STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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 Complaint Investigation: 2197158/IL138652 2197340/IL138882	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3)5) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 1 but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 2 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 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy on prevention and treatment of pressure injury and other skin alterations by not implementing a plan to prevent/reduce the risk of pressure sore development, failed to recognize changes in wound condition, and failed to effectively implement wound prevention interventions while using a low air loss mattress for 4 of 4 (R1, R2, R3 and R4) residents reviewed for pressure ulcers. This failure resulted in R1 developing a deep tissue injury and being sent to the local hospital where R1 was assessed and treated for necrotizing fasciitis and osteomyelitis. Findings include: 1. On 10/5/21 at 9:41am, V3, Wound Care Nurse (WCN) said that R1 was admitted on 9/2/21 with skin intact. R1 had Braden scale score of 10	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 3 which indicated high risk for pressure ulcer. R1 developed DTI (Deep tissue injury) on 9/14/21. Braden scale was done with score of 10 (high) and care plan was updated. V3 spoke with V4, R1's Family member and referred R1 to V15, Wound Care Physician (WCP). R1 was placed on special low air loss (LAL) mattress. V3 completed the consent form for wound care and unavoidable pressure ulcer injury condition on 9/14/21 and signed by V15 Wound care Physician (WCP) on 9/15/21. V15 did not talk to V4 (Family member) regarding R1's wound condition. V3, WCN said that R1 was seen by V15, WCP on 9/16/21. V3 and V15 did not call V4 to update regarding R1's wound condition (100% maroon colored) and plan of care and new treatment order(petrolatum dressing and foam dressing). V3 stated that R1 was seen again by V15 and V3 on 9/22/21 regarding R1's wound condition (50% maroon and 50% necrotic /black) and plan of care and new treatment order (Santyl [collagenase ointment], petrolatum dressing and foam dressing). V3 also said that the family was not updated with the changes of treatment and wound condition either 9/16/21 or 9/22/21. V3 said that the floor nurses did the wound dressing on 9/23 to 9/26/21 until R1 was sent out to the hospital. No nurses or Certified Nursing Assistants (CNAs) told V3 that R1's wound got worse not until R1 was being sent out to the hospital for wound evaluation on 9/26/21 by V14, Registered Nurse (RN). Surveyor asked how these 3 different nurses would be able to determine any changes in the wound condition of the R1. V3 said that the floor nurses can see or access R1's wound assessment in the chart and compare if there are any changes.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 4 On 10/6/21 at 12:46pm, V17, RN and V11, RN, who took care of R1 on 9/23/21 and 9/24/21, both said that they took care of wound dressing on R1 for the first time. Both said that they don't know if there was any difference in wound condition. Both said that it is not part of their daily work routine to read the wound assessments done by V3 and notify him if there is any changes from his notes. They said that if there is an identified and established wound, the wound care nurse will notify V15 and resident's family member. They notify V3 if there is a new development of skin alteration. On 10/6/21 at 2:09pm, V14, RN said that she took care of R1 on 9/25/21 and 9/26/21 and did R1's wound treatment. V14 said she did not know any difference in R1's wound condition because she took care of R1 for the first time. V14 does not read the V3's notes. It is not routine for her to read the wound assessments completed by V3. V14 said that she just followed the wound treatment as written in TAR (Treatment administration record). V14 will notify V3 if there is any new wound/skin alteration developed. V14 RN said that she did R1's sacral wound dressing after breakfast on 9/26/21. R1 did not have wound dressing when she did the wound care. V14 said that V13 CNA did not report to her that R1 had episodes of diarrhea. She said that V4 (R1's Family member) came to visit on 9/26/21, V14 observed V4 taking pictures of R1's sacral area and said that V4 wanted R1 to be sent out to the hospital immediately due to worsening of R1's wound and verbalized concern regarding care. V4 called 911. On 10/6/21 at 10:19am, V15 Wound Care	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 5 Physician (WCP) stated that he usually does not talk to the Residents's family member. V15 expected V3 (Wound Care Nurse) to call and update the Resident's family member of wound progress plan. V15 stated that he was informed by V3 that R1 was sent out to the hospital for wound evaluation on 9/26/21. V15 was not notified that R1's wound had worsened. V15 expected the nurses on the floor who do the daily dressing to notify V3 or him (V15) or the infectious physician for any changes in wound condition or any sign and symptoms of infection. V15 said that DTI (Deep Tissue Injury) is caused by continuous pressure on sacral area and a co-morbidity will increase chances of development. DTI could be prevented by turning and repositioning every 2 hours, incontinence care after each episode, keeping it dry and use of LAL (Low Air Loss) mattress. A review of R1's hospital record dated 9/26/21 noted that R1 had a CT scan which revealed CT of abdomen and pelvis shows heterogenous air collection measuring 10x4x 6cm within the subcutaneous tissues of gluteal crease. Findings compatible with necrotizing soft tissue infection and or emphysematous osteomyelitis of the coccyx. R1 was treated and admitted to the hospital with a diagnosis of Necrotizing fasciitis, Pressure injury of skin of sacral region, unspecified injury stage and Osteomyelitis of Coccyx. 2. R2's medical record denotes R2 dignosis include Critical illness myopathy, Chronic Respiratory failure, Cerebral palsy, Paraplegia, Dependent on respiratory ventilator, Pressure ulcer left hip stage 4, Pressure ulcer of left buttocks stage 3.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 6	S9999		

