STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016950	A. BUILDING: _____ B. WING _____	08/18/2021

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ALDEN ESTATES CTS OF HUNTLEY	12140 REGENCY PARKWAY HUNTLEY, IL 60142

(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 Annual Licensure and Certification survey	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 300.610a) 300.1010c) 300.1010e) 300.1210b) 300.1210c)1) 300.1210d)6) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies c) Every resident shall be under the care of a physician. e) All resident shall be seen by their	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.) 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. Section 300.3220 Medical Care	S9999		

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S9999	Continued From page 2 f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 were not met as evidenced by: Based on interview and record review the facility neglected to follow their policy and procedure for physician's orders for medications and failed to follow their policy regarding medical care services by the physician. These failures resulted in R97 not being seen by a physician for 181 days and R97 missed her (anticoagulant) medication for 192 days to a resident with a history of strokes. These failures contributed to R97 being hospitalized with a diagnosis of pulmonary embolism (blood clot in her lung) and deep vein thrombosis (blood clot in her leg). This applies to 1 resident (R97) reviewed for neglect and medication. R97's face sheet showed she was admitted to the facility on 12/21/20 with diagnoses including chronic kidney disease, long term use of anticoagulants, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and dysphagia.	S9999		

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S9999	Continued From page 3 R97's Physician Orders dated December 21, 2020 showed orders including for a anticoagulant medication 2.5 mg twice a day (anti-coagulation) therapy. R97's Medication Administration Record for December 2020, January 2021, February 2021, March 2021, April 2021, May 2021, and June 2021 were reviewed and showed R97's anticoagulant medication was not ordered and not administered as prescribed. R97 missed a total of 383 doses. R97's Nurse's note dated July 1, 2021 showed R97 was sent to the hospital in respiratory distress. R97's oxygen saturations were 84% on 3L (liters) of oxygen, respirations of 22 PM (per minute), and was weak and had a decline from her baseline. R97's hospital records dated July 1, 2021 showed she is a 79 year old female with significant history to include CVA (cerebrovascular disease), dysphagia, congestive heart failure, and chronic heart failure. R97 presented to the hospital on 7/1/21 with hypoxia and shortness of breath. R97's report showed an acute and subacute pulmonary embolism and deep vein thrombosis in the left popliteal vein. R97 was on a anticoagulant medication prior to admission. R97's anticoagulation therapy was changed from ordered anticoagulant medication to heparin and coumadin. R97 remains on a heparin drip for treatment of the DVT and PE (Pulmonary Embolism). R97's CT of the chest showed acute segmental pulmonary emboli are seen in the upper lobes. (R97 did not indeed receive the prescribed anticoagulant medication as the hospital presumed.)	S9999		

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The same hospital records showed "R97" whom reportedly had been on anticoagulant medication as an outpatient due to a history of a stroke. She now presents with hypoxia and what appeared to be acute pulmonary emboli in the upper lung fields as well as a subacute or chronic thromboemboli in other lung fields ... . "R97" on anticoagulant medication for history of CVA. (R97 did not indeed receive prescribed anticoagulant medication as the hospital presumed.)

R97's Physician Progress note dated July 8, 2021 showed she was recently hospitalized with hypoxia, acute respiratory failure, and pneumonia. R97 was also diagnosed with acute and subacute Pulmonary Embolism (blood clot in the lungs), and DVT (deep vein thrombosis) of the left popliteal vein. She was switched to coumadin.

On August 16, 2021 at 11:04 AM, V14 (R97's POA) said her mom was hospitalized in July for pneumonia and blood clots in her leg and lungs. V14 said (R97) was supposed to be on anticoagulant medication and she's not sure if she was getting her medication.

On August 18, 2021 at 9:00 AM, V24 (Nurse Practitioner) said residents with a history of stroke should receive an anticoagulant medication. If they don't receive the medication they are at risk for having another stroke, blood clots or pulmonary embolism. V24 said she was not aware of R97 not receiving her anticoagulant medication as prescribed.

On August 17, 2021 at 9:04 AM, V15 LPN (Licensed Practical Nurse) said when a resident is admitted to the facility the medications are

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S9999	Continued From page 5 reviewed with another nurse and verifies all the medications are ordered. V15 said an anticoagulant medication is a blood thinner and if a resident does not get the medication they could be at risk for developing blood clots. On August 17, 2021 at 8:49 AM, V9 (RN) said when a resident is admitted the facility the nurse calls and verifies the orders with the physician. All admit orders and medications should be reviewed by the ADON(Assistant Director of Nursing)/DON (Director of Nursing). V9 said anticoagulant medication is a blood thinner used to prevent blood clots. On August 17, 2021 at 10:50 AM, V3 (Interim DON) said in July 2021 we implemented a new process for admission orders. Two nurses should check admission orders to ensure they are done correctly. At 11:45 AM, V3 said residents with a history of stroke should be on a blood thinner. V3 said anticoagulant medication is used to prevent blood clots and should not be discontinued unless ordered by a physician. On August 17, 2021 at 10:50 AM, V3 (Interim DON) said it's considered neglect for not entering in a resident's prescribed medication as ordered. On August 18, 2021 at 8:40 AM, V3 said nursing enters the physician orders into the electronic medical records. V3 said nursing must have missed entering R97's anticoagulant medication order and no one caught the error. V3 said she was not aware of R97 not receiving her anticoagulant medication. R97's inital Nurse Practitioner Progress note dated December 24, 2020 showed R97 is oriented to person, time and place, well	S9999		

