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
	IL6013098	A. BUILDING: ______ B. WING ______	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLATERRA ELMHURST	420 WEST BUTTERFIELD ROAD ELMHURST, IL 60126

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S 000	Initial Comments First Probationary Licensure Survey (CHOW-Change in Ownership)	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)2)3)4) 300.1210d)1)2)4)A)5)6) 300.1630d) 300.1630e) 300.3220f) 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 care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

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.

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

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 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.

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.

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d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

Section 300.3220 Medical Care

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.

These Regulations are not met as evidenced by:

Based on observation, interviews and record review, the facility failed to apply a hand splint as ordered to prevent decline/further decline in contracture, provide incontinence care timely in a manner to prevent infection and prevent possible development of pressure ulcer (s), ensure that a wound dressing was maintained/changed to prevent further skin damage or infection, ensure nail hygiene was maintained, ensure medications were not left at bedside and unattended, administer a lidocaine patch as ordered by a

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physician and implement a pressure ulcer intervention to prevent the development/worsening of pressure ulcers.

This applies to 7 of 8 residents (R102,103, R104, R105, R106, R107 and R108) reviewed for various nursing care and personal care in the sample of 8.

The findings include:

On 9/8/2021 at 11:30 A.M., R107 was trying to get out of bed by herself and was yelling "I need help, I want to eat my cake, can you hand me a fork?" R107 was alert and oriented. R107 was observed with a left-hand contracture. All four fingers were in a closed fist position. R107 said that she uses a hand splint for her contracted hand, however, the staff does not put it on every-day. R107 also stated that she cannot put the hand splint on by herself.

R107 was observed with long fingernails that were embedded to her inner palm area. R107 said she wanted her nails short because it was causing pain in her palm.

V10 (Certified Nurse Assistant/CNA) came into the room. V10 stated that she does not apply the hand splint because it was the restorative department staff who apply the splint.

The POS (Physician Order Sheet) for the month of September 2021 showed a physician order dated 7/12/2021 for R107 to provide assistance with hand splint to the left hand every morning.

The MDS (Minimum Data Set) dated 8/15/2021 showed that R107 requires extensive assistance of 1 staff with most aspects of her ADLs

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(Activities of Daily Living) including hygiene.

On 9/8/2021 at 11:00 A.M., R105 was heard from the hallway yelling for help. R105 said "Help me, help me, my bottom hurts and I need my diaper changed."V11 and V12 (CNAs) were summoned to help R105.

V11 stated that she came in to work at 7:00 A.M. on 9/8/2021 and did not have the time to change R105 yet. V11 with assistance from V12, unfastened R105's incontinence brief. R105 was heavily soaked with urine and stool. R105's perineal area was raw red and had linear marks indented on her skin caused from the elastic band of the incontinent brief.

R105 was lying on an air mattress but the middle part of the mattress had already sunk in from R105 not being repositioned for long hours. R105's fingernails were noted to be long with a black substance under the nails. V11 said that she was trying to provide care to all her assigned residents but has not got to R105 yet. V12 stated that R105 was totally dependent on staff for all aspects of ADLs.

On 9/8/2021 at 10:45 A.M., R106 was in her room sitting in her wheelchair. R106 was on isolation prçcaution as precautionary measures for COVID -19 infection. R106 said "Please take care of my leg, I have a large blister on my leg, and it might burst, the dressing was not protecting my blister, it's loose." Together with V13 (Licensed Practical Nurse), R106's blister was checked. R106 has a fluid filled blister on the frontal aspect of her left lower leg. The blister was approximately the size of a quarter coin. R106's wrapped dressing was loosely wrapped down to her ankle and the blister was exposed. The date

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documented on the dressing was 9/7/2021. V13 said she will inform V6 (Treatment Nurse) to apply the dressing.

On 9/8/2021 at 1:00 P.M., V6 stated that she had obtained a physician order for R106's blister to have a thick dry pad dressing wrapped with Kerlix every day and as needed to protect the blister for further skin damage.

