STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDEN OF WATERFORD	2021 RANDI DRIVE AURORA, IL 60505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist residents identified as needing assistance with personal hygiene, oral care and dressing. This applies to 5 of 6 residents (R15, R52, R62, R67 and R75) reviewed for personal hygiene, oral care and dressing assistance in the sample of 18. The findings include: 1. R15 has multiple [DIAGNOSES REDACTED]. R15's quarterly MDS (minimum data set) dated 1/3/20 shows that the resident is moderately impaired with cognition and would require extensive assistance from the staff with regards to personal hygiene. On 3/02/20 at 1:15 PM, R15 was being wheeled by V3 (activity aide) along the hallway in front of R15's room. R15 was alert, oriented and verbally responsive. R15 had accumulation of long, curling chin hair and hair around her lips. R15 stated that she wants her facial hair removed. R15's fingernails were also long. R15 stated, My fingernails needs trimming, it is very long. V3 was present during this observation. R15's care plan shows that the resident has an ADL (activities of daily living) self-care performance deficit and would require assistance with personal hygiene. The same care plan shows multiple interventions which included, Provide hand over assistance as needed for ADL tasks and Provide needed level of assistance and support to complete activities of daily living. 2. R52 has multiple [DIAGNOSES REDACTED]. R52's admission MDS dated [DATE] shows that the resident is moderately impaired with cognition. On 3/02/20 at 1:27 PM, R52 was in bed, awake, alert and verbally responsive. R52 had accumulation of ear hair mostly outside of his ears by the cartilages area. R52's fingernails were uneven (some were long) and jagged. R52's care plan shows that the resident has an ADL self-care performance deficit and that R52 requires assistance with personal hygiene. 3. R62 has multiple [DIAGNOSES REDACTED]. R62's admission MDS dated [DATE] shows that the resident is moderately impaired with cognition. On 3/2/20 at 12:05 PM, R62 was sitting in her wheelchair inside her room. R62 was alert and verbally responsive. R62 had long and jagged fingernails. R62 stated that she wants the staff to trim her fingernails. R62 has a care plan which shows that the resident has an ADL self-care performance deficit and would require assistance with personal hygiene. The same care plan shows multiple interventions which included, Assist with personal hygiene as needed. 4. R67 has multiple [DIAGNOSES REDACTED]. R67's significant change MDS dated [DATE] shows that the resident is severely impaired with cognition and would require extensive assistance from the staff with regards to personal hygiene. On 3/2/20 at 12:44 PM, R67 was inside her room watching television. R67 was alert and verbally responsive. R67 had long fingernails and most of her nail polish were chipping. R67 stated that she wants the staff to trim her fingernails and apply a new polish. V7 (CNA) was made aware of this observation. R67's care plan shows that the resident has an ADL self-care performance deficit. This ADL care plan has multiple interventions which included, Assist with ADL tasks as necessary and Provide needed level of assistance and support to complete activities of daily living. 5. R75 has multiple [DIAGNOSES REDACTED]. R75's admission MDS dated [DATE] shows that the resident is cognitively intact. The same MDS shows that R75 has impaired range of motion on one side of her upper extremity. On 3/2/20 at 12:16 PM, R75 was eating lunch inside the first-floor dining room. R75 was alert and oriented. R75 had a right-hand splint in place. R75's fingernails were long and jagged, and her nail polish was chipped. R75 stated that she wants the staff to trim her fingernails and apply new polish because she cannot do it herself because of her right hand. V4 (CNA) was made aware of this observation. R75's care plan shows that the resident has an ADL self-care performance deficit related to arm weakness and would require assistance with personal hygiene. On 3/4/20 at 2:20 PM, V2 (Director of Nursing) stated that it is part of the nursing service to make sure that residents unwanted facial and ear hair are removed with the approval of the resident. It is also part of the nursing service to make sure that residents' fingernails are trimmed and cleaned with the approval of the resident.