On 10/6/21 at 11:04am, R2 was lying in bed with trach connected to oxygen. R2 has special LAL mattress. R2 is alert and responds with gestures. Observed V3, WCN and V8, CNA prepare R2 for wound care. A fitted sheet (thick linen similar to bath blanket), cloth pad and pillowcase were noted underneath R2. V3 said that he already in-serviced the CNAs regarding only 2 layers of sheets underneath residents on LAL mattress

3. R3's medical record indicated R3 was admitted with diagnosis listed in part: Encephalopathy, Anoxic brain damage, Acute Myocardial infarction, Acute respiratory Failure, dependence on supplemental oxygen, Tracheostomy, Gastrostomy. Wound care assessment identifies R3 with Stage 3 pressure ulcer on 9/16/21.

On 10/5/21 at 11:18am, R3 was lying in bed. R3 opens eyes when called but has no verbal response. R3 has trach connected to oxygen. R3 is on special LAL mattress. Observed flat sheet, cloth pad and disposable adult brief underneath R3. V3 removed sacral wound dressing (foam dressing) soaked with reddish greenish brown drainage, moderate in amount. V3 stated that R3 has unstageable pressure ulcer, with greenish slough formation attached to wound base.

4. R4's medical record denoted R4 was admitted with diagnosis listed in part: encephalopathy, acute respiratory failure with hypoxia, dependent on respiratory ventilator.

On 10/6/21 at 11:33am, R4 was lying in bed. R4 had trach connected to ventilator. R4 was on special LAL mattress. Observed flat sheet, cloth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 7 pad and folded towel in between R4's upper thigh and groin up to the suprapubic area. V3 removed the sacral dressing which had a small amount of serosanguinous drainage. V3 said that R4 has stage 3 pressure ulcer on left buttocks. On 10/6/21 at 12:06pm, V9, Unit Manager/CNA stated that residents on special LAL should have only 2 layers over the mattress. Flat sheet and disposable adult brief or cloth pad only. Residents with pressure ulcers are being repositioned and checked for incontinence every 2 hours. Residents should be kept dry and clean. On 10/6/21 at 12:31pm, V10, CNA stated that she is the CNA for R3 and she (V10) applied flat sheet, cloth pad and disposable adult brief after she cleaned R3 this morning. On 10/6/21 at 12:30pm, V18, Nurse Consultant stated that the nurse should notify the physician and responsible party of any changes in medical condition such as worsening of wound. On 10/8/21 at 12:04pm, V1, Administrator stated that wound care/treatment is done between V3 and floor nurses. The Wound care Coordinator, V3 does assessments and evaluations of new admission, wound vac care and priority wound treatment. The floor nurses are dictated to do the wound care/treatment of the residents. The nurses can read the wound notes of V3 in resident's chart. The nurses are trained to know if there are sign and symptoms of changes of wound worsening or wound infection and to notify V3 or physician. Guideline for linen usage for specialty support surfaces, (Low air loss, overlay, gel, water): May use: 1 sheet and 1 pad or incontinence brief	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(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
S9999	Continued From page 8 between the skin and support surface. Facility's policy on Alternating Pressure Air Mattress indicated: Purpose: 1. To maintain and promote adequate circulation. 2. To relieve pressure and aid in the healing and prevention of pressure ulcers. 3. To reduce pain due to pressure. NOTE: AVOID USING ADDITIONAL LINEN THAT WILL NEGATE ACTION OF THE ALTERNATING PRESSURE MATTRESS. Facility's policy on Change of Resident Condition indicated: to ensure that the resident's physician /physician on call/Nurse Practitioner and Responsible party is kept informed regarding the resident's change in condition. Procedure: 1. Attending physician or physician on call/Nurse Practitioner and responsible party will be notified of all changes in condition. 5. Place call to responsible party to notify them of the resident's change in condition. Facility's policy on Prevention and Treatment of Pressure injury and other skin alterations indicated: Policy: 1. To identify resident at risk for developing pressure injuries. 2. To identify the presence of pressure injuries and or other skin alterations. 3. Implement preventive measures and appropriate treatment modalities for pressure injuries and or other skin alterations through individualized resident care plan. Procedure: 8. At least daily, staff should remain alert for potential changes in the skin during resident care. (A)	S9999		