STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510352	A. BUILDING: _____ B. WING _____	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF NAPERVILLE	960 E CHICAGO AVE NAPERVILLE, IL 60540

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A 000	Initial Comment Annual Licensure Survey	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 interview and medical review the facility failed to employ staff with adequate skills and experience to provide monitoring and timely/effective interventions to one high risk resident (R3) who developed 2 facility acquired pressure wounds. This failure caused harm to R3 when skin alterations progressed to an unstageable heel wound and a stage 4 sacral wound. Findings include: Review of medical record documents R3 is 81 years old and moved into facility on 7/7/23 with diagnosis of multiple sclerosis. R3 requires the	A3000		

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A3000	Continued From page 1	A3000		

use of a Hoyer lift for transfers, utilizes a wheelchair with one physical assist for mobility and 2 person assists for ADL's. R3 also has a Foley catheter and weighs 209 lbs. R3 is alert and oriented but moderately confused.

Review of nursing progress note dated 9/5/24 suddenly documents 'home health to evaluate and treat left heel wound.' This progress note identifies a left heel wound measuring 7.5.cm x 5.5 cm. There is no documentation of the wound bed appearance. Progress note dated 9/6/24 states a physician evaluated R3's left heel wound and ordered a left heel X-ray, 2 views to rule out bone pathology. This physician order indicates the wound was likely a stage 4 or unstageable at the time of identification by the facility.

E2 (DON) stated on 10/31/24 that the caregivers monitor for any skin alterations and inform the nurse if there is a change. E2 stated there is no documentation by the staff who are responsible for monitoring skin alterations. E2 confirmed that R3 requires 2 physical assist for showers and transfers. It is unclear how R3's left heel pressure ulcer was not identified until it was severe at a stage 4 or greater if two staff were providing hands on assist for showers, dressing, and transfers. The same is true for when R3 was identified with an acquired sacral pressure sore on 10/21/24.

Home health Wound Care Worksheet dated 10/28/24 documents R3's sacral wound to measure 6 x 8 x 0.1 cm with serosanguinous drainage and 2 light gray areas in the center of the wound. Narrative documentation for this visit states "found wound on sacrum with no dressing, noted increased redness and drainage. High risk for wound infection."

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A3000	Continued From page 2 E2 stated R3's sacral and heal wounds were most likely caused by his decreased mobility, incontinence, and sitting in his recliner for long periods of time.	A3000		
A7010	Section 295.7010 Establishement Records This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.7010 Establishment Records a) The establishment shall maintain the following records: 1) Reports of known resident injury requiring a physician's intervention. 3) Incident and accident reports that are required to be submitted to the Department. 5) Quality improvement program. These requirements are not met as evidenced by: Based on interview and record review the facility failed to: Report and maintain all state reportable incidents and accidents. Provide documentation of a quality improvement program addressing non-reportable resident incidents (an incident that requires unexpected evaluation and/or physician treatment but an incident nevertheless, i.e., falls, behaviors, injury of unknown origin).	A7010		

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A7010	Continued From page 3	A7010		

Follow their own Incident and Event Reporting policy and procedure.

This failure creates a substantial probability of harm to all residents residing in this community who experience adverse incidents/accidents.

Findings include:

E1 (Executive Director) provided a binder of the facility's reportable incidents and accidents for the past year, October 2023 - October 2024. Included were a total of 10 state reportables. E1 stated on 10/31/24 at 11:45am that the prior ED had not kept copies of the state reportables but were most likely in her email of which E1 could not access . Additionally, E2 (DON) stated she thought the only incidents that had to be reported to the department included residents who had received treatment at the hospital: "if they don't get stitches or if they have a negative scan, I didn't think we had to send a report even if they did go to the hospital" said E2.

On 10/31/24 at 12:10pm, E1 stated the facility does not create in-house incident reports (incidents not requiring to be reported to IDPH). When asked to provide the method the facility tracks incidents and accidents within the facility so as to identify trends and patterns, E1 stated she does not have access to that data, that corporate does not allow for that information to be shared.

Facility incident and event reporting policy and procedure states on Page 1 that an Event is defined as "a confidential (facility) internal report regarding an adverse resident event. An event is an unanticipated occurrence or set of circumstances that caused or could cause harm

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A7010	Continued From page 4	A7010		

to a resident. The purpose is to gather information to assist the facility in its evaluation of opportunities to improve resident safety and the outcomes of care rendered to residents."

The facility was unable to provide documentation indicating the facility evaluates Incident/accident data to improve resident safety and outcomes of the care rendered to its residents as stated above.

Review and analysis of R2's falls provide an example of the above:

R2 was admitted to the facility on 8/15/23 with diagnosis of history of following, dementia, and hypertension. R2 was 102 years old.

R2 began experiencing frequent falls in May of 2024:

5/17/24 laceration to back of head (no I & A report to IDPH)
5/22/24 found on floor no incident report
6/19/24 fell backwards in bathroom fractured ribs (crying in pain x 2 days)
6/22/24 found on floor no incident report
6/27/24 Placed in Hospice care
7/11/14, 7/23/24, 7/27/24, 7/30/24. Falls - no incident reports

R2 expired 9/7/24.

The only incident and accident report identifying any of these falls occurred on the 6/19/24 fall resulting in fractured ribs. E1 and E2 stated the facility does not write up individual incident reports but rather document resident falls in the

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A7010	Continued From page 5 nursing progress notes. Each of the falls listed here were identified by going through each of R2's nursing notes. There is no method available to assist in identifying patterns and trends of falls within the facility, either on an individual or facility wide basis without combing through individual nursing progress notes and compiling the data oneself. On 11/1/24 E1 provided a small print, 3-page document titled 'Assessment History of Post Fall Evaluation'. It is an alphabetical list which, under each person's name on the list, only identifies the date of an incident or accident with no further information relating to the type of incident, the circumstances/details or outcomes of an incident. This does not allow the facility to identify patterns and trends of incidents/accidents and falls with injury, including behaviors and injuries of unknown origin. Without this information a facility's compliance with IDPH regulations cannot be confirmed. It cannot be determined if perhaps there is enough and adequately trained staff to provide necessary care and services or any identifiable patterns and trends related to the incidents and accidents.	A7010		