The facility's policy for "Care Guidelines dated 10/31/2018 showed:
"ADL care is provided for each resident in the facility...
2. Nurses and CNAs are trained in providing general/routine ADL care to residents. The facility has an active program of restorative nursing services which is developed and coordinated through resident's care palm.
3. The facility's restorative nursing program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence as well as helping slow down and/or prevent decline in functioning.
4. ADL nursing care is performed daily for the residents such as...
b) Encouraging and assisting bedfast residents to change positions at least every (2) hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures and deformities...
d) Assisting residents to adjust to their disabilities/impairment, to use their prosthetic devices, appliance....
g) Incontinent care...
h) Daily Assistance in... Grooming/hygiene ...mobility... "

On 9/8/21 at 10:55 AM, R103 had a square bandage taped to her neck and the date on the bandage showed 9/3/21. R103 stated the nurse

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was supposed to change her bandage every three days but three days ago the staff brought a thick foam bandage that was not foam adhesive. R103 stated the foam was very thick and would be uncomfortable around her neck. R103 asked to have foam adhesive dressing (Mepilex) used as was customarily used. R103 stated no staff returned to change the bandage.

Progress notes, dated 8/27/21 to 9/8/21, show no documentation that R103's tracheostomy bandage was changed or that R103 refused a dressing change.

TAR (Treatment Administration Record), printed 9/8/21, shows a physician order (dated 7/9/21) for "Stoma site on trachea every day shift every three days old trach site." The TAR shows the nurse signed off that the treatment was performed on 9/1/21, 9/4/21, and 9/7/21.

On 9/8/21 at 12:38 PM, V6 (Wound Nurse) stated the floor nurse usually changes R103's dressing but she will do it if she is present at the facility. V6 stated the facility had not been out of Mepelex products. V6 stated if R103 refused her dressing change, the nurse was expected to document the refusal in the clinical record. V6 reviewed the POS order, "stoma site on trachea every day shift every 3 days old trach site" 7/8/21 on TAR - and stated the order must mean every 3 days staff should be looking at R103's old trach site and the dressing should be changed. V6 stated that was not how the order should be worded.

Tracheostomy care plan, revised 7/17/21, shows R103 has a partial tracheostomy site from a previous tracheotomy and the care plan goal was to prevent infection on the wound site. Interventions included, "Apply wound treatment

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as ordered by the physician, keep skin clean and dry, monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to physician.

Facility document Skin Care Treatment Regimen, revised 7/28/21, shows, "Routine daily wound care treatment/ dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician."

On 9/8/21 at 10:35 A.M., R108 was watching the television while sitting in the chair in her room. There were several medications inside a cup on top of R108's bedside table. R108 stated "my nurse left it there." On 9/8/21 at 10:37 A.M., V5 (Nurse) was called to R108's room. V5 stated she left the medications at R108's bed side for her to take. V5 stated she should have stayed with R108 until she took her medications. V5 admitted the medications belonged to R108 and they were all her 9 A.M., medications.

Review of R108's EHR showed R108 was admitted to the facility 10/5/15 with diagnoses that included Parkinson's Disease, Depression, Cerebrovascular Disease, Dementia, Anxiety, Hemiplegia and Hemiparesis.

On 9/9/21 at 11:01 A.M., V2 DON (Director of Nursing) stated nursing staff must administer medications directly to the resident and medications should not have been left at the bedside.

Facility's policy titled "Medication Pass" with a revised date 7/28/21 showed: "It is the policy of the facility to adhere to all federal and state

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S9999	Continued From page 9 regulations with medication pass procedures." On 9/8/221 at 10:34 AM, R102 was lying in his bed with his tray table in front of him. A Lidoderm patch 5% package was open and sitting on the tray table with a patch inside of the package. R102 stated the nurse brought the patch into his room that morning and was going to replace the old Lidoderm patch located on his right groin area. R102 stated he only had one Lidoderm patch on his body which was the one located on his groin. V9 (Licensed Practical Nurse) came into the room and confirmed there was a patch in the open package and stated the night nurse usually puts the patch on at 6:00 AM. V9 stated she probably did not see the open package because there was a breakfast tray on the table covering the Lidoderm patch package. On 9/8/21 at 10:37 AM, V7 (Nurse Manager) checked R102's physician order and stated R102 had an order for the patch to be placed on R102's lower back every day at 6:00 AM. V7 came into the room and assessed R102's old patch which was adhered to R102's right groin. V7 stated the date on the patch was 9/6/21. R102 stated his pain level was 5 out of 10, with 10 being the worst pain. R102 stated he did have his oral pain medications that morning which he felt were helping his hip pain. R102 stated his hip pain normally runs 5-7 out of 10 and the night prior was a 6 out of 10. MAR (Medication Administration Record, dated 9/1/21 to 9/8/21, shows the staff signed that R102 was administered his Lidoderm patch 5% each day and the patch was applied to his lower back on all applications except 9/2/21 (which was	S9999		

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applied to his right leg).

