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	146008	A. BUILDING _____ B. WING _____	03/27/2015

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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	Annual Licensure and Certification 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report and investigate an allegation of neglect for one (R8) of four residents reviewed for abuse in the sample of 17. Findings Include: Face Sheet documents R8 was admitted on 2/27/2015 with the following pertinent diagnoses: aftercare for vertebrae fracture, muscle weakness, osteoporosis, difficulty walking, and rheumatoid arthritis. On 3/24/2015 at 11:17 AM, E5 (Resident Care Coordinator) entered R8's room. R8 was sitting in a wheel chair and Z3 was standing at the bedside. R8 said when she was on the 2nd floor an aide came into her room and turned her call light off 3 times in one night without addressing her needs. R8 also said they would not give her any pain medication and no one would help her to the bathroom. R8 said the room was cold and no one would help her. R8 said she informed a nurse about the treatment she received while on the second floor and 3 days later she was moved to the first floor. R8 did not know the names of staff who allegedly mistreated her and could not provide a description of the staff she spoke with. Z3 (R8's visitor) said he was glad they moved R8 to the first floor and staff were aware of the neglectful treatment of R8. Z3 could not provide any names of staff or descriptions of staff who were alleged to mistreat R8. Abuse allegations were reviewed from February	F 225		

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F 225	Continued From page 2 of 2015 until March 24, 2015, there were no reports/investigations of R8's allegations. Abuse Policy dated 5/8/2014 states, " Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Once an allegation has been made the administrator will investigate the allegation and obtain a copy of any documentation related to the incident. Initial Reporting of Allegations shall be completed immediately upon notification of the allegation. The written report shall be sent to the Department of Public Health." On 3/25/2015 at 9:22 AM, R8 was sitting in her room in a wheelchair. R8 continued to complain of the treatment she received while she was on the 2nd floor. R8 said the treatment was neglectful and she had a business card of E6 (Customer Service Liaison), the person who moved her to the current floor. On 3/25/2015 at 9:35 AM, E6 said she was not aware of any neglectful treatment R8 received. E6 said R8 was on the 2nd floor from 2/27/2015 and moved to the first floor on 3/2/2015. On 3/25/2015 at 12:00 PM, E1(Administrator) said she was not aware of any abuse allegations of R8. E1 said she will initiate an investigation and in-service E5 (Resident Care Coordinator) for not reporting the allegations that she heard on 3/24/2015. E1 said in-services will be provided for all staff on reporting allegations	F 225		
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246		

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F 246 SS=E	Continued From page 3 OF NEEDS/PREFERENCES	F 246		

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to respond to residents call lights in a timely manner, adjust and accommodate residents' environment to facilitate access to lighting controls and telephones, failed to provide enough mechanical lifts and batteries for the lifts to help residents when they need to get out of their chair, failed to ensure a bed is wide and long enough to accommodate a resident's height and size and failed to provide accessible electrical outlets.

This applies to four of 10 residents (R2, R3, R4, R7,), reviewed for accommodations of needs inside 17 resident samples and seven residents (R19 through R25) in the supplemental samples.

The Findings include;

1) During 3/25/15 4:15 PM interview, R7 stated staff made her wait 45 minutes to remove soaking wet clothing from her body. R7 stated the nurse aide came into the room, turned off the call light and said she would return with dry clothing and linen but did not. R7 stated sometimes I have to call the front receptionist to get assistance due

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F 246	Continued From page 4 to call lights not being answered. R7 also stated she is unable to reach light controls in her room and sometimes staff place her telephone out of reach. R7 was admitted to facility 3/16/15, is totally dependent on staff for all activities of daily living and is alert and oriented to person, place and time. R7 requires frequent break through, as needed, pain medication administration. Without timely call light response, R7's pain increases and is prolonged. 2) During the tour on 3/24/15 at 10:00 a.m. R4 was interviewed regarding how quickly call lights are answered. R4 said, "I turn the call light on because I want to get into bed. They usually come in about 12 minutes." They say, "I have to get help to use the lift" They come back a half hour later and say, "The battery is dead." "There is supposed to be an extra battery in the charger. I don't think they have one. It takes an hour to get to bed." On 3/24/15 R21 said, "It takes half an hour to answer the call light and get a lift." During the group interview on 3/25/15 residents (R19 and R22) complained that it takes a long time to get the lift and sometimes the battery is dead. On 3/27/15 at 11:00 a.m. R25 said, "It takes an hour to get into bed. They don't answer the light. When they do come, they say, I'll have to get so and so to do it. I don't think they know how to use the lift because its always the same guy and a couple of girls who come back. I sit up until I can't stand the pain any longer. I tell them I need to go to bed and then it takes another hour of pain before I can lay down. They don't have enough help to answer the call lights and when they come the lift is being used by some one else. R20 said,	F 246		