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developed and well nourished. She had a fall resulting in acute C2 fracture and will continue skilled therapy services (physical therpay/occupational therpay).

R97's next Nurse Practitioner Progress note dated June 23, 2021 (181 days later) showed R97 had a recent decline in functional mobility. A chest x-ray showed right lung base density consistent with an infiltrate and/or effusion. R97 is now on oxygen and complains of fatigue and has noted a decline in ambulation and transfers. (The facility did not provide evidence of physician progress notes after December 24, 2020 to June 22, 2021).

On August 17, 2021 at 2:08 PM, V3 (Interim DON) said physician visits should be once upon admission and once a month for skilled care residents. V3 said she could not find any evidence of physician visits for R97 after December 24, 2020 to June 23, 2021.

On August 18, 2021 at 9:00 AM, V24 (Nurse Practitioner) said her medical group starting seeing R97 in July 2021.

The facility's Medication Administration General Guidelines Policy dated March 2018 states, All medications should be administrated as prescribed by licensed personnel ...."

The facility's Physician's Orders for Medications or Treatments policy dated March 2018, states "The nurse will transcribe any telephone or transfer sheet orders to the POS ...fax a signed hard copy of the physician's orders to the pharmacy ....for facilities using e-MARs that interface with pharmacy, the pharmacy will enter orders based on the faxed POS and orders will

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S9999	Continued From page 7 be electronically transmitted immediately after pharmacist verification ...." The facility's Abuse Policy dated September 2020 states, " Neglect is the failure of the facility, it's employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress." The facilities Medical Care Services policy dated September 2020 states, "Residents will receive medical care and services which met their individual needs and ensures adequate health care.....4. Residents will be seen by a physician, or delegated physician's assistant or nurse practioner at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required..." (A) 2) Statement of Licensure Violations: 300.610a) 300.696a) 300.696c)2)7) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or	S9999		

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S9999	Continued From page 8 the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) 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 (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings 7) Guidelines for Infection Control in Health Care Personnel Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary	S9999		

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S9999	Continued From page 9 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. These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a person under investigation for possible covid remained in transmission based precautions, failed to ensure a visitor was in a designated visiting area, failed to ensure staff removed an N95 and disinfected a face shield after leaving an isolation room.These failures have the potential to affect all residents in the facility and has the potential to infect high risk residents with Covid 19 and spread Covid 19 to other residents. The findings include: 1. R349's Face sheet printed on August 16, 2021 showed R349 was admitted to the facility on August 6, 2021. R349's Physician Order Sheet printed on August 16, 2021 showed R349 was to be on transmission based contact/droplet precautions beginning August 6, 2021. The facility's COVID vaccination list dated August 15, 2021 showed R349 is not vaccinated for COVID-19.	S9999		

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S9999	Continued From page 10 On August 16, 2021 at 10:15 AM, R349's room has an isolation cart and isolation signage on their door. R349 was not observed in their room at this time. At 10:30 AM, R349 was sitting on the patio with eight other residents during the patio music activity not being social distanced (at least 6 feet apart) from other residents in the activity. On August 16, 2021 at 11:25 AM, V8 Memory Care Unit Manager moved R349 into the unit from the patio by wheelchair. R349 was moved into the dining room and positioned at a table with 3 other residents (R42, R68, and R49). The residents were not at least 6 feet apart at the table. R349 completed her meal while at the table. On August 16, 2021 at 2:30 PM, V8 stated R349 was not socially distancing during lunch, she is out of her room because she was a fall risk, but should be socially distanced. R349 was observed multiple times outside of her room with V8, V16, and V17 (CNAs), V18 Licensed Practical Nurse (LPN), and V19 and V20 Activity Aides had engaged R349 at various times without attempting to redirect R349 to wear a mask, or socially distance R349 from other residents. On August 16, 2021 at 3:00 PM, V13 Nurse Consultant/Interim Infection Control Preventionist (ICP) stated memory care staff should attempt to redirect residents on quarantine (droplet/contact) isolation to go back to their rooms, attempt to wear a mask, and attempt to socially distance (6 feet) from other residents to try to reduce potential spread of Covid. CDC guidance updated May 12, 2020 for Memory	S9999		

