STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014500	A. BUILDING: _____ B. WING _____	C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF NORTHMOOR	5831 NORTH NORTHWEST HIGHWAY CHICAGO, IL 60631

(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: 2181486/IL131518	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)d)2)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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 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: 2)All treatments and procedures shall be administered as 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. These Requirements were not met evidencded by: Based upon observation, interview, and record review, the facility failed to follow (R4's) wound care orders, failed to turn and reposition (R1, R3, R4, R6) as directed, and failed to provide timely incontinence care for four of six residents (R1, R3, R5, R6) reviewed for pressure ulcers. These failures resulted in R2 and R3 developing (facility acquired) pressure ulcers and R1 developing a (facility acquired) DTI (Deep Tissue Injury). R3's sacrum wound became necrotic and required surgical intervention on 3/4/21. Findings include;	S9999		

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S9999	Continued From page 2	S9999		

The pressure injury list affirms R3 developed a (Facility Acquired) sacrum DTI on 2/24/21. R3's (3/4/21) sacrum skin assessment affirms an unstaged pressure ulcer was identified with 30% necrotic/eschar tissue present, and an excisional debridement was conducted. R3's (12/27/16) care plan states; keep skin clean and dry. Turn and reposition every 2 hours. On 3/8/21 at 11:10am, an individualized turning schedule was observed on the wall above R3's bed stating 10:00 (Left) however she was lying on her back. Surveyor inquired why R3 was not on her (left) side as directed V5 (LPN/Licensed Practical Nurse) responded "She can go back to her back on her own." [There was nothing in place to ensure that R3 laid on her side]. V5 removed R3's incontinence brief and stated "There's BM (Bowel Movement) on the bandage" (referring to her dressing). Diarrhea was present, her skin excoriated, and a dark brown discoloration encircled the sacral wound (debrided 4 days prior). On 3/10/21 at 12:49pm, surveyor inquired about R3 V3 (Wound Care Coordinator) stated "She has a time clock for turning and repositioning we turn her left, right to offload the sacral area. She's compliant with her care so we would put a pillow above the area where the wound is to make sure she's lying on the side."

R2's (8/14/20) care plan states turn and reposition every two hours and as needed. R2's (2/9/21) skin assessment includes a (Facility Acquired) right buttock DTI. The (undated) pressure injury list affirms R2 developed a (Facility Acquired) right buttock stage 3 pressure ulcer.

On 3/4/21, IDPH (Illinois Department of Public Health) received allegations that R1 has pressure ulcers due to lack of turning and being left

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S9999	Continued From page 3	S9999		

dirty/unchanged for hours. R1 was discharged from the facility prior to this investigation however (3/4/21) wound assessment affirms he sustained a (Facility Acquired) right buttock DTI (Deep Tissue Injury) measuring 3 x 3 x 0cm (Centimeters) described as 100% Deep Maroon Patches. On 3/10/21 at 12:33pm, surveyor inquired about R1's (3/4/21) DTI V3 (Wound Care Coordinator) stated "I did rounding with the wound care Nurse Practitioner and found the DTI. The entire area was darkened, it was non-blanchable." Surveyor inquired how someone develops a DTI V3 responded "Constant pressure on that area will cause a pressure injury." [R1's care plan includes; (8/21/20) turn and reposition every two hours and as needed. (8/24/20) Resident is incontinent of bowel needs extensive assistance with toileting. (9/14/20) Resident requires assistance from staff for bed mobility; unable to turn and reposition self in bed without physical assistance from staff].

R6's (3/28/20) care plan states resident has potential for alteration in skin integrity related to; cognitive impairment, contractures, decreased mobility, and incontinence. Turn and reposition every 2 hours. On 3/8/21 at 11:39am, surveyor requested to inspect R6's incontinence brief V4 (Certified Nursing Assistant) affirmed he was assigned to R6 (7am-3pm) and stated "I haven't changed her yet." V4 removed R6's incontinence brief and stated "She's wet, soaking wet and she's having menstruation too." R6's brief was completely saturated with urine, and blood, the sheet beneath her was also soiled. A repositioning schedule was posted on the wall above R6's bed stating 10:00 (left) however she was lying on her back. Surveyor inquired about R6's current position V4 stated "She's lying flat, she should be on the left side."

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R4's (6/30/11) care plan states resident requires extensive assistance with bed mobility. On 3/8/21 at 12:10pm, V5 (LPN) affirmed that she was assigned to R4. Surveyor requested V5's assistance to inspect R4's incontinence brief and advised that her assigned CNA was assisting another resident. V6 (Licensed Practical Nurse) and surveyor waited for V5's assistance (outside R4's room) for several minutes but she never came. An individualized turning schedule was posted on the wall above R4's bed stating 12:00 (right) however she was lying on her back at 12:15pm. [R4's (2/18/21) physician orders include; puracol plus pad (Collagen) apply to sacrum topically. Apply medihoney gel on collagen, apply collagen, cover with foam, apply tegaderm]. Surveyor inquired about R4's wound V6 stated "It doesn't close, it's been here since she came here about 9 years now." V6 removed R4's (undated) foam dressing and an deep sacrum wound was observed (additional treatments were not present). Surveyor inquired about R4's dressing V6 stated "It's an optifoam." Surveyor inquired if only a foam dressing was beneficial to healing R4's wound V6 responded "Yeah, I believe so, in case she poop." On 3/10/21 at 12:57pm, surveyor inquired if R4 is able to turn herself V3 responded "She needs to be turned and repositioned. She also has a turning clock right, left to offload the sacral area."

R5's (11/12/20) care plan states; check resident for incontinence. On 3/8/21 at 10:59am, V4 (CNA) removed R5's incontinence brief and stated "It's soaked." Surveyor inquired when his brief was last checked and/or changed R5 stated "It was 5:00 in the morning when I got up."

On 3/8/21 at 3:17pm, surveyor inquired about

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S9999	Continued From page 5 potential harm if residents are not turned every 2 hours and soiled incontinence briefs are not timely changed V9 (Medical Director) stated "You run into skin problems, deconditioning, things of that nature." Surveyor inquired about the prescribing and following wound care orders V9 responded "Typically we get a wound care consultation, I'm expecting them to follow the orders the wound care people make." The (09/2020) perineal care policy includes PURPOSE: to maintain skin integrity. The (3/2/21) prevention and treatment of pressure injury policy states; identify the presence of pressure injuries and/or other skin alterations. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. At least daily, staff should remain alert for potential changes in the skin condition during resident care. " B "	S9999		