STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016216	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING BURR RIDGE	6801 HIGHGROVE BOULEVARD BURR RIDGE, IL 60521

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S 000	Initial Comments Complaint Investigation 2271803/IL144345	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.710a) 330.710b) 330.710c1) 330.720b) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public. c) The written policies shall include, but are not limited to, the following provisions: 1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers. Section 330.720 Admission and Discharge Policies	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.

These requirements were NOT met as evidenced by:

Based on observation, interview, and record review, the facility failed formulate and provide written policies describing circumstances for resident transfers from sheltered care; and failed to ensure that a resident in need of nursing care for an infected and unstageable facility-acquired pressure ulcer was not kept in a sheltered care area.

Findings include:

R1's face sheet documents an initial admission date of 10/23/18 to the memory care unit of the Sheltered Care section of the facility.

R1's face sheet documents the following diagnoses: left femur fracture, presence of cerebrospinal fluid drainage device, mild protein-calorie malnutrition, encephalopathy, nontraumatic subarachnoid hemorrhage, left hemiplegia and hemiparesis following cerebral infarction, weakness, anemia, aphasia, dementia without behavioral disturbance, and dysphagia. R1's informed consent for hospice was signed by R1's POA on 7/26/19.

On 3/4/22 at 10:05am, V1 (Administrator) stated, "I'm new to this place. I don't know how someone qualifies for sheltered care and skilled care. I'm

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still learning the regulations. I'm responsible for both the sheltered and skilled. You will have to talk to my Director of Wellness (V2) about this."

On 3/8/22 at 3:20pm, V2 (Director of Wellness) stated health assessments were completed twice a year and as needed. V2 stated the facility does not really have a document that has criteria that shows if R1 or any other residents are appropriate for sheltered care or not.

The facility's most recent Senior Living Comprehensive Assessment Tool for R1 showed it was effective on 12/07/2021. (R1's Comprehensive Assessment Tool showed only Section K [regarding Falls] was electronically signed by V2 on 12/7/2021, and all other sections from A-M were electronically signed by V2 on 3/8/2022, which was during the survey.) The Tool identified the "reason for review" as simply "review," and showed R1 was severely cognitively impaired, cannot/does not make her needs known to staff, and is not independently mobile.

Section J "Functional Status- Activities of Daily Living" in R1's Assessment Tool further showed R1 is incontinent of bladder and bowel, wears incontinence briefs, requires assistance with meals three times a day, and had a sacral wound. Section J also showed R1 requires extensive assistance of two people for bed mobility, requires total assist/two persons with lift for transfers, and requires total assistance for bathing, grooming, and dressing of her upper and lower body. Under 3a Toileting, the Tool showed R1 needs total assistance/two person with lift and requires a schedule, which was identified as every two hours/day, every three hours/day, every four hours/day, and then "other," which was specified as "frequent re-positioning due to poor

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S9999	Continued From page 3 nutrition, immobility, and sacral wound." Section L in the Tool showed R1 was at moderate risk for skin breakdown and had an unstageable pressure ulcer to her sacrum. Section L showed the frequency of staff assistance required for turning and repositioning R1 was four times/day, and showed R1 did not require wound/skin treatment assistance, (but "frequency of staff assistance required for dressing changes" was PRN ["as needed"]). Under "Additional information" was written "no active wounds at this time." V3's (Hospice Nurse) visit note for R1 from 1/10/22 described R1's sacral wound as unstageable, measuring 4.5cm (centimeters) by 7.5cm, with 100% black, necrotic eschar, and having purulent, thick, opaque drainage with an odor. The note describes the area around R1's sacral wound as "dark red and/or non-blanchable." On 3/4/22 at 2:10pm, V3 (Hospice Nurse) performed dressing treatment dressing change to the deep wound on R1's backside. V3 stated the measurements of the wound were 8cm by 11cm with undermining of 2.5cm, and tunneling was present. V3's hospice note from 3/7/22 showed "Pressure Sore on Sacrum-Extensive depth," with the presence of necrotic tissue and undermining between 2-4cm, and wound tunneling. On 3/4/22 at 2:00pm, V3 (Hospice Nurse) stated she did not look at R1's wound in December because she thought it had healed in November and she could not find CNAs (Certified Nursing Assistant) on the unit to help and move R1 in bed to assess that area. V3 stated when she had previously said she did a head-to-toe assessment	S9999		

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on R1, she had not looked at R1's back or her sacrum because R1 was too heavy. V3 stated she got a call from a facility floor nurse sometime in January 2022 that R1 had developed a stage 4 necrotic pressure sore on her coccyx. Hospice documentation from 11/11/2021 showed R1 had "skin discoloration." On 3/4/22 at 2:38pm, V3 stated that because R1's immobility, poor nutrition, and hospice status, the skin discoloration should have been monitored.

On 3/4/22 at 12:15pm, V4 (CNA-Certified Nursing Assistant) stated, "I gave (R1) bed-baths and I primarily took care of her. In December, there was an open wound in (R1's) coccyx. I told my nurse and I can't remember who. I remember the nurse putting a dressing on it. It never healed. I even told (V3) (Hospice Nurse) and she said that she didn't have any dressings with her. The wound never got better."