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F 246	Continued From page 5 "In the past it's been a problem but not recently." E10 (restorative nurse) said, "We have a back up battery in the charger. Third shift is supposed to charge the batteries of lifts during the night so they will be ready to go in the morning. We have two lifts. One is broken. We have rented another one. I'll show you the battery charger. The battery charger did not have a battery. E10 said, "Check with with E8 (unit director of supplies)". E8 did not find any extra batteries in the supply room. Six of the nine residents (R4, R19, R20, R21, R22, R25) listed on the mechanical lift sheet complained it takes too long to use the lifts. R2, R3, R24 are residents who are cognitively impaired, unable to speak for themselves and requires the used of mechanical devices/lifts for transfer. 3) During the initial tour on 3/24/2015 at 10 AM, R3 was observed lying in bed. R3's feet were at the end of the foot of his bed, and R3 had very little additional space to move up in bed. The width of R3's bed also gave him very little room to move from side to side. E11 (R3's nurse) was present and said R3 is a tall man. E11 also stated she would get the certified nurses aide to move him up in bed, and would order R3 a larger bed. During the Daily Status Meeting with the administrative staff on 3/26/15 at around 9:45 AM, E1 (Administrator) stated facility placed an order for a bed appropriate for R3's size. Review of R3's Admission Face Sheet, showed	F 246		

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F 246	Continued From page 6 he was originally admitted to the facility on 5/24/14. Review of R3's most recent MDS Assessment, dated 2/15/2015 showed, R3 was 73 inches in height or 6 feet and 1 inches. R13 required a long bed to accommodate his tall height. 4) Face Sheet documents R2 was admitted on 4/23/2014 with the following pertinent diagnosis: Late effects of acute poliomyelitis. On 3/24/2015 at 1:15 PM, R2 was sitting in an electrical wheelchair with limited movement of both hands. R2 said he has requested accessible electrical outlets in January of 2015 and no one has addressed his need for the outlets. R2 said he was informed the electrician was sick in January. R2 said he was upset because it has been 3 months he was sorry the electrician was sick, but that should not keep him from having access to outlets. On 3/24/2015 at 2:07 PM, R8 demonstrated he could not reach the two electrical outlets on the wall due to weakness in both hands related to post poliomyelitis. On 3/24/2015 at 3:04 PM, E7 (Maintenance Director) said R2 did request electrical outlets in January of 2015 but the electrician has been out sick and could not provide access for R8 for 3 months. E7 said that he informed R2 that the electrician was sick. Moving forward E7 said he would have the electrician come in and provide accessible outlets for R8 on 3/25/2015.	F 246		

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F 246	Continued From page 7 Receipts for the electrical outlet equipment dated 3/24/2015 was reviewed.	F 246		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to thoroughly and aggressively assess, identify, pursue provision of services and monitor a resident with medically related social service needs. This applies to one of 17 residents (R1), reviewed for social service needs in the sample of 17. The Findings include; R1 was admitted to facility 3/19/15 after sustaining a traumatic right hip fracture from the hospital. R1's 3/20/15 physician progress note, 3/20/15 history and physical report and "accumulative diagnosis record" include history of suicide attempts and depression. R1's 3/19/15 admission nursing notes and 3/20/15 physician progress note include admitted for physical and occupational therapy services.	F 250		

