

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Westminster Place		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Grant Street Evanston, IL 60201	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to limit layers of linens when using a low air loss (LAL) mattress for residents with pressure ulcers. The facility also failed to follow a physician's order and failed to implement a wound prevention intervention. This deficiency affects two (R108 and R110) of three residents in the sample of 14 reviewed for Wound Care management.</p> <p>Findings include:</p> <p>1.) On 10/15/24 at 10:16AM, Observed R108 lying in bed on Low air loss (LAL) mattress. R108 has fitted sheet covering the LAL mattress. V6 (Wound Care Nurse/WCN) lifted the top sheet linen to check the LAL mattress. Observed cloth pad and folded linen in quarters underneath R108. R108 wears disposable brief. V6 said that R108 should have only a flat sheet over the LAL mattress, no cloth pad, and folded linens. V6 said that multi layers of linen over the LAL mattress will impede its function and purpose. R108 does not have bilateral heel protectors.</p> <p>On 10/15/24 at 11:06AM, V13 (Certified Nursing Assistant/CNA) said that he is assigned to R108, but he has not seen and provided care to R108. V13 said, R108 has private care giver who provides care and makes the bed for her. R108 left around 8AM or 9AM.</p> <p>Reviewed R108's wound care plan with V6 (WCN). There was no documentation in care plan indicating R108's caregiver noncompliance with wound care treatment and prevention. There was no documentation of caregiver education in the chart.</p> <p>On 10/14/24 at 11:09AM, Observed V6 (WCN) and V13 (CNA) preparing to provide wound care to R108. Observed thick pad lining inside the disposable brief. V13 CNA said that R108's caregiver has been applying the pad lining inside the disposable brief because R108 poops a lot. V13 said that he did not report this to his nurse and to V6 WCN. V6 said that V13 should report to the floor nurse of R108's caregiver noncompliance to wound care management because they don't allow pad lining inside the disposable brief in the facility. The CNA should be checking the resident every 2 hours for incontinence.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/15/24 at 11:16AM, V6 (WCN) checked R108's disposable brief while V13 (CNA) assisting R108 to left side lying position. Observed large amount of soft brown fecal matter. V6 took the wet disposable wash cloth and wiped R108's rectal to perineum (back to front). V6 continued to wipe several times from rectal to perineum. Surveyor informed observation to both V6 and V13. V13 (CNA) said that it should be wipe from front to back to avoid infection (UTI). V6 asked V13 to clean R108, and they switched position.</p> <p>On 10/15/24 at 11:20AM, V6 (WCN) removed the foam dressing on sacral area. V6 said that R108 has moderate yellowish wound drainage from sacrum and has blood stained from left buttocks. V6 cleansed left buttocks and sacrum with wound cleanser. V6 said that R108 has unstageable pressure ulcer on sacrum due to 100% yellowish slough formation. Stage 3 on left buttocks covering with dried blood. She applied (brand name ointment) to sacrum and left buttocks and cover with foam dressing. Observed non-blanchable redness on entire sacral area. V6 applied zinc cream to affected area.</p> <p>On 10/16/24 at 9:12AM, V18 (R108's Private Caregiver) said that they have been in the facility for more than 1 month. V18 said he does not do incontinence care to R108. V18 said, he called the CNA for incontinence care as needed. V18 said that R108's son is a lawyer, and he was told to let the staff do the care for R108 for liability issues. V18 said the staff is aware that he is applying pad lining inside the disposable brief to R108, and the staff is aware, and they are using it too.</p> <p>On 10/16/24 at 11:49AM, Informed V2 (Director of Nursing) of above concerns. V2 said, LAL mattress recommendation of using flat sheet over the mattress. V2 said, the floor nurse should check resident on LAL appropriate cover when making rounds or during medication administration. V2 said that they follow physician's orders in wound care prevention and management. V2 provided Medication Administration general guidelines policy. V2 said that they used the same policy for Treatment administration.</p> <p>On 10/16/24 at 1:58PM, Review R108's wound assessment dated [DATE] with V6 (WCN). V6 said that she completed the wound assessment, and she did the measurement. Informed V6 that her wound assessment dated [DATE] has worsened compared to wound observation made with surveyor on 10/15/24. V6 said, it will still have the same treatment. Informed V6 (WCN) that R108 does not have bilateral heel protectors as ordered by physician.