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident positioning needs were met. This applies to 1 of 1 (R55) reviewed for positioning and mobility. The findings include: R55's EHR (electronic health record) showed [DIAGNOSES REDACTED]. On 3/2/20 at 12:53 PM, R55 stated I'm glad you saw that too (referring to one leg rest on the wheelchair). R55 was seated in hallway B in his wheelchair with his left leg crossed over on the right leg which rested on the wheelchair's right footrest. When asked where his other leg rest was, R55 stated its been this way for a couple of weeks. R55 added my butt is too big for this chair, its uncomfortable and this sock is too small to cover my bandages on my foot. On [DATE] at 02:16 PM, in the basement level hallway, R55 stated they gave me bigger socks, and put the leg on my wheelchair today after I had complained for several weeks. This chair is still too small. V2 (Director of Nursing) was asked to join the conversation and stated she had would get R55 evaluated. V2 stated R55 had been given a different wheelchair before but it was too wide for him to navigate. R55's 8/27/19, care plan showed the following; alteration in comfort and left leg pinning due to left femur; limited LE (lower extremity) ROM (range of motion) affecting function with regards to the following joints: hips and knees; limited mobility secondary to [MEDICAL CONDITION]. The interventions identified as: to assist with repositioning as needed, support hip/leg to prevent adduction. Provide positioning pillows or devices as needed to increase comfort and support and to not allow resident to cross legs.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were properly transferred using gait belts. This applies to 3 of 3 (R72, R81 & R190) residents reviewed for transfers. The findings include: 1. R190's face sheet showed [DIAGNOSES REDACTED]. On 3/2/20 at 11:34 AM, R190 was in bed with family member present. V19 (CNA certified nursing assistant) placed the gait belt above the waist and under the breast of R190. V19 then transferred R190 from bed to wheelchair by grasping the waistband of R190's flannel pants, assisted R190 to stand and then to move to be seated in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) wheelchair. 2. R72's face sheet showed [DIAGNOSES REDACTED]. On 03/04/20 at 10:06 AM, R72 was seated at bedside with left arm and hand in a sling and requested to lie down. V18 performed transfer to bed after placing gait belt above the breast on the chest. V18 then transferred R72 using the slide board and assisted R72 to position in bed with the gait belt located above the breast. 3. R81 has multiple [DIAGNOSES REDACTED]. On 3/3/20 at 2:26 PM, R81 was sitting in her wheelchair inside her room with a family member present. R81 had a gait belt on, wrapped around her chest area (under her armpits). V11 (CNA/Certified Nursing Assistant) used the gait belt that was already on R81 to transfer the resident from wheelchair to bed. V11 assisted R81 to stand by using her right hand, to hold on to the front gait belt of R81 which was positioned on the resident's chest area and using her (V11) left hand, to hold on to the back of R81's pants waist band. R81 was being transferred towards her left side. While R81 was pivoting on her left leg to reach/sit on her bed, V11 assisted the resident by holding only the back of the resident's waist band. During this transfer procedure, R81 was not using her left hand to reach and hold on to the side rail of the bed for support. R81 had to use her right hand (crossing over her left arm and hand) to use the bed rail for support. R81 was also noted with weakness on her left leg. After R81 had transferred from wheelchair to bed, the resident stated that she is not able to use her left hand and arm. R81 demonstrated showing her moving her left hand and arm only with the assistance of her right hand. R81 stated that she also has weakness on her left leg. On 3/3/20 at 3:03 PM, V17 (Physical Therapy Aide) stated that R81 can transfer using a stand pivot with 1 staff assistance. V17 stated that the gait belt should be applied at the pelvis area and for residents' safe transfer, the staff should hold the gait belt on both sides. The facility's policy and procedure regarding gait belt/transfer belt dated 6/19 shows, To assist with a transfer or ambulation. A gait belt will be used with weight-bearing residents who require hands on assistance and The gait belt is securely clasped around the resident's waist, unless medically contraindicated. The facility's policy and procedure regarding transfer techniques dated 6/19 shows under general instructions, 1. Resident should move toward the unaffected side.