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F 250	Continued From page 8 R1's nursing progress notes between 3/19/15 admission through 3/24/15 discharge, frequently document alert and oriented to self with periods of confusion but able to communicate needs. On 3/24/15 at approximately 10:00 AM, during initial tour with E2 (Director of nurses), R1 was observed in a resident room at the end of the corridor. R1's room was the furthest room on her wing from the nursing station. R1 was observed lying in bed and her husband (Z1), seated in a chair at the foot of R1's bed. Z1 stated he was upset this facility was planning to transfer R1 back to a previous facility. Z1 stated he wanted R1 to stay long term at this facility. E2 responded to Z1 saying: the transfer was out of facility's hands. After responding to Z1, E2 left R1 and Z1 alone in the room to continue touring with the surveyor. Once near the nursing station, at approximately 10:15 AM, E2 stated R1 has a current on-going investigation with the facility Ombudsman (Z2). The investigation is related to R1 possibly being abused by Z1. E2 further stated Z2 told E3, she feels R1 would be safer and more supervised at her previous facility. R1 resided at a supportive living facility prior to being hospitalized with current hip fracture. R1's supportive living facility has a skilled nursing / rehab section. Z1 told the hospital to transfer R1 to this facility for therapy services and not back to her previous facility. E2 also stated E3 (Social Service Designee), has been speaking to Z2 and	F 250		

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F 250	Continued From page 9	F 250		

assisting to facilitate R1's transfer back to previous facility on 3/24/15.

During 3/24/15, 10:40 AM interview, E3 stated upon admission, R1 told facility staff her husband was abusing her. E3 notified E1 (Administrator), who contacted the county Senior Services. The Senior Services staff notified E1 that an investigation for abuse was conducted in December 2014 and was un-founded. E3 also stated on 3/23/15, Z2 called E3 requesting R1 be transferred back to her previous supportive living facilities skilled care section. Z2 stated she felt the previous facility staff were more aware of Z1's behaviors. Z1 has not acted inappropriately toward R1 while in this facility. E3 further stated she did not feel R1 was being abused by Z1.

During 3/24/15, 11:05 AM telephone interview, Z2 stated Z1 is very aggressive, violent and boisterous. R1 is very afraid of Z1. R1 told Z2 she wants to return to the supportive living facility. It is Z1 who does not want R1 to return to prior facility. Z1 knows the prior facility knows his behaviors and are supervising R1 closely. Z1 told the hospital he wanted to take R1 home with him after hospitalization. The hospital notified Z1 that R1 required therapy prior to being discharged home with him, so Z1 told hospital to send R1 to this facility for therapy. Z2 stated Z1 wants to isolate R1 by taking her home and then no one will know what he is doing.

Z2 also stated R1 has a lot of money from a prior marriage. R1 told Z2 her family is also financially abusing her and she had to lock her bank books up in a vault to prevent Z1 from taking it all.

R1 requested Z2's assistance to protect her and

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F 250	Continued From page 10 help her divorce her "abusive husband." Z2 stated R1's December 2014 investigation by Senior Services was only un-founded because when the time came for R1 to sign paperwork about the abuse, R1 became scared and backed out. R1 would switch her story when Z1 walks into the room because R1 is afraid of Z1. Z2 also stated she (Z2) notified the facility about the above situation. R1's 3/20/15 "Resident Safety/ Abuse Assessment," completed by E3, include: - no history of domestic (i.e., family or intimate relationships) abuse (i.e., verbal, physical, emotional/mental, sexual and/or exploitation). - no history of self injurious behaviors and/ or suicide attempts. "During assessment no disclosure about abuse. (Hospital), reported an open investigation, Administrator notified Senior Services and Ombudsman aware." No recommendations that a care plan needs to be generated or for any additional supervision or interventions to monitor for potential abusive situations. E3 only documented two progress notes in R1's medical records, both on 3/24/15 to include: - 7:49 AM, (Z2), contacted E3 regarding R1. Z2 stated that due to safety issues regarding (Z1), Z2 would feel better with R1 receiving therapy at (previous living facility), where R1 resides. The referral sent to previous facility. - 7:59 AM, R1 will be discharged to (previous living facility), where R1 resides. R1 will continue therapy. Transportation will arrive at 12:45 PM. E3 spoke to R1 about transfer and R1 is accepting of the transfer.	F 250		

