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	ASL5106197	A. BUILDING: _____ B. WING _____	C 02/03/2025

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A 000	Initial Comment Complaint Survey IL180059/2498878- Deficiency cited IL183314/24910549- Deficiency cited	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 2 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement is not met as evidenced by: Based on observations, interview and record review, the facility failed to provide adequate number of staff to meet the needs of residents. This deficient practice affected five (R1, R2, R3, R4, R5) residents reviewed for Nursing Services. Findings Include: An onsite survey was conducted on 1/30/2025 and 2/3/2025. Resident Council Meeting Minutes and Food Council Notes from April 4, 2024, to January 2, 2025, and Resident's Electronic Records were reviewed. Staffing Schedule for September 2024, October 2024, December 2024, January 2025 were also reviewed.	A3000		

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A3000	Continued From page 1 On 1/30/2025 at 9:35AM, E8 (Lead Life Engagement Assistant) said that staffing has been an issue lately, they are cutting hours, there is only one caregiver at times for each floor. The caregivers are always running around. E8 said that at times she also has to assist serving the residents. E8 said that at times there is only one nurse for the whole building and there is no nurse at night. E8 said, ambulatory residents from the second floor are brought down to the first floor for programing. On 1/30/2025 at 9:36AM E4 (Lead Resident Care Assistant) and E5 (Resident Care Assistant) both said there are only two caregivers per floor. The work is heavier because the residents were in Broda chairs requiring two persons assist. Completing the ADLS (Activities of Daily Living) in the morning for all of them was difficult, which made them late for breakfast. E4 said there were times there was only one caregiver per floor and no nurse at night. E5 said, "we have to feed 3 persons at the same time. There were times, there was no nurse specially at night." On 1/30/2025 E14 (Licensed Practical Nurse) said that she is assigned to second floor with 2 caregivers. E14 said that at night there is no nurse at times and sometimes one nurse for the whole building in the morning shift. E14 said that nurses work 12 hour shift and Caregivers 8-hour shift. On 1/30/2025 at 10:04AM, E9 (Lead Resident Care Assistant) said "Poor staffing, we are always short, we have a lot of residents that needs 2 persons assist. Always 2 caregivers, they say we are low census, but the residents need a lot of assistance, especially in the morning. Sometimes it's only one person in each floor. During meals I	A3000		

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A3000	Continued From page 2	A3000		

sit in the middle of two residents, and I have to use both hands, left and right. Unable to monitor residents when a caregiver goes on break and the resident is ambulating."

On 1/30/25 lunch observation was conducted on the first floor. It started at 11:55am. On one table there were three residents who needed feeding assistance including R1. E4 (Resident Care Assistant) was feeding all three residents at the same time, using the same gloved hands. At one point, E4 has to cease feeding the residents to bring one resident to the bathroom. E6 (Resident Care Manager) relieved E4 in feeding the three residents but had to stop, to go and check a resident that was coughing from the other table. E7 (Life Engagement Director), then started feeding the three residents. E7 had to stop feeding to help one resident in the other table. At 12:54pm, E5 (Resident Care Assistant) resumed feeding R1, but R1 refused to eat. R1 ate about 25% of served pureed food.

2/3/25 9:28am E3(Staff Development Director) said that she is not aware of any complaint about residents not being fed on time or food served cold due to lack of staff. E3 said "we do have enough staff. For each floor, depending how many residents, currently we have two caregivers on each floor. 1-2 nurses depending on time of the day. There is a nurse at nighttime, one nurse. For AM, PM, generally two nurses."

On 2/3/2025 at 9:49AM E9, E11, E13 (Resident Care Assistants) that everyone is total care and need at least 2person assist, "when we need to change someone and there are only two of us then we call the nurse if the nurse is not busy, she will come to monitor the residents otherwise it will be no one to monitor them."

