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
	IL6016216	A. BUILDING: ______ B. WING ______	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VISTA BURR RIDGE	**6801 HIGHGROVE BOULEVARD BURR RIDGE, IL 60521**

(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 First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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. This requirement was NOT met as evidenced by: Based on observation interview and record review the facility failed to transfer a resident with two staff members while utilizing a mechanical patient lifting device. This applies to 1 resident (R21) in a sample of 24 residents. Findings include: On 6/18/24 at 3:02 PM, the surveyor walked in to R21 room and observed V16 CNA (Certified Nursing Assistant) using a mechanical lift to place R21 in her wheelchair without the assistance of another staff member. V16 CNA stated she did not ask other staff members for assistance	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Electronically Signed 06/27/24

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because they usually disappear. V16 stated staff are allowed to use the mechanical lift with just one person, but she knows there should be two staff members transferring residents using a mechanical lift.

On 6/18/24 at 3:24 PM, V2 DON (Director of Nursing) covering the skilled unit stated for safety reasons there should be two staff members transferring residents when using the mechanical lift.

The facility policy Total Mechanical Transfer dated 8/22/23 states the total mechanical lift must have two staff members present.
(C)

Statement of Licensure Violations (2 of 2)

300.1640a)

Section 300.1640 Labeling and Storage of Medications

a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.)

This requirement was NOT met as evidenced by:

Based on observation interview and record review the facility failed secure medications left in residents' rooms. This applies to three residents (R13, R14, and R22) in a sample of 24 residents.

Findings include:

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S9999	Continued From page 2 1. On 6/18/24 at 10:09 AM, Acetyl L-carnitine 500 mg (Milligrams) 100 count bottle and Osteo Bi flex 150 count bottle was observed at R13's bedside. R13 stated on 6/18/2024 that he was told by staff he could keep his medications at this bedside. 2. On 6/18/24 at 10:38 AM, Ibuprofen liquid gels 20 count bottle was observed at R14's bedside. On 6/18/24 at 11:44 AM, V22 R14's family member stated she brought the ibuprofen in for R14 a few days prior. V22 stated the ibuprofen had been sitting out in the open ever since she brought it in. V22 stated no one told her she shouldn't bring it for him. On 6/18/24 at 3:24 PM, V2 DON (Director of Nursing) covering the skilled nursing unit stated neither R13 nor R14 had physician's orders to self-administer their medications. V2 stated an assessment would need to be done to assure residents can safely self-administer their medications. There is an added concern if they are not stored away properly another resident could access them medications. 3. On 6/20/24 at 8:08 AM a tube of bacitracin ointment prescribed for R23 was observed at R22's bedside. R22 did not verbalize knowledge of the bacitracin. V17 RN (Registered Nurse) stated he did not bring the bacitracin into the resident's room and did not know who did. On 6/20/24 at 9:45 AM, V18 Regional Nurse Consultant stated R23 was on the second-floor memory care unit. V18 stated if a resident has not been assessed to self-administer medications they should have been put away and not be left at	S9999		

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S9999	Continued From page 3 R22's bedside because it is not safe. The facility policy Medication Self Administration dated 3/1/24 states The resident shall have a screen completed by a licensed nurse to determine factor that may impact the safe administration of medications. Resident who have been deemed appropriate to self-administer medications independently or with supervision / cuing or after set-up, shall ava a physician's order to do so. The facility policy Medication Storage date 2/12/24 states compartments containing medications should be locked when not in use. (C)	S9999		

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S9999	Final Observations Statement of Licensure Violations (1 of 2) 330.790c)4) Section 330.790 Infection Control c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 330.340): 4) Infection Control in Healthcare Personnel This requirement was NOT met as evidenced by: Based on observation, interview, and record review, the facility failed to properly position a catheter bag for a resident. This applies to 1 of 3 residents (R1) reviewed for catheters in a sample of 24. The findings include: On 6/18/24 at 10:29 AM, R1 was sitting on his couch in his room watching TV (Television). R1 was unable to engage in dialogue with surveyor because his primary language was Spanish. His catheter bag was on the floor next to him and not kept in a privacy bag. On 6/18/24 at 10:47 AM, R1 was ambulating in	S9999		

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his wheelchair in the hallway. His catheter bag was in a privacy bag in his chair on his right side. It was not below his bladder.

On 6/18/24 at 11:43 AM, R1 was in the dining room eating lunch. His catheter bag was still in his chair on his right side next to him. It was not below his bladder.

On 6/18/24 at 2:37 PM, V2 (Director of Nursing of Sheltered Care) stated, "Catheter bags should not be on the floor because of infection control issues. It should be positioned below the bladder, otherwise the urine can backflow and cause an infection. It should not be on his seat."