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R108 is admitted on [DATE] with diagnosis listed in part but not limited to Pneumonia, Gastrostomy due to dysphagia, Alzheimer's disease, Dementia, Transient Ischemic attack, and Cerebral infarction. Active physician order sheet indicates: Bilateral heel protectors while in bed. LAL mattress, Sacrum and Left Buttocks- cleanse with NSS (normal saline solution). Apply (brand name ointment) cover with 4x4 foam daily and as needed. Most recent Braden scale for predicting pressure ulcer risk assessment done on 9/25/24 indicated at high risk. Most recent wound assessment dated [DATE] indicated: Sacrum- date identified 9/5/24, present on admission, Pressure ulcer Stage 3 measures 1cm x 0.4cm x 0.2cm, Red and yellow color wound bed, granulation 40%, 60% pink non-granulated, erythema on surrounding tissue, small serosanguineous drainage, wound edge distinct and attached. Left buttocks- date identified, present on admission, Pressure ulcer, unstageable, measures 2cm x 1.5cm x 0cm, red and yellow tissue wound bed, 30% slough non adherent, 70% red beefy granulation, erythema tissue surrounding, small serosanguineous drainage, distinct and attached wound edge. Peri anal area- 9/5/24, present on admission, MASD (moisture associated skin damage), excoriation, measures 0cm x 0cm x 0.1cm, red wound bed, 100% non-blanchable erythema, erythema on surrounding tissue. Comprehensive care plan indicates R108 has multiple pressure ulcer: Stage 3 to sacrum, UTS (unstageable) to left buttock and or potential for pressure ulcer development related disease process, Braden scale, contractures, and immobility. R108 has potential impairment to skin integrity related to reduced mobility, incontinence, generalized body weakness secondary to COVID, Pneumonia, Dysphagia status post PEG tube placement. Interventions: Low air loss (LAL) mattress. Heel protectors.</p> <p>2.) On 10/15/24 at 10:49AM, Observed R110 lying in bed on LAL mattress. V6 (WCN) lifted R110 top sheet linen to check the mattress. Observed flat sheet and cloth pad over the mattress. R110 is wearing disposable adult brief. V6 said that R110 should have only flat sheet over the LAL mattress.</p> <p>R110 is admitted on [DATE] with diagnosis listed in part but not limited to Fracture of base skull, Intracranial injury, History of falling, Nontraumatic subarachnoid hemorrhage, Moderate protein calorie malnutrition. Active physician order sheet indicates LAL mattress. Sacrum-cleanse with NSS. Apply skin prep around wound. Santyl and wet gauze packing in undermining area. Then cover with 4x4 gauze or abdominal pad then secure with med fix daily and as needed. Most recent Braden scale for predicting pressure ulcer risk assessment done on 8/8/24 indicated at high risk. Most recent wound report dated 10/14/24 indicated: Sacrum- dated identified 7/18/24, present on admission, Stage 4 pressure ulcer, measures 4cm x 3cm x 0.3cm, red and yellow wound bed tissue, 100% granulation, 12 o'clock to 12 o'clock undermining with 1.3 depth, erythema on surrounding tissue, small serous drainage, distinct and attached wound edge. Comprehensive care plan indicates he has pressure injuries, sacrum unstageable, 10/4/24 knee abrasion, 10/7/24 sacrum unstageable to stage 4. R110 is at risk for further skin impairment related to pressure injuries upon admission, generalized body weakness, reduced mobility, on and off pain, abrasion on left knee secondary to subarachnoid, subdural, intraventricular hemorrhage, left temporal bone fracture due to unwitnessed fall, hypertension, ETOH. Intervention: LAL mattress.</p> <p>Facility's policy on Use of Support Surfaces</p> <p>Policy:</p> <p>Support surfaces will be in accordance with evidence-based practice for residents with or at risk for pressure injuries.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's policy on Prevention and Healing of Pressure injuries and non-pressure related injuries review date: 3/31/24.</p> <p>Provides care and services to:</p> <ul style="list-style-type: none"> *Promote the prevention of pressure injury development *Prevent infection and promote the healing of pressure injuries that are present *Prevent development of additional pressure injuries *Residents with Non-pressure-related Skin injury/wound. <p>B. Plan/Intervention:</p> <p>a. Prevention</p> <p>iii. Provide appropriate, pressure-redistributing, support surfaces.</p> <p>Facility's policy on Medication Administration-General Guidelines March 2021 indicates:</p> <p>B. Administration</p> <p>2) Medications are administered in accordance with written orders of the prescriber.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to ensure proper perineal care is provided during incontinence care. This deficiency affects one (R108) of three residents in the sample of 14 reviewed for Incontinence care.</p> <p>Findings include:</p> <p>On 10/15/24 at 11:09AM, Observed V6 (Wound Care Nurse/WCN) and V13 (Certified Nursing Assistant/CNA) preparing to provide wound care to R108. Observed thick pad lining inside the disposable brief. V13 said that the caregiver has been applying the pad lining inside the disposable brief because R108 poops a lot. V13 said that he did not report this to the floor nurse and to V6 (WCN). V6 said that V13 should report noncompliance of R108's caregiver to the nurse because they don't allow pad lining inside the disposable brief in the facility. CNA should be is checking resident every 2 hours for incontinence.