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	IL6013429	A. BUILDING: _____ B. WING _____	05/05/2022

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ALDEN ESTATES OF EVANSTON	2520 GROSS POINT ROAD EVANSTON, IL 60201

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S 000	Initial Comments Annual Licensure and Recertification Survey Complaint Investigation: 2292224/IL144875	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610 a) 300.1210 b)3)4) 300.1210 c) 300.1210 d)4)A) 300.1210 d)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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and

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S9999	Continued From page 2 oral hygiene, in addition to treatment ordered by the physician. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide timely incontinence care and assistance with repositioning for a resident assessed to need staff assistance. This failure applied to one (R311) of four residents reviewed in a sample of 28 reviewed for pressure ulcers. This failure resulted in R311 developing an unstageable sacral pressure ulcer. Findings include: R311 was admitted to the facility on 4/15/2022 with diagnoses of Periprosthetic Fracture Around Internal Prosthetic Right Knee Joint; Muscle Weakness; Need for Assistance with Personal Care and Overactive Bladder. MDS (Minimum Data Set) dated 4/22/2022 documents that R311 has a BIMS (Brief Interview of Mental Status) score of 15, indicating a high level of cognitive functioning. R311 requires extensive assistance from two persons physical assist in bed mobility.	S9999		

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S9999	Continued From page 3 V10's (Registered Nurse) initial assessment note dated 4/15/2022 indicated that R311 presented with blanchable redness in the sacral area upon admission. V2's (Registered Nurse, Director of Nursing) progress notes dated 4/22/2022 indicated that R311 had superficial sacral deep tissue injury with purple discoloration, measuring 3 cm (centimeters) x 5.5 cm. Unable to find any documentation that wound care nurse practitioner or medical doctor were informed about the deep tissue injury. A week later, V9's (Wound Nurse Practitioner) note dated 4/29/2022 reads, "Unstageable pressure sore to the sacrum, measuring 3.8 cm x 6 cm x 0.3cm with 30% slough with defined margins. Re-positioning in the bed and with chair as needed, or per protocol, if patient cannot do it." Physician order dated 4/29/2022 reads in part, "Apply to sacral topically every day shift for skin condition cleanse with normal saline, apply Santyl/adaptic, Zinc oxide around the cover with foam dressing until resolve and Apply to sacral topically as needed for skin condition cleanse with normal saline, apply Santyl/adaptic, Zinc oxide around the cover with foam dressing until resolve." On 5/2/2022 at 12:02 PM, R311 was observed in her room, sitting in the wheelchair. R311 is on a low air loss mattress, set up to an alternating mode, and sequential compression device, noted at the foot of the bed. Turn clock schedule seen on the wall above R311's bed. R311 was asked regarding pressure ulcer in the sacral area. R311 stated, "This is the third time at this facility and	S9999		

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S9999	Continued From page 4 my stay is way worse than the two previous stays. I developed multiple wounds this time. Staff lets me sit in the dirty brief for hours. I know they are shorthanded, but it should be prioritized who needs help first. I had a bowel movement, the day before yesterday and it took them almost two hours to change me. Also, nobody turns me when I'm in the bed, so I try to turn myself." On 5/3/2022 at 9.56 AM surveyor observed wound dressing change on R311. V7 (Licensed Practical Nurse/LPN) described the wound as circle shaped skin opening, was not sure about the size or condition of the wound. V7 checked wound care order and proceeded to perform dressing change. V7 cleaned sacral wound with normal saline, put on Santyl ointment, covered it with oil emulsion dressing and put on a foam dressing as ordered. V7 was interviewed regarding R311's sacral ulcer if it was present during admission. V7 replied, "There was nothing, R311 didn't have any wounds at that time." Surveyor asked about repositioning routine, V7 stated, "R311 gets her wound dressing changed in the morning, next she is placed via mechanical lift in the wheelchair which has a foam pillow, and then she goes to the physical therapy. Once she's back, she eats her lunch and stays in the wheelchair for the rest of my shift (morning shift, 7AM-3PM)." On 5/3/2022 at 10:33 AM, V8 (Certified Nurse Assistant/CNA) was asked how often R311 is repositioned V8 stated, "She (R311) is repositioned every two hours unless she is in the wheelchair. She gets repositioned only in the bed. She (R311) is alert and oriented, so she can tell us when she wants to be put back into bed. She uses cushion pillow when she is in the wheelchair, she didn't like the waffle pillow."	S9999		