R1's face sheet shows a diagnosis of urinary tract infection.

R1's POS (Physician Order Sheet) shows an order of 12/11/23 of home health to change suprapubic catheter. V2 stated she just added an order today (6/18/24) of suprapubic catheter care. Staff to help with catheter care when needed. Every day and evening shift for catheter usage.

R1's service plan (1/15/24) shows: "Focus: Catheter Suprapubic. Goal: (R1) will be able to maintain their catheter with assistance. Intervention: Care Staff will report any leaking/pain/concerns.

Facility's policy titled Foley Catheter Management (3/1/24) shows: "6. Correct positioning of catheter will be maintained."
(B)

Statement of Licensure Violations (2 of 2)

330.1510f)

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Section 330.1510 Medication Policies

f) Oxygen may be administered in a facility. The oxygen supply shall be stored and handled in accordance with the National Fire Protection Association (NFPA) Standard No. 99: Standard for Health Care Facilities (2002, no later amendments or editions included) for nonflammable medical gas systems. The facility shall comply with directions for use of oxygen systems as established by the manufacturer and the applicable provisions of NFPA 99 and the NFPA Life Safety Code (see Section 330.340).

This requirement was NOT met as evidenced by:

Based on observation, interview, and record review, the facility failed to properly store and contain portable oxygen tanks. This applies to 8 of 8 residents (R4, R7, R8, R12, R18, R19, R20, R24) reviewed for oxygen in sample of 24.

The findings include:

1. On 6/18/24 at 10:53 AM, surveyor went to R7's room. R7 was not in his room. There was a portable oxygen tank that was full and unsecured in his room. It was not contained in his canister.

In close proximity to R7's room, were the rooms of R8 and R12. R8 and R12 would be potentially affected if R7's oxygen tank fell and caused a combustion.

On 6/18/24 at 2:47 PM, V2 (Director of Nursing for Sheltered Care) stated, "Oxygen tanks need to be contained in a canister. If not, it can fall and combust."

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R7's June POS shows no order for oxygen.

R7's care plans show nothing about oxygen.

2. On June 18, 2024 at 10:39 AM, R4 had an oxygen tank leaning on the wall in a black carrier bag. The oxygen tank was not stored upright in the oxygen carrier.

Near to R4's room were the rooms for R18, R19, R20, and R24, who would all be potentially affected if R4's oxygen tank fell and caused a combustion.

R4's face sheet showed R4 was admitted to the facility with diagnoses including atherosclerotic heart disease, anemia, insomnia, urinary tract infection. R4's POS (Physician Order Sheet) showed an order for oxygen to be administered via nasal cannula. R4's care plan did not have any care plans regarding oxygen administration.

3. On June 18, 2024 at 10:36 AM, R18's previous room had an oxygen tank which was not secured and was placed directly on the ground without a holder. On June 20, 2024 at 9:22 AM, R18's oxygen tank was still not secured, and was placed directly on the ground without a holder.

Near to R18's room were the rooms for R4, R19, R20, and R24, who would all be potentially affected if R18's oxygen tank fell and caused a combustion.

R18's face sheet showed R18 was admitted to the facility with diagnoses including muscle weakness, major depressive disorder, hyperlipidemia, hypertension, and dysphagia. R18's POS showed an order for oxygen to be

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administered via nasal cannula.

On June 20, 2024 at 9:25 AM, V8 (CNA/Certified Nurse Assistant) said the oxygen tanks should be stored in the oxygen tank room on the first floor if not in use. V8 also said it should not be stored directly on the ground as it can set off if it falls due to being flammable.

On June 20, 2024 at 9:27 AM, V9 (CNA) said the oxygen tank should have a stand or holder because if it fell, it could explode. V9 said if she saw an oxygen tank directly on the floor, she would place it in a holder.

On June 20, 2024 at 9:31 AM, V11 (RN/Registered Nurse) said the tank should be in a mobile holder so that it would not knock over. V11 said the holder keeps it stable as the tank is flammable if it falls.

On June 20, 2024 at 9:34 AM, V12 (Resident Care Coordinator) said the oxygen tanks should be in a canister because they would not want it to fall due to it being combustible. V12 was taken to R18's previous room and V12 said the canister should not be on the ground, but placed in a canister.

R7's policy titled Oxygen Administration and Storage (6/15/23) shows the following: "Oxygen cylinders must be stored in racks with chains, sturdy portable carts and/or approved stands in designated areas. May be stored in resident's room or living area when not in use. May not be left free standing."
(C)