

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE 800 West Oakton Street Arlington Hts, IL 60004	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543</p> <p>Based on observation, interview, and record review the facility failed to provide feeding assistance in a dignified manner and failed to utilize a catheter dignity bag. This applies to 2 of 2 residents (R108, R425) reviewed for dignity in the sample of 35.</p> <p>The findings include:</p> <p>1. R108's Admission Record (Face Sheet) showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia, lack of coordination, and need for assistance with personal care.</p> <p>R108's 10/2/24 Significant Change Minimum Data Set (MDS) showed he had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 0 out of 15.</p> <p>On 11/19/24 at 11:49 AM, V9 Certified Nursing Assistant (CNA) provided R108's feeding assistance. V9 stood over R108 during the entire noon meal while she provided feeding assistance.</p> <p>On 11/20/24 at 2:24 PM, V10 Memory Care Unit Manager/Registered Nurse stated staff can either sit or stand when providing feeding assistance.</p> <p>On 11/20/24 at 3:00 PM, V3 Assistant Director of Nursing (ADON) stated staff should be seated and making eye contact with residents while providing feeding assistance. V3 stated this is the dignified way to provide feeding assistance.</p> <p>The facility's Assistance with Meals policy (effective date 4/1/24) showed, Residents who require feeding assistance will receive appropriate assistance with meals in a safe, dignified manner. In implementing the policy, the following shall apply: .Resident who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals .</p> <p>39537</p> <p>2. On 11/19/24 at 11:46 AM R425 was lying in bed, on his left side. R425 had a catheter drainage bag, draining cloudy yellow urine, visible from the hallway. R425's catheter drainage back was not covered with a dignity bag. R425 said he'd prefer for everyone not to see his catheter bag.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R425's Facesheet dated 11/20/24 showed he had diagnoses to include, but not limited to: urinary tract infection; sepsis; cutaneous abscess of right lower limb; diabetes; prostate cancer; obstructive and reflux uropathy; other injury of the ureter; chronic kidney disease; and benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>R425's Brief Interview for Mental Status (BIMS) Evaluation dated 11/17/24 showed he was cognitively intact.</p> <p>R425's Physician Order Sheet dated 11/20/24 showed he had orders for a indwelling urinary catheter and a suprapubic urinary catheter.</p> <p>R425's Indwelling Urinary Catheter care plan initiated 11/18/24 showed he had an indwelling urinary catheter and a suprapubic catheter due to prostate cancer with ureteral stricture and obstructive uropathy. The Interventions included, but were not limited to: Position the catheter bag and tubing below the level of the bladder and away from the entrance room door.</p> <p>On 11/20/24 at 1:23 PM, V17 (RN - Registered Nurse/Unit Manager) said R425's catheter bag should be covered with a dignity bag, especially if the drainage bag was facing the hallway door. V17 said these bags are used to cover the catheter drainage back for the resident's dignity.</p> <p>On 11/21/24 at 9:59 AM, V24 and V25 (Restorative Aides) provided incontinence care and assisted R425 with getting dressed. V24 and V25 placed each drainage back through R425's short openings and placed each bag in a dignity bag. They said the catheter drainage bags should always be covered in the dignity bags.</p> <p>On 11/21/24 at 11:29 AM, V3 (ADON - Assistant Director of Nursing) said R425's catheter bag should have been covered or facing away from the hallway. V3 said the purpose of doing this is so people passing by can't see what is draining and for the resident's privacy and dignity.</p> <p>The facility's Resident Rights Policy reviewed 12/10/24 showed, Employees shall treat resident with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence . t. privacy and confidentiality .</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395</p> <p>Based on interview and record review, the facility failed to obtain a Level I Preadmission Screening and Resident Review (PASSAR) for a resident who admitted with a serious mental health diagnosis for 1 of 1 residents (R77) reviewed for PASSAR in a sample size of 35.</p> <p>Findings include:</p> <p>R77's face sheet documented that resident last admitted to the facility on [DATE] and has a past medical history not limited to major depressive disorder, recurrent dated 07/25/2023.</p> <p>Review of R77's care plan showed the following: has known history of displaying inappropriate behavior and/or resisting care/services. Specific behavior exhibited: paranoia in the evenings, hallucinations. She has diagnosis of dementia, delusional disorder. Date Initiated: 08/19/2022. Revision on: 08/19/2022; is an elopement risk/wanderer related to impaired safety awareness. Resident wanders aimlessly. Date Initiated: 11/09/2022; uses psychotropic medications (antipsychotic and antidepressant medications) related to behavior management, depression. Date Initiated: 01/05/2023. Revision on: 10/18/2024.