R1's Skin Integrity Forms from 11/3/2021, 12/2/2021, 12/7/2021, 12/10/2021, and 12/23/2021 all showed an open sore was noted on R1's "tailbone."

On 3/4/21 at 1:30pm, V6 (LPN) stated she remembered that R1 had a stage 2 pressure sore that where the first layer of skin was damaged. V6 stated it was never fully healed and she assumed somebody was treating it. V6 stated the next time she saw it, it had deteriorated and become necrotic.

R1's 2/8/22 Hospice Comprehensive Assessment and Plan of Care Update Report showed nursing problems as unstageable sacrum pressure ulcer with deep tissue loss, left heel black deep tissue blister, right hip non-blanching redness, left upper buttock and left posterior hip redness.

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S9999	Continued From page 5 On 3/4/22 at 2:40pm, V2 (Director of Wellness) stated, she did not have any Hospice collaboration notes from V3 in the hospice binder. Both V1 (Administrator) and V2 (Director of Nursing) stated they were under the impression that R1's wounds were being addressed and taken care of by V3. On 3/4/22 at 3:00pm, V2 stated, "We don't have a TAR (Treatment Administration Record) in sheltered care. If my nurses changed (R1's) dressing prn or as needed, they should be documenting in their progress notes. I remember that (R1's) wound was a stage 2. Someone who has poor nutrition, bed bound and on hospice is not going to have a wound that heals." R1's orders with the medical doctor document the following: 1/12/22: "Cleanse sacrum wound with dermal wound cleanser. Pat dry with 4x4 gauze sponges. Cover wound with 4 x 4 gauze soaked in iodine. Cover with ABD pads (2). Cover with 2 or 3 Island dressings. Hospice nurse to provide wound care on Mondays, Wednesdays, and Fridays during visits. Facility nurse to provide PRN wound dressing changes per order." 2/14/22: "Bactrim DS 800/160mg Tablet. Give 1 tablet BID by mouth for 14 days for wound (sacrum) infection." 3/3/22: "Wound Care Order Change: 1. Sacrum Stage 4 Wound: a. Cleanse wound with dermal wound cleanser. B. Pat dry with 4 x 4 gauze pads. C. Pack wound with 4x4 gauze pads with iodine. Apply Calcium Alginate dressing. Cover with foam dressing/island dressing. Secure edges of dressing with tape. Hospice nurse will change dressing every other day and prn on weekdays. Facility nurse will change dressing	S9999		

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S9999	Continued From page 6 prn on weekdays and weekends." R1's facility nursing progress notes for the month of January 2022 documents the following: 1/5/22 (Wednesday): "Tolerated about 80% of breakfast. Fluids encouraged. Sacral wound cleansed with normal saline. Calcium Alginate and foam dressing applied. Hospice nurse updated on condition of wound. She stated she will be in the facility to see (R1) today." 1/10/22 (Monday): "Staff repositioned appropriately for comfort. Treatment to sacral wound applied." 1/12/22 (Wednesday): "Repositioned to ease pressure of sacrum. Sacral wound with foul smelling drainage. Dressing changed. Hospice nurse to visit later today. (R1) noticed with nickel size pressure area to left heel. Not opened, just discolored at this time. Both heels where off-loaded and hospice nurse made aware and said she will see [R1] tomorrow." 1/16/22 (Sunday): "[R1] started on antibiotic Bactrim for wound. No adverse reactions noted." 1/17/22 (Monday): "Antibiotics in progress for wound. No adverse reaction noted." 1/21/22 (Friday): "Wound care to coccyx wound. Cleansed with dermal wound cleanser, patted dry with 4x4. Covered with Betadine. Soaked 4x4's, applied 1 ABD pads and secured with 4 pieces of bordered gauze. [R1] tolerated wound care without pain." 1/26/22 (Wednesday): "Wound dressing changed. [R1] repositioned. Kept clean and dry." 1/27/22 (Thursday): "Dressing changed today." 1/28/22 (Friday): "Dressing changed today [R1] continues on antibiotics for wound." Facility's hospice contract with R1 documents the following: "II. Your Responsibilities and Representations: D. Health Assessment-You	S9999		

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S9999	Continued From page 7 agree that we may periodically assess your health and update a personal service plan and/or to determine whether you are appropriate to remain at the Community." On 3/8/22 at 3:30pm, V7 (Regional Director of Quality and Clinical Services) and V2 were asked for policies regarding admissions, discharges, and transfers for their sheltered care. At 5:09pm, V7 emailed surveyor the sheltered care regulations instead of policies. On 3/9/22 at 8:15am, a telephone interview was conducted with V7. V7 stated she emailed the sheltered regulations because she did not have policies for sheltered admissions, transfers, and discharges. V7 stated, "We will work on writing these policies. Any resident who needs skilled services in sheltered care can get those skilled services from hospice or home care. If they are not hospice, and require more types of skilled care, then they should be transferred to the skilled nursing section. In [R1's] case, I think the wound worsened, so she should have been transferred to skilled care." (A)	S9999		