POS (Physician Order Sheet), dated 9/8/21, shows R102 had a physician order (dated 8/4/21) for "Lidoderm Patch 5% Apply to per additional directions topically in the morning related to discitis, unspecified, lumbar region."

Review of R102's progress notes, dated 9/1/21 to 9//21, shows R102 was administered his Lidoderm patch on 9/2/21 at 5:46 AM.

Care plan, undated, shows R102 was experiencing pain and interventions included "provide analgesic as ordered."

Facility document Transdermal Drug Delivery System, undated, shows, "Purpose: To administer medication through the skin through proper placement of the patch and care of the application sites .... 2. Identify the location on the body for patch placement. Always rotate application sites to prevent irritation ....7. Label patch with date and nurse's initials ...."

ADL (Activities of Daily Living) care plan, revised 8/31/21, shows R104 required extensive to total assistance with bed mobility and transfers.

Pressure ulcer care plan, created 8/5/21, shows R104 has unstageable pressure ulcers to coccyx, right outer ankle, right heel, right medial foot and DTIs (Deep Tissue Injuries) to left outer ankle, left lateral foot, and right lateral foot.

The care plan shows R104's pressure ulcers were related to multiple factors including immobility. Interventions included follow facility policies/protocols for the prevention/ treatment of skin breakdown, offloading of bilateral heels when

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in bed every shift and as needed, and provide assistance to turn/reposition at least every 2 hours and more often as needed or requested.

On 9/8/21 at 11:20 AM, R104 was lying supine in bed with his heels resting directly on his bed and not offloaded for pressure relief. R104 had two heel protector boots sitting on the chair next to his bed.

On 9/8/21 at 1:06 PM, R104 was still lying supine in his bed, R104 had no protective boots on his feet, and his heels were resting directly on the bed and not offloaded for pressure relief.

On 9/8/21 at 2:25 PM with V7 (Nurse Manager) and V8 (Registered Nurse), R104 was lying in bed, slightly turned to his left side, with his left lateral foot resting on the air mattress and his right medial foot resting on his mattress. V7 stated R104's feet needed to be moved off the bed and more on to the pillow. V7 asked R104 if she could put his blue heel protectors on his feet and 104 responded, "I don't care." R104's wounds were dry with black tissue on his heel, ankle and lateral foot.

Wound Care Notes, dated 9/8/21, shows R104 had the following active pressure ulcerations:
1. right medial foot - unstageable - 100% necrotic hard - 0.5 cm (Centimeters) by 0.5 cm by unknown depth
2. right lateral foot - deep tissue pressure injury - 100% necrotic hard - 0.5cm by 1.0 cm by unknown depth
3. right heel - unstageable - 100% necrotic hard - 4.0 cm by 4.0 cm by unknown depth
4. right outer ankle - Stage 4 - 100% necrotic hard - 2.2 cm by 2.0 cm by unknown depth
5. medial left foot - deep tissue pressure injury -

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S9999	Continued From page 12 100% epithelial 6. coccyx - Stage 4 - 25% necrotic soft, 50% slough loosely adherent, 25% bright beefy red - 10cm by 10.5 cm by 3.4 cm POS, dated 9/8/21, shows R104 had physician orders for, "Offloading of bilateral heels when in bed as needed and every shift (Ordered 8/23/21) .... Turn and reposition at regular intervals for comfort every shift (ordered 8/22/21). Facility document Wound Care Program Care Guidelines, revised 7/3/21, shows, "g. Resident may be properly positioned in bed using pillows or other supportive devices to help protect boney prominence areas susceptible to pressure .... J. Offload elbows and heels as needed. A heel protective device may not be indicated if resident is utilizing and air mattress. K. Elevate resident heels off the bed as indicated (e.g., place pillows under calf - not under ankles- to raise heels off the bed, unless contraindicated due to medical condition). (B)	S9999		