</p> <p>Review of R77's Minimum Data Set (MDS) quarterly resident care assessment screening dated 10/17/2024 documented in Section I for Active Diagnoses under Psychiatric/Mood Disorder, the diagnoses of Depression and Psychotic Disorder.</p> <p>On 11/21/24 at 09:21 AM, V4 (Social Services Director) said she attempted to complete a level I PASSAR screen upon R77's admission to the facility, but the system would not allow her to do so and showed an error message. V4 reviewed R77's medical diagnosis list with surveyor and indicated that R77 has a diagnosis of major depressive disorder dated 07/25/2023. At 09:58 AM, V4 (Social Services Director) said the hospital usually does the level I PASARR screening prior to admission, but if the screening is not completed by the hospital, then she is the person responsible to complete the screen. V7 then said that R77 was hospitalized in 2024 with covid so a screening should have been done upon her readmission.</p> <p>On 11/21/2024, requested PASSAR policy from the facility. Received Referral and Admission Process for Short-Term Skilled Nursing Admissions policy that did not include any information related to the PASSAR screening process.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395</p> <p>Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living for a resident assessed to be dependent on staff for grooming and personal hygiene for 1 of 1 residents (R166) reviewed for activities of daily living in a sample size of 35.</p> <p>Findings include:</p> <p>R166's face sheet documented that resident last admitted to the facility on [DATE] and has a past medical history not limited to: cerebral infarction, dementia, need for assistance with personal care, problem related to care provider dependency, pain and anxiety disorder.</p> <p>Review of R166's functional abilities and goals assessment with effective date of 10/14/2024 documented that R166 is dependent on staff for shower/bathing and personal hygiene.</p> <p>Review of R166's Minimum Data Set (MDS) quarterly resident care assessment screening dated 10/15/2024 documented in section C for cognitive patterns, a brief interview for mental status (BIMS) score of 15/15 that indicated no cognitive impairment. Section GG for functional abilities documented that R166 is dependent on staff for shower/bathing self and requires partial/moderate assistance with personal hygiene that includes the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).</p> <p>On 11/19/24 at 10:55 AM, R166 was observed by surveyor lying in bed watching television. Resident was wearing a hospital gown and appeared disheveled with noted facial hair to her upper lip and chin that was long and coarse in appearance. Her fingernails extended approximately 0.5 centimeters (cm) in length beyond the tips of her fingers to both hands and were noted with debris under several fingernails to both hands. R166 said she was last given a bed bath on Sunday and has not received any type of bathing since then.</p> <p>On 11/20/24 at 10:08 AM, R166 was observed by surveyor with a visibly unkept appearance, her hair was uncombed and appeared disheveled and her fingernails remained long in length with noted debris under several fingernails to both hands. R166 voiced that she had not received any recent assistance with oral hygiene then stated that she was last given a bed bath on Sunday and has not received any type of bathing since then.</p> <p>On 11/20/2024, reviewed R166's care plan with last completion date of 10/30/2024 that documented resident has a behavior, prefers and want to stay in bed 24/7 with date initiated on 08/09/2023. No documentation was found indicating that resident is resistive to care.</p> <p>On 11/21/2024 at 09:33 AM, R166 was again observed by surveyor with a visibly unkept and disheveled appearance, her hair was uncombed, and her fingernails remained long in length with noted debris under several fingernails to both hands. R166 again voiced that she had not received any recent assistance with oral hygiene then stated that she was last given a bed bath on Sunday and has not received any type of bathing since then. Facial hair to upper lip and chin remains long and course in appearance.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/24 at 09:37 AM, V6 (Registered Nurse) said R166 receives a bed bath weekly on Sundays and as needed if we see that she needs it and she receives daily hygiene and grooming which includes shaving her facial hair and trimming her long fingernails. V6 added that R166 is also seen by podiatry monthly for nail trimming to her hands and feet, then said if R166's family complains or requests for her facial hair to be trimmed, then staff will do so. V6 (Registered Nurse) also said that staff should encourage residents daily to receive grooming, that R166 refuses care often and any refusals of care should be documented within the resident's progress notes.