</p> <p>On 10/15/24 at 11:16AM, V6 (WCN) checked R108's disposable brief while V13 (CNA) assisting R108 to left side lying position. Observed large amount of soft brown fecal matter. V6 took the wet disposable wash cloth and wiped R108's rectal to perineum (back to front). V6 continued to wipe several times from rectal to perineum. Surveyor informed observation to both V6 and V13. V13 (CNA) said that it should be wipe from front to back to avoid infection (UTI- urinary tract infection). V6 asked V13 to clean R108, and they switched position.</p> <p>On 10/15/24 at 11:30AM, V6 (WCN) said that she should clean from front to back when performing incontinence care to R108. Requested for policy.</p> <p>On 10/16/24 at 1:30PM, Informed V2 (Director of Nursing) of above concern.</p> <p>R108 is admitted on [DATE] with diagnosis listed in part but not limited to Pneumonia, Gastrostomy due to dysphagia, Alzheimer's disease, Dementia, Transient Ischemic attack, and Cerebral infarction. Comprehensive care plan indicates she has bladder and bowel incontinence related to impaired cognition, poor safety awareness, generalized body weakness, decreased mobility secondary to COVID, Pneumonia, Dysphagia status post PEG tube placement. She has an ADL self-care performance deficit related impaired cognition, poor safety awareness, generalized body weakness, decreased endurance, and activity tolerance, reduce dynamics balance and coordination, on and off pain. She has impaired ability to perform or complete activities of daily living for oneself, such as feeding, dressing/grooming, bathing, toileting, bed and or wheelchair mobility, transfers, and ambulation secondary to COVID, Pneumonia, Dysphagia status post PEG tube placement.</p> <p>Facility's policy on Perineal Care indicates:</p> <p>Policy: It is the practice of this facility to provide perineal care to all incontinent resident's routine bath, and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Definition: Perineal care refers to care of the external genitalia and the anal area.</p> <p>Policy explanation and compliance guidelines:</p> <p>9. If perineum is grossly soiled, turn resident on side, remove any fecal material with toilet paper, then remove and discard.</p> <p>a. Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes.</p> <p>b. Thoroughly dry.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39781</p> <p>Based on observation, interview, and record review the facility failed to document count verification of controlled substances during nurses' shift change for one of three medication carts reviewed for Medication storage of controlled substances.</p> <p>Findings include:</p> <p>On 10/15/24 at 9:35AM, Checked medication cart with V11 (Registered Nurse/RN). Observed controlled substances count verification form for October 2024 has several missing initials of nurses dated 10/1/24, 10/2/24, 10/3/24, 10/11/24, and 10/15/24. V11 said that incoming nurse and outgoing nurse will sign the controlled medication verification form after counting the medications. V11 RN said that she counts the narcotic medications with the 11-7 shift nurse this morning around 7:30AM but she forgot to sign after counting.</p> <p>On 10/15/24 at 12:08PM, V14 (Nursing Supervisor) informed of above observation. V14 said that at each shift change, both nurses incoming and outgoing should sign the controlled medication verification form after counting the medications. Requested for policy.</p> <p>On 10/16/24 at 11:49AM, Informed V2 (Director on Nursing) of above concern. V2 said, the incoming and outgoing nurses during shift change should sign the controlled substance count verification after counting the medications.</p> <p>Facility's policy on Medication Storage in the facility: Controlled Substance Storage</p> <p>Policy: Medications included in the drug enforcement administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other applicable laws and regulations.</p> <p>Procedures:</p> <p>E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances (CII-CV) that are stored in locked compartments, including refrigerated items as conducted by two licensed nurses and is documented.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to implement its protocol on Enhanced barrier precaution. This deficiency affects all four (R42, R45, R108, and R110) residents in the sample of 14 reviewed for Infection Control Management.</p> <p>Findings include:</p> <p>1.) On 10/15/24 at 9:34AM, Observed V12 (Certified Nursing Assistant/CNA) came out from the room donning off gown, gloves and face shield then disposed it to the garbage container outside the room. The he performed hand hygiene. Observed isolation set up outside the R42's room.