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A3000	Continued From page 3 E11 said that she works here PRN (as needed) and that she was called to work on Sunday, but she told them that she could work Monday, she was told. "that's good because the State is coming". E11 said even the residents who are independently walking need assistance with toileting and Management does not take that into consideration. She said that management said that they are independent. E11 said that mostly all residents need 2 persons assist specially hospice, because they have Hoyer lift. On 2/3/2025 at 1:00PM, E1 (Executive Director) said that "with the caregiver we have and the nurses, it is appropriate number to care for the 34 residents we have. It is appropriate for one caregiver to feed 2-3 residents at the same time. E1 said that Is not fair for a resident to wait to be fed because the caregiver has to stop feeding him/or her to take someone to the bathroom." September 2024 staffing schedule indicated that on 9/14/2024 there were only two caregivers working the morning shift and three caregivers working the evening shift. October 2024 staffing schedule indicated that there was no night nurse on 10/1/2024, 10/4/2024 and 10/19/2024. December 2024 staffing schedule indicated that there was no nurse on 12/4/2024 night shift, 12/29/2024 day shift. 12/30/2029 day and night shift, 12/31/2024 only one nurse for day shift, no night shift nurse. On 12/13/2024 there were 3 caregivers for the evening shift. On 12/15/2024 there was one caregiver for the night shift. On 12/25/2024 there were only three caregivers for the day shift, on 12/26/2024 there were three	A3000		

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A3000	Continued From page 4 caregivers for the day shift, on 12/29/2024 and 12/30/2024 there were two caregivers for the day shift. January 2025 Staffing Schedule indicated that there was no nurse for the night shift the following dates: 1/1/2025, 1/2/2025, 1/5/2025, 1/7/2025, 1/10/2025, 1/23/2025, 1/24/2025, 1/28/2025.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and	A4010		

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A4010	Continued From page 5 revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan. These requirements are not met as evidenced by: Based on observation, interview and record review, the establishment failed to ensure	A4010		

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A4010	Continued From page 6 interventions are in place to promote wound healing and prevent skin breakdown for one resident (R1) at risk for developing wound. Findings include: On 1/29/25 at 10:49am, R1 was observed in the Activity area, R1 was on a semi reclined Broda chair. R1 was alert but nonverbal. At 11:50am, R1 was still observed in the activity area on the Broda chair. Staff were escorting other residents to go to the dining room for lunch. At 11:55am, R1 was brought to the dining room for lunch. At 12:54pm, R1 still in the dining room, for lunch. R1 was on the same position from the start of observation. At 1:59am, E4 (Lead Resident Care Assistant) and E5 (Resident Care Assistant) transferred R1 from the Broda chair to the bed using a Hoyer lift for incontinence care. Per E4, the wounds on the buttocks had healed but R1 has wounds on left foot. E4 removed R1's sock. There were two wounds on R1's left foot. One wound was located at the back of the ankle and the other one on the outer side of the left foot. Both wounds were not covered by a dressing to prevent possible exposure to infections or irritants. R1's lower extremities were contracted; bilateral legs were folded on the knees. R1's documents titled "Pressure/Non Pressure Sores Weekly Report documented the following: Left heel: Stage 2. Treatment: Clean with NSS, apply Calcium Alginate and secure with Opti foam twice weekly and as needed. 1/3/25 1cmx1cm, 1/17/25 Healed. 2/1/25 1x 0.8cm , 2/3/35: 1x0.8 cm. Left lateral foot: Deep Tissue Injury: Treatment: Apply foam gauze to relieve pressure after cleaning with Normal Saline Solution, pat dry 2x weekly and PRN.	A4010		

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A4010	Continued From page 7 1/23/25: 2.5cmx 2cm, 1/27/25: 2.5cm x2cm On 1/31/25 at 10:16am, Z1 (Hospice Nurse) said, hospice visits twice weekly or as necessary for wound treatment." I leave supplies there in case it needs to be done by the nurses." Z1 was asked if R1 needs to be repositioned, Z1 said, "Yes, every two hours. The heel needs to be turn to the other side, but he prefers the other side. He can't turn himself, while on Broda chair or in bed. For the left foot, put pillow under it to relieve pressure." Z1 said the wounds need to have a dressing. The establishment nurse has supplies to use. Z1 said R1 was contracted. On 2/ 3/25 at 10:57am, R1 was on the Broda chair, there was no pillow under the affected leg. There was no protection for the bony prominences. The wounds were covered with gauze but laying directly against the chair. R1's Care plan dated with an effective date of 2/3/25 stated in part; Problems/Needs Wound: Coordination of care with Home Health, hospice or agency providing wound care. ALC hospice conducts wound care and dressing changes. Interventions: Wound: Coordination of care ALC hospice nurse to provide dressing and wounds care with nurses to review any changes. Discipline: Nurse. The service plan did not indicate individualized interventions to promote wound healing, what to do when dressing come off, how often R1 needs to be repositioned, how to off load the affected area to promote healing or other interventions to follow to prevent wound deterioration or further skin breakdown.	A4010		