</p> <p>On 11/21/24 at 09:43 AM, V7 (Certified Nursing Assistant) said she is assigned to R166 and was just about to provide her with morning care. When surveyor asked what care will be provided, V7 said that she will change her gown, diaper and bed pad and will check her for any skin issues. When asked by surveyor if she will provide any other type of care, V7 (Certified Nursing Assistant) said see if her linens need to be changed and that's it.</p> <p>On 11/21/2024 at 10:07 AM, V5 (Clinical Educator) said residents receive either a shower or bed bath weekly and as needed. She then said residents should be provided with daily hygiene that includes face and hand washing, grooming and/or shaving, oral hygiene and hair combing. She added that female should not have long facial hair.</p> <p>On 11/21/2024 at 11:05 AM, V5 (Clinical Educator) provided care plan for R166 that documented the following revision that was not previously noted by surveyor, the resident is resistive to care (washing face, brushing teeth, washing and combing hair, shaving) related to anxiety with date initiated of 03/10/2023 and last revision date of 11/21/2024.</p> <p>Review of R166's podiatry notes for last three months showed care provided to bilateral feet only. Progress notes for last thirty days showed no documented refusals of care including daily bathing and/or grooming.</p> <p>Review of Activities of Daily Living Policy retrieved on 11/21/2024 indicated that residents will be provided with the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene.</p> <p>Requested bathing, grooming and/or personal hygiene policies from facility. None were provided.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891</p> <p>Based on observation, interview, and record review the facility failed to ensure a wound vacuum was operational, failed to ensure physician orders were obtained, and failed to have care interventions in place for 1 of 3 residents (R371) reviewed for non-pressure wounds in the sample of 35.</p> <p>The findings include:</p> <p>R371's face sheet printed on 11/20/24 showed an admitted [DATE] and diagnoses including but not limited to aftercare following joint replacement, displaced fracture of the left femur, and the presence of left artificial hip joint. R371's brief interview of mental status report dated 11/15/24 showed cognitively intact.</p> <p>On 11/19/24 at 12:09 PM, R371 was seated in an upright recliner in her room and stated she had left hip surgery a week ago. R371 said she was wet underneath her left buttocks and the aide was on her way to get her cleaned up. R371 repeatedly said she was soaked and could not understand why her pants were all wet. A wound vacuum was lying on her bed and the tubing was running under her clothing, to the left side of her body. The vacuum fluid collection chamber appeared to be dry and empty.</p> <p>On 11/19/24 at 12:15 PM, V27 (RN-Registered Nurse) stated R371 came from the hospital with the wound vacuum following hip surgery. V27 said the surgical site orders are to change and empty the wound vacuum device as needed. V27 said there were no scheduled orders for the surgical site care. V27 said the only other order is for a follow up appointment with the orthopedic surgeon. V27 said there was nothing related to when or how to change the surgical dressings.</p> <p>On 11/19/24 at 12:21 PM, V28 (CNA-Certified Nurse Aide) entered the room and assisted R371 to stand to change her wet pants. V28 said R371 was at a therapy session earlier in the morning and she found the wound vacuum disconnected. V28 said she assumed R371's left side and buttocks were wet because the vacuum was not working. R371's left side and buttocks were observed. A large wound sponge was on the side of her left hip, a white dressing was top of her left hip, and a white dressing was near her left knee. The areas were covered with a clear, plastic dressing. The hip and buttock were wet with a clear fluid. V28 removed R371's brief which was clean and dry. V28 stated she was sure it was the surgical site draining onto R371's pants. V28 stated she was not sure how long the wound vacuum was not working but guessed quite a while since the clothing was thoroughly saturated.</p> <p>On 11/19/24 at 1:33 PM, V27(RN) examined R371's wound vacuum. V27 said it was not working. The device should have a light turned on to show it is suctioning fluid from the surgical wound. V27 examined the collection chamber and noted it was empty. V27 examined the surgical site and said fluid has been leaking out of the site. V29 (R371's family member) was seated on the edge of the bed. V29 said she was glad someone finally noticed the device. V29 said when R371 came into the facility last week, in the evening, none of the staff knew how to work it. It was acting weird and nobody could figure it out.