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observation, interview, and record review, the facility failed to ensure proper control of controlled substances. This applies to 5 of 5 residents (R33, R74, R79, R91 and R191) reviewed for accurate reconciliation and accounting for all controlled medications in the sample of 18. The findings include: On [DATE] at 11:12 AM, in the presence of V16 (Assistant Director of Nursing), the narcotic reconciliation for cart for A & B halls was reviewed and the following concerns were identified: V8 (nurse) acknowledged starting her shift at 7:00 AM. On the Controlled Substance Shift Count Documentation (2 Shifts) form, V8 initials were present for signing on duty and pre-signed as signing off duty which would end at 7:30 on the same day, as well as signed on duty for the next day of 3/4/20. V8 acknowledged she should not have pre-signed and added she was scheduled to work 3/4/20 that's why she went ahead and signed. By not following the policy, V8's lack of signing in the presence of another nurse, showed the ability to not identify discrepancies of controlled drugs on hand and accurate balances. V8's actions affected narcotic reconciliation for R33, R74, R79, R91 and R191 R33's Controlled Drug Receipt/Record/Disposition Form was not completely filled out and showed a lack of the name of the drug being controlled and only indicated a strength. [DATE] 02:21 PM in the presence of V15 (Nurse), the narcotic reconciliation for cart for C & D halls was reviewed and the following concerns were identified: The Controlled Substance Shift Count Documentation (2 Shifts) forms for the months of January, February and March 2020 showed missing signatures indicating 2 person counts on (January 10, 13, 29 and 31) (February 8, 16,) and March (2). On 3/5/20 at 11:45 AM, V2 (Director of Nursing) stated R33's controlled drug form should have indicated which drug was being counted. V2 added the shift count documentation sheet should be signed daily at the time the 2 shift count is occurring. The Controlled Drug Documentation, provided by the facility and dated 03/18, showed the purpose is to control and prevent loss and/or diversion of controlled substances. Procedure 2 showed: Controlled substances must be counted and verified every shift, usually at shift change, by two (2) licensed nurses. Balances are documented on the Shift Count form and must be signed by both nurses performing the count .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that hand hygiene and proper glove usage are performed during PICC (Peripherally Inserted Central Catheter) line antibiotic therapy, [MEDICAL CONDITION] care and incontinence care to prevent potential cross contamination and infection. The facility also failed to ensure that a chair cushion has a cover for resident's use. This applies to 4 of 4 residents (R25, R34, R72 and R91) reviewed for infection control in the sample of 18. The findings include: 1. R91 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. R91's Nurse Practitioner progress notes dated [DATE] shows that the resident was admitted to the facility with left septic knee arthritis with order to continue the IV (Intravenous) antibiotic therapy. R91's current order summary report shows an order dated 2/21/20 for, [MEDICATION NAME] [MED] ([MEDICATION NAME]) Solution Reconstituted 1 GM (gram), use 1.5 gram intravenously every 12 hours for Antibiotic Therapy until 03/26/2020. The same order summary report shows an order dated 3/2/20 for PICC line flushing, flush while in use, flush with 10 ml saline before each use, additive, then flush with 10 ml saline after each use (use 10 cc syringe or greater every 12 hours flush per protocol. On 3/4/20 at 8:33 AM, V8 (nurse) carried in her hands the IV [MEDICATION NAME], NS (normal saline) 10 ml syringe in a plastic packaging, 1 alcohol prep pad (unopened) and 2 pairs of gloves. All of these supplies were placed on top R91's overbed table where resident's personal belongings (computer, folded cloths, box of tissue) were kept. These IV therapy supplies were placed directly on top of R91's overbed table without any barrier. R91 was in bed with right upper arm single lumen PICC line with clear intact dressing. V8 put on a pair of gloves (after washing her