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F 250	Continued From page 11 On 3/25/15 (the day after R1 discharged), E3 completed another "Resident Safety/ Abuse Assessment," for R1. This assessment stated yes to history of domestic violence but continued to say No to history of history of self injurious behavior/ suicide attempts. R1's medical record contained a blank, un-dated, un-labeled "Interim Care Plan." R1 had no care plan for supervision, monitoring, placement issues or psycho-social support. R1 had no care plan to address depression diagnosis with history of suicide attempts. R1's facility medical records failed to address potential candidate for being abused.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

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F 279	Continued From page 12 under §483.10(b)(4).	F 279		

This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to develop or have a comprehensive care plan addressing possible safety or supervision needs for one resident who has a history of violent behavior and manslaughter.

This applies to one of two identified offenders (R15) in the sample of 17 residents.

The findings include:

Review of R15's Admission Sheets showed he (R15) was admitted to the facility on 10/10/2014.

Review of R15's background check, dated 10/22/1014, showed R15 had multiple convictions for causing Great Bodily Harm, Unlawful Use of Weapon and Murder.

R15's Identified Offender Risk Assessment, dated 10/23/2015, showed R15 had a history of conviction for a felony, which was identified as murder/manslaughter. R15 was assessed as alert and ambulatory. But, the staff completing R15's assessment left blank the answer or plan of care to the following question: "13. Other specific interventions that may be utilized to ensure safety of this resident, other residents, visitors and staff"

R15's Criminal History Analysis, dated 11/14/14, showed R13 was at "Low Risk", but needed to be monitored for: "Behavioral changes suggesting a need for closer observation should be noted and

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F 279	Continued From page 13 responded to..." However, review of R15's closed clinical record contain no plan of care for staff to monitor nor supervise for change in behaviors or possible violent behaviors. On 3/26/2015 at 12:02 PM E1 stated, "We don't have an identified offender's care plan for R15."	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to perform comprehensive assessments, include underlying factors supporting the medical justification for the continuing use of an indwelling urinary catheter, determine which factors can be modified or reversed (or rationale for why those factors should not be modified), and the develop of a plan for removal. This applies to two of seven residents (R7 and R10) reviewed for Indwelling Urinary Catheter use	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. BUILDING _____ B. WING _____	03/27/2015

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

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F 315	Continued From page 14 in the sample of 17. 1) R7 was admitted to facility 3/16/15 with an indwelling urinary catheter and diagnosis including urinary tract infection (UTI). R7's admission physician orders include use of antibiotic used to treat UTI's (Nitrofurantoin). R7 also has physician orders for topical analgesics (Lidocaine ointment), to be applied to indwelling urinary catheter insertion site as needed for pain management. There was no comprehensive assessment made for the continuing use of an indwelling catheter. 2) Per medical records; R10 is a 70 year old male who has multiple medical diagnoses to include Chronic Kidney Disease (CKD), urinary retention related to Benign Prostatic Hypertrophy (BPH), and Urinary Tract Infection (UTI). R10 also undergoes hemodialysis 3 times a week. R10's Physician Order Sheet (POS) dated 3/7/15 indicates; May use indwelling urinary catheter (Foley Type) 18 Fr size with 5 ml balloon size due to urinary retention. On 3/24/15 at around 2:00 PM, R10 was sitting up in his wheelchair with an indwelling catheter. His urinary drainage bag was dry and empty. R10 stated he didn't want the staff to do frequent straight catheter to him to check for urine output so staff inserted indwelling catheter. On 3/27/15 at around 10:30 AM E2 (Director of Nursing/DON) stated, R10 has an indwelling catheter due to urinary retention related to BPH. and Post Void Residual (PVR) needs to be monitored. The physician ordered straight	F 315		

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F 315	Continued From page 15 catheter every shift as needed but R10 refused frequent straight catheter. An indwelling catheter was inserted on 3/7/15. E2 also stated, a comprehensive assessment needs to be started as soon as E10 (Restorative Nurse) is available to assess resident. There was no evidence that a comprehensive assessment was made for the use of an indwelling catheter.	F 315		