</p> <p>R371's progress note dated 11/15/24 at 6:47 AM (morning following the prior evening admission) stated Resident's wound vac battery dead. No charger to charge the equipment. Endorsed to the oncoming nurse to contact the facility wound care nurse for possible solution to the situation.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/20/24 at 8:44 AM, R371 was seated in the upright chair in her room. R371 stated the wound vacuum was removed yesterday. She said she had no idea why it was removed or if it was going to be replaced.</p> <p>R371's November 2024 physician orders and care plan were reviewed by this surveyor. There was nothing related to the surgical site care, order to remove the wound vacuum, or interventions in place. There was an order start dated 11/14/24 to check wound vacuum placement and functioning. The treatment administration record was documented as being done twice per day, including 11/19 (day found by surveyor not operating).</p> <p>On 11/20/24 at 12:41 PM, V11 (Wound Care Nurse) stated she removed R371's wound vacuum just yesterday on the evening shift. V11 said the device light was flickering and the battery was close to dead. V11 said the floor nurse (V27) told her it was not working so she took it out. V11 said wound vacuums are important to suction the open skin area. Wound drainage can set in and cause the potential of a delay in healing. Skin maceration can be an issue if the drainage is allowed to sit on the skin too long. Infection is always an issue for surgical sites. V11 reviewed R371's electronic medical record and confirmed there were no treatment orders for the surgical wound site. V11 said there should be orders stating how often to change dressings, the type to use, and how to monitor the site. V11 confirmed there were no care plan interventions related to the surgical site or use of a wound vacuum. V11 said both are important to ensure wound healing, reduce the risk of infection and guide resident care. V11 said they should already be in place for a resident who has been here for a week.</p> <p>On 11/20/24 at 1:16 PM, V2 (Director of Nurses) stated physician care orders need to be in place within 24 hours of admission. They are important to give staff direction on how to care for residents. Orders are necessary to indicate when to start or stop medical intervention. Care plans do just as they say, direct care. A baseline care plan should be done within 48 hours of admission.</p> <p>On 11/21/24, R371's November 2024 Treatment Administration Record (TAR) showed orders start dated 11/20/24 (7 days after admission) to clean left hip surgical incision with normal saline and cover with dry dressing. Monitor daily for signs of infection. The TAR showed at second order start dated 11/20/24 to monitor surgical site of left hip daily for signs of infection, increased drainage, foul smell, redness. R371's care plan showed a focus area related to the potential/actual impairment to skin start dated 11/20/24. The goal and intervention sections were blank.</p> <p>The facility's Non-Sterile Dressing Change policy last revision dated 7/18/23 states under the procedure section: 1. Review the medical orders for wound care related to wound care.</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>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</p> <p>Based on observation, interview, and record review the facility failed to ensure preventative measures were in place, correct treatment orders were in place, and air mattress settings were for a resident's weight for 3 of 3 residents (R197, R280, & R466) reviewed for pressure in the sample of 35.</p> <p>The findings include:</p> <p>1. On 11/20/24 at 8:59 AM, R 197 was laying in bed on his back with his heels resting on the bed. R197 had a pillow under his calves that was flat and did not provide any offloading to his heels. R197 had a dressing to his right heel dated 11/20/24.</p> <p>The Face Sheet dated 11/20/24 for R197 showed diagnoses including right femur fracture, type 2 diabetes mellitus, atrial fibrillation, congestive heart failure, hypertension, abnormalities of gait and mobility, muscle weakness, hyperlipidemia, benign prostatic hyperplasia, cardiomegaly, fall, and need for assistance with personal care.</p> <p>The Physician Orders for November 2024 for R197 showed, 10/3/24 - elevate heels. Apply boots on both heels. 11/5/24 - To Right heel, cleanse wound with normal saline, apply foam dressing, and offload heel when in bed. Apply boots on both heel every shift. Elevate heels every shift.</p> <p>The Wound Care Physician's Progress note dated 11/14/24 for R197 showed, stage 3 pressure wound of the right heel; wound size (L x W x D) 2.4 x 4.2 x 0.1 cm; moderate serous exudate. Treatment plan alginate calcium once daily with a gauze island dressing with border.