</p> <p>On 10/15/24 at 9:37AM, V11 (Registered Nurse/RN) said that R42 is on Enhanced Barrier Precaution (EBP), but she does not know the reason. V11 is wearing surgical mask, she donned gown and gloves. V11 administered medications to R42 orally and subcutaneous injection. After administration of medication. V11 removed the gown and placed it on garbage outside the door. V11 removed her gloves and placed it in her medication garbage cart. Then she performed hand hygiene.</p> <p>On 10/15/24 at 9:49AM, V4 (Infection Preventionist) said that Personal Protective Equipment (PPE) use inside the EBP room should be disposed inside the room garbage container not outside. Hand hygiene should be performed inside the room after removing the PPE. V4 said, staff should follow their infection control protocol. Requested for policy.</p> <p>R42 was admitted on [DATE] with diagnosis listed in part but not limited to Fracture of Right lower leg, Dislocation on right ankle, History of falling. Active physician order sheet indicates that she is on Enhanced Barrier Precautions due to history of MRSA (Methicillin-Resistant Staphylococcus Aureus) nares.</p> <p>2.) On 10/15/24 at 12:03PM, Observed R110 on Enhanced Barrier Precaution. V11 (RN) was wearing a surgical mask. She donned gown and gloves, then administered medications to R110. After medication administration, V11 removed the gown outside the room and disposed the gown to the garbage container located outside the room. V11 removed gloves and discarded it into the medication cart garbage. Then she performed hand hygiene.</p> <p>On 10/16/24 at 1:00PM, V4 (Infection Preventionist) said, there should be an order in R110's chart for resident on enhanced barrier precaution.</p> <p>R110 was admitted on [DATE] with diagnosis listed in part but not limited to Fracture of base skull, Intracranial injury, History of falling, Nontraumatic subarachnoid hemorrhage, Moderate protein calorie malnutrition. Active physician order sheet indicates daily wound care and as needed on sacrum due to pressure ulcer. There was not an enhanced barrier precaution order found in medical record.</p> <p>3.) On 10/16/24 at 9:12AM, Observed R108 is on Enhanced Barrier Precaution. Observed V18 (R108's Private Caregiver) performing personal hygiene to R108 without using PPE- no mask, gown, and gloves. He was cleaning R108's face using wash cloth. He said that he was informed by the staff to wear PPE when providing care to R108, but he forgot.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/17/24 at 11:41AM, V2 (Director of Nursing/DON) said that per V1 (Administrator) they won't allow surveyor to access R108's paper hospital transfer record from the admission of 9/4/24. Surveyor inquired about history of UTI (urinary tract infection) or if a urinalysis and/or urine culture was done at the hospital. V2 said R108 does not have history of UTI, no urinalysis and urine culture were done at the hospital.</p> <p>R108 was admitted on [DATE] with diagnosis listed in part but not limited to Pneumonia, Gastrostomy due to dysphagia, Alzheimer's disease, Dementia, Transient Ischemic attack, and Cerebral infarction. Active physician order sheet indicates that she is on daily wound care and as needed for pressure ulcers on sacrum and left buttocks. Bolus G-tube feeding. R108 has order for Enhanced Barrier Precaution. There was no documentation in R108's care plan of V18 (Private caregiver) non-compliance on infection control management to her care.</p> <p>Facility's policy on Enhanced Barrier Precaution (EBP) revision dates: 9/3/24 indicates:</p> <p>Purpose:</p> <p>EBP are an infection control intervention designed to reduce transmission of resistant organism that employs targeted gown and glove use during high contact resident care activities.</p> <p>Procedures:</p> <p>6. Ensure an order for EBP is written on the chart.</p> <p>8. Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves)</p> <p>9. Make PPE, including gowns and gloves, available immediately outside of the resident room.</p> <p>11. PPE, gloves, and gowns will be required for all staff providing high contact care activities</p> <p>12. Position a trash can inside the resident room and near the exit for discarding PPE after removal prior to exit of the room or before providing care for another resident in the same room.</p> <p>49871</p> <p>4.) On 10/15/2024 at 10:50 AM, during initial round R45's room did not have Enhance Barrier Precaution (EBP) signage, set-up, and Personal Protective Equipment (PPE) available to the staff and visitors. R45 was in the room, sitting down on a chair. R45 said he has a wound on his back and staff comes to treat and do his dressing daily.</p> <p>On 10/15/2024 at 10:52 AM, V4 (Infection Preventionist) said there should be a set-up, PPE, and EBP signage outside R45 room for staff and visitors' information.</p> <p>On 10/16/2024 at 1:50 PM, V2 (DON) said there should have been a set-up, PPE, and EBP signage on R45's room. This should have been done on admission.</p> <p>Order Summary Report:</p> <p>(continued on next page)</p>		

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