hands) to open the plastic packaging of the NS syringe and the alcohol prep pad (all taken directly from the top of the over bed table without barrier) then, placed the items back on top of the same overbed table. Using the same gloves, she got the alcohol prep pad and wiped the end port/cap of the PICC line lumen. V8 then got the 10 ml NS syringe, connected it to the cap and flushed the PICC line. After flushing the PICC line, V8 spiked the IV [MEDICATION NAME] bag with a new IV catheter tubing using the same gloves and started the IV therapy. At 10:25 AM, V8 carried in her hands one 10 ml NS syringe in a plastic packaging, 1 alcohol prep pad and 2 pairs of gloves. All of these supplies were placed directly on top of R91's overbed table (without any barrier) where the resident's belongings were kept. V8 put on a pair of gloves (after washing her hands) to open the plastic packaging of the NS syringe (taken directly from the top of the overbed table without barrier) and placed the item back on top of the same overbed table. Using the same gloves, V8 removed the IV antibiotic tubing from the PICC line port/cap (IV antibiotic was consumed), connected the 10 ml NS syringe (which she picked up from the over bed table) and administered the NS. V11 then opened the alcohol prep pad and wiped the lumen port/cap using the alcohol prep pad. On 3/4/20 at 10:32 AM, V8 was told about the observation of her placing IV therapy supplies on top of the residents overbed table without a barrier or a tray and using the gloves from the overbed table to perform the procedure. V8 responded, I messed up, I should have some kind of a barrier. On 3/4/20 at 10:34 AM, V2 (Director of Nursing) stated that V8 should have a disposable tray to put her supplies and not directly place the supplies on top of the resident's overbed table to prevent cross contamination and infection. 2. On 3/2/20 at 12:43 PM, V20 (nurse) prepared to empty the [MEDICAL CONDITION] bag of R34. After washing hands, V20 donned 2 pairs of gloves, one over the other. After the contents of the bag had been emptied into the basin, V20 tied the bag of waste. V20 removed one set of gloves and continued to rearrange R34's clothing, bedding and call light. 3. On 3/2/20 at 1:20 PM, R72 requested to lie down. V18 (CNA-certified nursing assistant),, donned gloves without handwashing, moved R72's bedside table, puzzle box and sliding board from R72's chair. With same gloved hands placed gait belt on R72 and proceeded to transfer to bed. When shown linen was soiled, V18 removed bed linens and placed all soiled items in a plastic bag. V18 then removed gloves and opened door to go get more linen without hand hygiene before or after donning gloves. V18 assisted V14 CNA with incontinence care. V18 used hand sanitizer provided by V14 and donned gloves. After the task was completed, V18 removed gloves and left room with plastic bag that contained wet pants of R72, without performing hand hygiene. 4.) R5 was admitted to the facility June 30, 2016. R25's care plan showed her [DIAGNOSES REDACTED]. R25's most recent

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Minimum Data Set (MDS) dated [DATE], documented R25's cognition as moderately impaired. The MDS showed R25 was frequently incontinent of urine and stool. R25's care plan showed a focus problem (initiated July 1, 2016) potential for alteration in skin integrity due to.incontinence of B&B (bowels and bladder) and the interventions included, Pressure reduction support on wheelchair (initiated January 18, 2018). On March 2, 2020 at 2:22 PM, R25 was noted seated in a wheelchair in the common lobby area near the nurses station. R25 was seated on a thick yellow foam cushion, and also rested her right arm on a smaller yellow foam cushion which was placed between her torso and the chair. It was noted that neither of the foam cushions had coverings. R13 (Restorative Manager) was nearby and also noted the foam cushions had no coverings. R13 confirmed it was unusual that the cushions were not covered. R13 stated the individual cushions should have covering for infection control purposes. The facility's policy Hand Washing and Hand Hygiene (dated March 2019) stated in part, 1. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items. Specific examples include but are not limited to: g) After touching any item or surface that may have been contaminated with blood or body fluids, excretions or secretions (i.e. measuring graduate, commode).