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A4010	Continued From page 8 R1's Braden Scale score (Skin Assessment) dated 7/10/24 was 15, indicating Mild risk, even though R1 already have wounds, and had history of recently healed pressure ulcer to left and right buttocks. According to R1's wound notes, R1's right and left buttocks had Stage 2 pressure ulcer that was just healed on 12/16/24 (right buttock) and 12/30/24 (left buttock). With this to consider, interventions should be in place to ensure wounds will not reopen.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. This requirement is not met as evidenced by: Based in observations, interview, and record	A6000		

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A6000	Continued From page 9	A6000		

review, the establishment failed to provide adequate number of staff to feed residents in a dignified and timely manner for six residents (R1, R2, R3, R4, R5, R6) who need physical assistance with meals.

Findings include:
On 1/30/25 lunch observation was conducted on the first floor. It started at 11:55am. On one table there were three residents who needed feeding assistance including R1. E4 (Resident Care Assistant) was feeding all three residents at the same time, using the same gloved hands. At one point, E4 has to cease feeding the residents to bring one resident to the bathroom. E6 (Resident Care Manager) relieved E4 in feeding the three residents but had to stop, to go and check a resident that was coughing from the other table. E7 (Life Engagement Director), then started feeding the three residents. E7 had to stop feeding to help one resident in the other table. At 12:54pm, E5 (Resident Care Assistant) resumed feeding R1, but R1 refused to eat. R1 ate about 25% of served pureed food.

On 1/30/2024 at 12:05pm E 10(Lead Resident Care Assistant) was observed assisting to feed R4 some salad, then she stopped assisting him to help pass plates to other residents. R4 needs physical assist with meals.
E9 was observed assisting R3 with lunch and when E10 stopped assisting R4, E9 started feeding both R3 and R4, alternating between residents.
At 12:10 pm E10 sat in between R4 and R2. E10 began to assist both residents with their lunch.

At 12:13pm E14 (Licensed Practical Nurse) began assisting R6 with meals. E9 stopped assisting R3 with her lunch in order to deliver

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A6000	Continued From page 10	A6000		

other residents' meals.
At 12:12pm, E14 went to relieve E9 from assisting R3. E9 had to assist another resident was constantly getting up from the chair. E14 alternately fed R3 and R6. E14 was wearing gloves.
At 12:27 pm- E9 went to assist E6. No hand washing or sanitizing was done at all in between residents. At 12:30pm. E9 stopped assisting R6 to help a resident go to the bathroom.
E14 started assisting R3 & R6 again.

Service Plan for R1, R2, R3, R4, R5 were reviewed. Service Plans indicated that all R1, R2, R3, R4, R5 need DINING: Physical Assist 1 Staff to physically assist resident to eat and drink meals supporting independence where possible.

2/3/25 9:28am E3 (Staff Development Director) said that she is not aware of any complaint about residents not being fed on time or food served cold due to lack of staff. E3 said "we do have enough staff. For each floor, depending on how many residents, currently we have two caregivers on each floor. 1-2 nurses depending on time of the day. There is a nurse at nighttime, one nurse. For AM, PM, generally two nurses."

On 2/3/2025 at 1:00pm, E1 (Executive Director) said that "with the caregiver we have and the nurses, it is appropriate number to care for the 34 residents we have. It is appropriate for one caregiver to feed 2-3 residents at the same time. E1 said that it is not fair for a resident to wait to be fed because the caregiver has to stop feeding him/or her to take someone to the bathroom."