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S9999	Continued From page 5 Surveyor asked if R311 can reposition by herself while in the bed, V8 stated, "No, she cannot do it by herself." Surveyor asked how staff keeps track of R311's repositioning, she (V8) stated, "CNAs don't chart, we just tell nurses when we reposition residents." On 5/3/2022 at 10:39 AM, surveyor asked V7 (LPN) how staff tracks residents' repositioning times, V7 stated, "There is no tracking system for repositioning in the electronic medical record system, we use turn clocks that are placed in residents' rooms." On 5/3/2022 at 11:45 AM, V3 (Nurse Consultant) stated that there is no repositioning policy available in the facility. On 5/3/2022 at 12:25PM R311 was sitting in wheelchair eating lunch. Continuous observations of R311 were made from 12:25PM to 2:35PM and was not observed to be repositioning or receive any incontinence care during this time. On 5/4/2022 at 11:09 AM, V2 (Director of Nursing) was interviewed regarding R311's pressure ulcer. V2 stated, "The wound presented as blanchable redness on the sacrum upon admission. I assessed it again on 4/22/22 and it was a Deep Tissue Injury at that time, so I notified V9 (Wound Nurse Practitioner) to further assess it. He gave me orders over the phone and came to assess it on 4/29/22. R311 never complained about any skin issues." On 5/4/2022 at 1:56 PM, V9 (Wound Nurse Practitioner) was interviewed regarding R311 and pressure ulcer. V9 stated, "I recommended foam dressing before I saw her for the first time on	S9999		

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S9999	Continued From page 6 4/29/22. I received a text message from the nurse before 4/29/22, don't remember the exact day they texted me." V9 was asked why would R311's wound deteriorates. V9 stated, "Turning and repositioning would make a big difference, the wound can deteriorate over night without proper turning and repositioning. Residents should be repositioned whether they are in bed or in wheelchair. Residents should not be in the wheelchair for no more than two hours, my expectation of the staff would be to reposition her (R311) every two hours. Incontinence care is very important as well, stool and urine are really acidic, and it worsens the condition of the wound, it macerates the skin." On 5/4/2022 at 3:20 PM, V2 was again interviewed regarding factors that could worsen a wound. V2 stated, "There are multiple factors that play role in wound deterioration, some of them are co-morbidities or limited mobility. Incontinence care is also very important, lack of incontinence care can have a negative outcome pertaining to wounds. Skin exposed to urine and bowel movement deteriorates because of the acidity. Repositioning is very important too. If a resident stays in the same position, they can develop wounds. Repositioning should occur every two hours or as needed, whether a resident is in the bed or in the wheelchair." Surveyor asked about R311 repositioning and incontinence needs, V2 stated, "R311 should be repositioned and get checked for incontinence every two hours and changed as needed." Facility's policy titled "Prevention and Treatment of Pressure Injury and Other Skin Alterations" dated 3/2/2021, reads in part, "Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin	S9999		

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S9999	Continued From page 7 alterations through individualized resident care plan. At least daily, staff should remain alert for potential changes in the skin condition during resident care." Skin integrity care plan dated 4/22/2022 reads in part, R311 has actual alteration in skin integrity due to surgical wound on right thigh, DTI (deep tissue injury) on the sacral region. Interventions include but are not limited to teach resident to shift weight in the wheelchair; turn and reposition every two hours and as needed. "B" Statement of Licensure Violations II of II: 300.610 a 300.1210 b) 300.1210d)6) 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	S9999		

