls/accidents. This plan of care is communicated to all appropriate staff. 5. Resident care plans should be evaluated and updated with each fall with a new and applicable intervention based on root cause. The focus is to be on prevention and maintaining a safe environment. 7. Any episode of a fall should be documented within the electronic health record within risk management/incidents. Each incident/accident or fall must be investigated and/or assessed to determine the root cause of the episode to prevent any further injury. The interdisciplinary team will review all incident/accident. 9. A post fall assessment will be conducted following any fall episode. 2. R122 is an 83-year-old female with diagnoses history including Dementia, Alzheimer's, Restlessness and Agitation, Bipolar Disorder, Anxiety Disorder, Difficulty in Walking,	S9999		

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Unsteadiness on Feet, Need for Assistance with Personal Care, and Chronic Congestive Heart Failure who was admitted to the facility 03/16/23.

On 05/15/23 from 10:55 AM - 11:02 AM, observed R122 lying in her bed in her room with no clothes or socks on attempting multiple times to get out of bed. R122 stated, "Can I get out of here?" Observed there were no staff in or near R122's room.

On 05/15/23 at 12:24 PM, observed R122 was placed next to the nurse's station in her wheelchair and given an activity book. Observed R122 appeared agitated and sat book down on a chair next to her. Observed R122 was not engaged in activities with staff or residents. V6 (Registered Nurse/RN) stated R122 is a high fall risk.

On 05/15/23 at 02:26 PM, V17 (Family Member) stated she received a call from the facility today notifying her that R122 had fallen by the nurse's station earlier in the morning and then received another call later that she had rolled out of bed. V17 stated unfortunately, R122 does fall often.

R122's progress note dated 3/26/2023 10:00 AM documents she was observed sitting on the floor near her bed.

Initial Abuse Reportable reviewed 05/16/23 documents on 03/28/23 at approximately 2:30 PM R122 was reported to have a fall and her left-hand fingers showed signs of swelling.

R122's progress note dated 3/29/2023 3:27 PM documents R122's left middle finger is swollen, discolored and immobile. Physician was notified.

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S9999	Continued From page 13 R122's progress note dated 3/31/2023 9:54 AM documents writer went to check on R122, and she was observed on the floor on her knees in a crawling position in her room. R122 was wet and wanted to go to the bathroom. R122 has full range of motion in her lower extremities but complains of pain to her left leg. R122 does not remember how she fell. R122's progress note dated 4/3/2023 3:45 AM documents she became restless, screaming for her family, and trying to get up by herself, attempted to calm her down but was unsuccessful. Placed R122 on close watch, she is a high risk for fall. R122's progress note dated 4/4/2023 6:23 PM documents a Certified Nursing Assistant passed by R122's room and saw her on the floor. Writer went to check, noted resident sitting on the floor, wearing nonskid socks, with her wheelchair behind her. Asked R122 what happened, per R122 "I don't know." R122's progress note dated 4/4/2023 06:19 AM documents she had episodes of on and off screaming, attempted to get up, able to redirect. Continuous monitoring done. R122's fall risk assessment dated 05/13/23 documents she has impaired mobility, severely impaired cognition, poor safety awareness, is becoming restless and increased anxiety always attempting to get up from chair or roll out of bed; Requires one-on-one sitter. R122's progress note dated 5/15/2023 3:18 PM documents she was noted to be on the ground by writer, Certified Nursing Assistant and two therapists.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014328	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING PROSPECT HTS	700 EAST EUCLID AVENUE PROSPECT HEIGHTS, IL 60070

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S9999	Continued From page 14 The facility's fall log from 11/15/22 to 05/15/23 documents R122 had 15 unwitnessed falls from 03/28/23 - 05/15/23. There were no post fall/fall risk assessments completed for R122's falls occurring 03/26/23, 03/28/23, 03/31/23, 04/05/23, and 04/08/23. R122's medical records did not include progress notes or incident reports for 10 of her falls. The facility could not provide incident reports for 14 of her falls. R122's current care plan initiated 03/16/23 documents she is at risk for falls and/or has the potential for complications with or falls related to current medical/physical status. R122 has medications and diagnoses that can/may affect fall risk. R122 fell 3/26/2023, 3/31/2023, 3/28/2023, 4/2/2023, 4/4/2023, 4/7/2023,5/13/2023, and 5/15/2023 with interventions including - frequent checks (initiated 03/28/23); toilet her after lunch and dinner, encourage her to stay in common area if not sleeping, Involve her in activities (initiated 5/15/2023); Provide individualized AM activities (initiated 4/10/2023); Check for unmet needs: pain, toileting, hunger, thirst, temperature (initiated 3/29/2023); Continue frequent checks, toilet before meals, Put resident close to nurses station/common area, nonskid socks, Keep in common before meals area when awake (initiated 3/31/23, revised 4/07/23). R122's fall care plan did not include any initiated or revised interventions for falls occurring 03/26/23, 04/02/23, 04/04/23, 04/05/23, 04/06/23, 04/08/23, 05/10/23, or 05/13/23. On 05/17/23 at 11:09 AM, V3 (Director of	S9999		

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S9999	Continued From page 15 Nursing/DON) stated floor nurses complete incident reports and post-fall reviews. V3 usually stated the next day in the clinical meeting the Director of Nursing and the clinical teem review these reports, and a new intervention is implemented and added to the care plan. On 05/17/23 at 01:22 PM, V3 (DON) stated if post fall reports are not completed, it could prevent care plan interventions from being implemented. V3 agreed if post-fall assessments are not completed, this may prevent identification of potential contributing factors of falls. On 05/17/23 at 03:07 PM, V3 (DON) she was informed by V18 (Registered Nurse/RN) that R122 needs constant supervision, and if you turn your head from her for even a moment she'll fall. V3 stated R122 requires constant monitoring while in her room. V3 stated she doesn't believe the facility can provide one-on-one care for R122 unless there is an emergency or under certain circumstances. V3 stated R122's room is not necessarily close to the nurse's station but somewhat close. V3 stated R122 was closer to the nurse's station. V3 stated a room close to the nurse's station would be close enough to the nurse's station so that you can respond within seconds if an issue arises. V3 stated if R122 does move around, her room is not close enough to the nurse's station for staff to respond in seconds. V3 stated the facility does not currently use any devices to detect a resident's movement. V3 stated R122 has a habit of trying to get out of her bed. V3 stated when R122 is awake, she is in the common area. (A)	S9999		

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