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S9999	Continued From page 11 Care Units states " ...Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated) ...Limit number of residents or space residents at least 6 feet apart as much as feasible when in common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. The facility's Positive COVID-19 tracking for August 2021 showed the facility entered outbreak status on August 3, 2021 due to R82 having a positive COVID-19 result. Consecutive positive results are: R64 on August 8, 2021, V21 Certified Nursing Assistant (CNA) on August 11, 2021, V22 Social Services Director on August 15, 2021, and V23 Assistant Administrator on August 16, 2021. The facility resident vaccination rate printed on August 16, 2021 showed 83% of residents are vaccinated. The facility staff vaccination rate printed on August 16, 2021 showed 56.37% of staff are vaccinated. On August 16, 2021 the Kane county positivity rate for Kane County was 6.1% per the www.dph.illinois.gov website. The facility's Census list printed on August 16, 2021 showed R8, R9, R13, R14, R15, R31, R36, R42, R43, R44, R45, R47, R49, R50, R56, R58, R68, R84, R87, R94, R199, and R349 are residents on the 200 wing (Building A) of the memory care unit. On August 18, 2021 at 11:00 AM, V3 (Assistant	S9999		

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S9999	Continued From page 12 Director of Nursing) stated the facility has 2 buildings, but we do share staff between buildings to cover the schedule. The Residents Census and Conditions of Residents Form (form CMS-672) completed on August 17, 2021 showed the facility census was 101 residents. 2. R249's Physician Order Sheet shows an order for Isolation: Contact and droplet precautions due to possible exposure to COVID-19. The facility's Census list printed on August 16, 2021 showed R249 resides on the second floor of Building B. The facility's list of PUI (Person Under Investigation-for COVID illness) shows that R249 is quarantine for COVID precautions. On 8/16/21 at 10:06 AM, there was a contact/droplet sign on R249's door. There was a container of disinfectant wipes on top of the isolation cart outside of R249's room. The isolation cart included disposable gowns, gloves, and N95 masks. At 10:08 AM, V5 CNA (Certified Nursing Assistant) entered R249's room and shut the door. V5 exited R249's room and did not disinfect his face shield or dispose of his N95 mask. V5 then went into another resident's room that was not on isolation. At 10:15 AM, V5 said R249 is on isolation because R249 went out to the hospital. V5 said, "We are supposed to change our N95 mask and disinfect our face shields when we leave [R249's] isolation room. I forgot to change my mask and disinfect my shield." The facility's list of COVID vaccinated residents	S9999		

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S9999	Continued From page 13 dated 8/15/21 shows R249 is not vaccinated for COVID. On 8/16/21 at 2:20 PM, V6 RN (Registered Nurse) and V7 LPN said that staff change their N95 masks when exiting rooms that are on droplet and contact precautions for COVID illness. At 3:00 PM, V13 Infection Control Preventionist said staff should be changing their N95 masks when they leave contact/droplet isolation rooms for COVID. The CDC guidance updated 2/23/21 shows, "Recommended infection prevention and control practices when caring for a patient with suspected or confirmed SARS CoV-2 infection: Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door. Reusable eye protection must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use." The facility's Universal Eye Protection policy updated 3/12/21 shows, "Eye protection and/or face shields should be cleaned/disinfected; after each encounter with patients on quarantine (new admissions or readmissions)." The facility's Use of N95 Respirations policy updated 2/12/21 shows, "An N95 respirator should be used instead of a facemask when performing or present for aerosol-generating procedures for residents with known or suspected COVID-19 or who are on droplet precautions for other illness or reason. To reduce the amount of contamination, staff may wear either a surgical mask or face shield over the N95. In such cases, the surgical mask must be discarded, or face shield cleaned after providing care. To reduce the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016950	A. BUILDING: _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES CTS OF HUNTLEY	12140 REGENCY PARKWAY HUNTLEY, IL 60142

(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 14 amount of contamination when providing care to a resident with confirmed or suspected respiratory infection, staff may wear either a surgical mask or face shield over the N95. In such cases, the surgical mask must be discarded, or face shield cleaned after providing care." 3. R8's Face sheet printed on August 17, 2021 showed R8 was originally admitted to the facility on October 23, 2018. On August 16, 2021 at 11:35 AM, V11 (R8's family) was sitting at a dining room table with R8, R9, R50, R199. V11 was not social distanced (6 feet apart) from the other residents. V8, V16, V17, and V18 made no attempts to redirect V11 or R8 away from other residents to R8's room or to a designated visiting area. On August 16, 2021 at 3:00 PM, V13 stated compassionate care visitors should be visiting residents in their rooms and/or in designated visiting areas. Visitors should not be sitting in the dining room with other residents. Visitors still need to socially distance from other residents. The facility's Visitation Guidance revised August 10, 2021 showed " ...Visitors should physically distance from other residents, staff and visitors in the facility ...Visits may occur: a. outdoors, b. in dedicated indoor visitation spaces, and c. in private rooms ..." (B)	S9999		