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S9999	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to prevent a resident from falling during toileting. This failure affects one (R264) out of 4 total residents (R58, R53, R41) who were reviewed for falls in the facility and led to R264 requiring immediate hospitalization with an admitting diagnosis of lumbar fracture. Findings include: R264 was admitted to the facility 1/11/2020 with diagnoses that included cervical fracture, lack of coordination, difficulty walking and generalized muscle weakness. At the time of Admission, R264 had a BIMS of 15 assessed 1/11/2020 indicating a high level of cognitive functioning. R264 was admitted to the facility after a fall	S9999		

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S9999	Continued From page 9 incident, in which she sustained a cervical spine fracture. According to a Minimum Data Set assessment dated 1/16/20, R264 used a walker requiring one-person physical assistance for locomotion and required supervision and one-person physical assistance for toileting. On 2/3/2020, R264 fell in the bathroom unattended and was sent to a local hospital shortly after due to complaints of back pain. R264 was admitted that day with a primary diagnosis of lumbar vertebral fracture. 5/4/22 3:27 PM V2 (Director of Nursing) said, most falls can be prevented by educating and asking the resident to call for assistance if they are alert and are able to make their needs known. Everyone is at risk of falls. On admission when the resident is assessed for fall risk, we utilize the assessment guide as a means to monitor for falls. For a patient who has had a history of falls prior to admission and based on their co-morbidities it could contribute to a resident being a high fall risk. If the patients are alert and oriented and want to be provided with privacy, we have to provide it upon request when toileting. If the patient tells us they will call us when they are ready, once we hear the bathroom light, we will check on the patient. On 5/4/22 at 11:47AM V6 (Licensed Practical Nurse) said, residents who use any type of ambulatory (walking) device is considered a high fall risk. We are trained not to leave resident's alone unattended in the bathroom as a safety precaution because they can fall or injure themselves. For residents that are able to toilet, we try to round on them hourly to assist to the toilet if needed. Some things that can contribute to falling is a previous history of falling, their	S9999		

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S9999	Continued From page 10 cognitive status and medications. Some medications such as narcotic pain meds can alter their thinking and balance. On 5/5/22 at 10:45AM, V11 (Medical Director) said, if anyone is utilizing a walker, they would be at a higher risk of falling. I would not expect for a resident who is using a walker to be left unsupervised while using the bathroom because they would have a higher risk of falling. Lumbar fractures are significantly painful. Depending on the resident and other factors it could potentially be categorized as a serious injury. Facility fall incident report dated: 2/3/2020 at 3:15AM, reads: R264 was found in the bedroom bathroom sitting on the floor. In the report, it indicated that R264 ambulated to the bathroom using a walker without assistance. Nursing Progress note dated 2/3/2020 read: Patient noted to be using the bathroom at 3:12AM without calling for assistance. Writer encouraged patient to call for assistance when done. At 3:15AM, writer heard a noise in the patient's room from the nursing station. Writer responded immediately and entered the bathroom, noted patient on the floor sitting down. R264 Physician Order Sheet dated: January 2020. Resident had orders for narcotic pain medication hydrocodone-acetaminophen 10-325mg 1 tablet every 6 hours as needed for pain dated 1/13/2020. R264 also had an order for hypnotic medication zolpidem tartrate 2.5 mg as needed every night for insomnia dated 1/30/20. Review of Medication Administration Record dated 02/03/20 notes that R264 was given a dose of hydrocodone-acetaminophen 10-325mg at 3:09PM prior to when the fall incident occurred.	S9999		

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S9999	Continued From page 11 R264's care plan dated 1/11/20 reads: R264 had limited functional transfer skills with transferring to the toilet indicating that she was not at the highest level of independence for toileting. R264 also care plans for impaired ambulatory skills and limited transfer skills with interventions that include lower leg strengthening. Care plan initiated 1/11/20 stated that R264 was high risk for falls with goal to be free from injury from falls. Facility fall management program updated 08/20 states in part, the facility is committed to minimizing resident falls and /or injury so as to maximize each resident's physical, mental and psychosocial wellbeing. ...It is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. Management of falls policy updated 8/20 states in part; "Risk factors may include but are not limited to the following: Medications (Narcotics, Antihypertensives, etc.), assistance required with ADL's, gait/transfer/balance issues, behaviors, and/or cognitive status. "B"	S9999		