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	IL6015192	A. BUILDING: _____ B. WING _____	C 11/14/2025

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EDEN VISTA HOFFMAN ESTATES	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

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S 000	Initial Comments Complaint Investigation 25110262/IL198435 - No deficiency 25919987/IL198041 - S330.1110, S330.4240	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 330.1110f) Section 330.1110 Medical Care Policies f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to follow their wound care policy by failing to prevent a resident (R2) from developing three pressure ulcers who was admitted with no pressure ulcers and failed to assess R2 to see if the pressure ulcers were unavoidable for one out of three residents reviewed for medical policies in a total sample of six. Findings Include: R2 is an 89 year old with the following diagnosis: type 2 diabetes, dementia, and atrial fibrillation. R2 no longer resides in the facility. A Health Status note dated 5/16/25 documents R2 admitted to the facility from the hospital. The	S9999		

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skin assessment revealed a discoloration to the back of both hands and heel area was soft. This needs to be monitored to prevent further skin breakdown.

A Nurse Practitioner note dated 5/19/25 documents R2 moved into the memory care unit. Skin was intact.

A Nurse Practitioner note dated 6/2/25 documents R2 was examined for follow-up with bilateral heel blisters. Skin was intact. Home health nurse to evaluate.

A Health Status note dated 6/10/25 documents a stage two pressure ulcer was noted in the sacral region. The nurse practitioner was notified.

A Health Status Note dated 6/12/25 documents the physician ordered for R2 to be sent to the hospital due to worsening sacral wound. 911 was called and R2 left the facility at 4:10PM.

A Nurse Practitioner note dated 6/10/25 documents a stage two to the sacral area was noted today. R2 still has deep tissue injuries to the right heel and unstageable pressure injury to the left heel. R2 is currently under wound care services. The sacral ulcer needs immediate attention to prevent further breakdown. Plan to implement pressure redistribution measures.

On 11/13/25 at 2:13PM, V8 (Care giver) stated R2 was a total assist resident that was incontinent. V8 denied remembering if R2 was admitted with wounds but reported needing to tell the nurse about new wounds on R2's heels. V8 stated if the nurse is notified of a new skin alteration then it means the wound is new.

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S9999	Continued From page 2 On 11/13/25 at 2:58PM, V9 (Registered Nurse) stated V9 sent R2 out to the hospital per physician's order due to the worsening of R2's wounds. V9 reported R2 had a wound to the sacral area and bilateral heel wounds at discharge. When asked what risk factors R2 had for developing wounds, V9 stated R2 was diabetic, did not move unassisted, and needed to use a mechanical lift for transfers. V9 was unsure when the heel wound developed but reported the sacral wound did develop at the facility. V9 denied the facility uses any tool or other documentation to determine if a wound was unavoidable if it develops. V9 denied know what unavoidable means. On 11/14/25 at 12:41PM, V5 (Health and Wellness Director) stated R2 did not have any wounds upon admission but did develop deep tissue wounds to the bilateral heels and incontinence dermatitis to the sacral area. V5 reported R2 was discharged form the facility because the facility could no longer manage the wounds. V5 stated R2 was a total assist with ADL care and needed a total mechanical lift for transfers. V5 reported the facility does not do any unavoidability screens for residents. V5 stated a resident is assessed upon admission and and interventions are added to the service plan as needed. V5 denied knowing why an unavoidability screen for wounds would be necessary. On 11/14/25 at 1:15PM, V10 (Nurse Practitioner) stated V10 only saw R2 on admission and R2 didn't have any wounds at that time but developed wounds bilaterally to the heels. V10 reported R2 was admitted with some redness to the heels but this is not considered a wound because the skin is not open and there is no other discoloration. V10 stated the heel protectors	S9999		

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should have been put on R2 as soon as they were available when V10 placed the order.

On 11/14/25 at 3:02PM, V11 (Primary Physician) stated R2 admitted to the facility with no wounds but had wounds quickly develop. V11 reported R2 was at high risk for developing wounds due to being advanced age, combative with treatments due to advanced dementia, was bed bound, and had extensive peripheral arterial disease. V11 reported R2 was kept at the facility until the wounds were not manageable any longer. V11 denied having any documentation that the wounds were unavoidable. V11 stated V11 does not normally document whether wounds are avoidable or not in V11's notes.

The Admission Hospital Records dated 5/9/25 documents R2 presented to the emergency room with an episode of combativeness at home. There was no documentation of any skin breakdown while at the hospital.

The Physician Communication form dated 5/19/25 documents V9 (Nurse Practitioner) ordered bilateral heel protectors on 5/19/25. The order was not entered into the MAR until 5/30/25. There is no other documentation that R2 had the heel protectors in place from 5/19/25 to 5/29/25.

The Illinois Assisted Living Nursing Services and Assigned Point Assessment that is undated documents R2 requires constant reminders and/or supervision in and out of residence. R2 requires hands on assistance with toileting, application of incontinence products and related hygiene needs. R2 requires assist of mechanical total lift with two staff assist. R2 Requires assistance with wheelchair.

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The Weekly Skin Check dated 5/18/25 documents R2 refused the skin check. There's no documentation that another skin assessment was performed or attempted that day. The Weekly Skin Check dated 5/24/25 documents redness on the right and left heel. The Weekly Skin Check dated 5/22/25 documents R2 had no skin concerns. The Weekly Skin Check dated 5/24/25 documents a skin impairment was observed during assessment but there is no documentation where or what the skin impairment was. The Weekly Skin Assessment dated 6/11/25 documents redness and irritated skin was noted to the buttocks.

The Home Health Evaluation dated 5/30/25 documents R2 had limited cooperation during the skin assessment. The right heel wound was a deep tissue injury that measured 8.5cm x 7.7cm x 0cm. The left heel wound was a deep tissue injury that measured 4.3cm x 2.2cm x 0cm. Both heels were tender to touch. R2 required maximum assist with ADL care and used a mechanical total lift for transfers. Plan was to continue reassessing wounds, completing the full skin assessment, infection prevention, and coordination of staff regarding wound progression. Potential skilled nursing placement will be recommended if there is no improvement within 30 days.

The Home Health Nurse Visit dated 6/2/25 documents the skin assessment was completed. The deep tissue injuries were present on both heels with skin intact. Heel protectors were applied after wound care treatment. Skin on the buttocks was red but blanchable. Prompt incontinence care and applying barrier cream barrier cream to every brief change to prevent skin breakdown. No wound measurements were

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S9999	Continued From page 5 documented this assessment. The Home Health Nurse Visit dated 6/5/25 documents the deep tissue injuries were present on booth heels still with skin intact. The discoloration did not seem to spread further from last visit. Skin on buttocks still red but intact. Plan was to have R2 seen by wound nurse practitioner tomorrow. The Home Health Nurse Visit dated 6/9/25 documents both deep tissue injuries on the heels ruptured. The right heel was dark/gray and draining serosanguineous exudate. The left heel was pink/red draining serosanguineous exudate. Skin on the buttocks was red but blanchable. Assistance was requested from the wound nurse practitioner. The Nurse Practitioner Wound Note dated 6/10/25 documents R2 had a deep tissue injury to the right heel and unstageable pressure injury to the left heel. The unstageable advanced to a stage three on this date. The right heel wound measured 7cm x 5cm x 0cm. The left heel wound measured 2.5cm x 2cm x 0.1 cm. New dressing changes were ordered three times a week. The Home Health Nurse Visit dated 6/12/25 documents R2 was very apprehensive about being touched. The skin flap on the right heel came off during wound care exposing a red/moist wound bed. The left heel was unstageable and covered mostly with slough. Dressings were changed and heel protectors were applied. A small amount of incontinence dermatitis was noted on the sacrum. Wound bed was pink and moist with a very scant amount of serous exudate. A thick layer of barrier cream was applied. Management and wound nurse	S9999		

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practitioner were notified. Skilled nursing facility placement was discussed due to possible need for daily wound care to prevent further decline.

The Hospital Records dated 6/12/25 document R2 admitted to the emergency room due to bilateral heel wounds and a sacral wound. R2 was screaming in pain so the emergency room was unable to be examine the sacral area. R2 was alert and oriented times one. Per the family, the heel wounds developed approximately 2 to 3 weeks ago and the sacral wound is new from about one to two weeks ago. A left heel wound culture was positive for an infection. R2 was treated with IV antibiotics and discharge to a skilled nursing facility. The MRI of the heels indicates soft tissue swelling of both heels, but there are no findings for osteomyelitis. The emergency room physician spoke with the primary physician at the community center. The primary physician advised the facility is no longer able to manage the stage three decubitus wound to the left heel and is requesting admission. A later skin assessment revealed R2 had a stage one decubitus ulcer to the sacrum, a stage two ulcer to the right heel approximately 3 cm in diameter, and a stage three ulcer to the left heel approximately 1.5 cm in diameter. The left heel wound had a foul odor. The foul order was associated with skin necrosis and cellulitis. R2 was admitted under observation. (B)

(2 of 2)

330.4240a)

Section 330.4240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or

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S9999	Continued From page 7 neglect a resident. (Section 2-107 of the Act) (Source: Amended at 15 Ill. Reg. 516, effective January 1, 1991) This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their abuse policy by financially exploiting a resident (R2) after not issuing a refund for more than 30 days after R2 discharged for 1 out of 3 residents reviewed for financial exploitation in a total sample of 6 Findings include: R2 was a 89year old resident admitted to Eden Vista Hoffman estate on 5/16/2025, private pay Memory Care 2025, private suite. R2s medical diagnosis that include and are not limited to: Dementia, type 2 Diabetes Mellitus and Paroxysmal atrial Fibrillation. R2 was discharged to the hospital per the census on 6/12/2025. The Resident Occupancy Agreement, in the termination after occupancy section documents in the case of resident's death or transfer to the Communities Assisted Living the monthly service charge shall be prorated too and include the dates of the resident's apartment has been fully vacated and keys returned to management. On 05/18/2025 V1 signed the agreement for R2. On 11/13/2025, at 11:10 AM, V2 (R2's Family member) stated V6 (Business Office Manager) would credit R2's family back for the days R2 was vacated out of his room the last days in August, but the family has not received or heard anything	S9999		

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regarding the refund.

On 11/13/2025, at 1:28 PM, V4 (Executive Director) states the family is supposed to get a refund if R2's family paid in full they were supposed to be prorated for the days not used in August.

Email communication dated August 27, 2025 at 1:33 PM between R2's family and V4 documents V4 notified R2's family to notify V6 when the room is vacant so V6 can give R2's family the refund as long as the room is vacant prior to August 31st.

Email communication dated August 28, 2025 at 9:56 AM between V6 and V2 documents all of R2's personal belongings were removed from the room as of August 27, 2025. V2 requested a confirmation that a refund will be processed.

Email communication dated August 28, 2025 at 8:16 PM to R2's family documents that V6 has informed the billing team regarding the funding.

On 11/14/2025, at 12:20 PM, V6 stated V6 has not sent the refund request to the accounts receivables (AR) and cooperate. V6 stated AR will then send the refund request to corporate and corporate has 30 days to issue the refund. V6 stated she has not sent R2's refund request to AR. V6 stated it was not sent within 30 days from the R2's discharge from the facility. V6 stated she does not give families updates regarding refund request/refund process. V6 confirmed the refund check for R2 was for dates August 29, 2025 - August 31/2025 in the amount of $967.76. V6 stated she did remember receiving an email regarding a refund for R2's family "a while ago."

On 11/14/2025 at 1:15 PM, V5 (Health and

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S9999	Continued From page 9 Wellness Manager) stated the facility does not have policy and procedure for Billing/Refunding residents. On 11/14/2025 at 2:02 PM V12 (Regional Director of Operations) stated usually the community will fill out a refund form then send it over to accounts payable, and once approved, the corporate office will cut a check and put it into the mail which is sent to the family. V12 stated they are not aware a resident needs a refund unless the person in the business office from the community lets corporate know through the form first. V12 reported once corporate is aware a check is put in the mail within a week. The Billing Statement dated 9/30/2025 issued to V2 documents R2's family is credited for $967.76 for the dates in August R2 was discharged. The statement due date is documented as 10/05/2025. At the time of exit, the facility could not provide any information the refund check was issued to R2's family. Policy and Procedure for Abuse and Neglect- ALF Sheltered Care revised on 3/1/24 documents: "For the purposes of this policy, abuse shall be defined as: Financial exploitation which includes illegal or improper use of a resident's resources or personal property for the personal profit or gain of another person; borrowing a resident's funds; spending resident funds without the resident or their designee's consent or if the resident is not capable of consenting; spending resident funds for items or services from which the resident cannot benefit or appreciate; or spending resident funds to acquire items for use in common areas when such purchase is not authorized by the resident." (B)	S9999		