</p> <p>The TAR (Treatment Administration Record) for November 2024 for R197 showed right heel - cleanse wound with normal saline, apply foam dressing, and offload heel when in bed with a start date of 11/5/24. The order was completed every Tuesday, Thursday, and Saturday on 11/5, 11/7, 11/9, 11/12, 11/14, 11/16, and 11/19/24. R197's pressure ulcer treatment was changed on 11/14/24 by the wound care physician and that change was not on the R197's TAR; he did not receive the correct wound care treatment.</p> <p>On 11/20/24 at 12:59 PM, V14 RN (Registered Nurse) stated, R197 has a dressing change daily and as needed. His dressing was changed this morning. V14 went into R197's orders and stated his heels are to be offloaded and on Tuesday, Thursday, Saturday the residents wound is cleaned with normal saline and a foam dressing applied. V14 stated the order was placed on 11/5/24. V14 stated the wound nurse does the wound orders. V14 stated the wound care nurse looks at the wound care doctor's note for treatment orders and puts those in as orders. V14 reviewed the 11/14/24 wound care physician note and stated the treatment order was for calcium alginate daily for 30 days with a secondary dressing of gauze island with border.</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>On 11/20/24 at 1:15 PM, V 11 RN (Registered Nurse/Wound Care Nurse) stated, she looks at the physician orders for the treatment orders. The treatment orders for R197 pressure ulcer said to clean with saline and apply a foam dressing on Tuesday, Thursday, Saturday, and as needed. Those orders come from the wound care physicians progress notes when he see's the patient. V11 reviewed the Wound Care Physician Note dated 11/14/24 and stated the doctor changed the treatment to calcium alginate. V11 stated R197 has not been receiving the correct treatments. V11 stated R197's heels should be offloaded when he is in bed to take pressure off the wound.</p> <p>The Care Plan dated 10/3/24 for R197 showed, the resident has a right heel deep tissue injury. At risk for skin breakdown related to impaired mobility; right hip fracture - status post surgery. Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>The facility's Pressure Injury Prevention policy (1/10/24) showed a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The wound team will manage wound care, implement prevention interventions, and monitor compliance with documentation. Residents with pressure injury whether facility acquired or present on admission will have specialized mattress and wheelchair cushion appropriate to the resident's need. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc).</p> <p>2. On 11/19/24 at 11:39 AM, V11 and V12 RN (Registered Nurse/Wound Care Nurse) changed the dressing on R280's coccyx/right buttock area. R280 had a round open area to his right inner buttock. V12 stated it was a stage 3 pressure ulcer. R280 had a flat pressure relief cushion between two towels on his wheelchair seat. After the dressing change was completed, V11 and V12 were asked to look at the pressure relieving device in R280's chair. V11 stated that sometimes the cushions get flattened out.</p> <p>The Face Sheet dated 11/21/24 for R280 showed diagnoses including benign neoplasm of pancreas, secondary malignant neoplasm, severe protein-calorie malnutrition, type 2 diabetes mellitus, gastrostomy, thalassemia, anxiety, hypertension, essential tremor, benign prostatic hyperplasia, sepsis, and acquired absence of pancreas.</p> <p>Physician Order dated 11/12//24 for R280 showed, apply calcium alginate and then foam on coccyx (buttock) pressure wound every night shift and as needed.</p> <p>The Wound Care Physician's Note dated 11/14/24 for R280 showed, Dressing Treatment Plan: Primary Dressing(s) Foam silicone border apply three times per week for 30 days</p> <p>The November 2024 TAR (Treatment Administration Record) for R280 showed starting on 11/12/24 the treatment provided was calcium alginate and then foam dressing daily every night to coccyx (buttock). This was being completed 11/12/24 - 11/18/24.</p> <p>The Physician Orders for R280 showed on 11/19/24 the wound care nurse changed the wound care treatment orders in the physician orders 5 days after the physicians treatment orders changed. The order entered on 11/19/24 for R280 showed, apply foam dressing on right medial buttock pressure ulcer wound every night shift every Tuesday, Thursday, Saturday for wound and as needed if dressing is soiled or loose.</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>On 11/21/24 at 10:00 AM, V11 RN (Registered Nurse/Wound Care Nurse) reviewed R280's wound orders and stated the original order was for calcium alginate because he had drainage. V11 stated the orders from the wound care physician's visit on 11/14/24 should have been entered as the current treatment order for R280 and that was not done. V11 stated R280 had only one pressure ulcer that the facility said was on the coccyx and the wound care physician stated it was located in the right inner buttock.</p> <p>The Care Plan dated 11/1/24 for R280 showed, the resident has pressure ulcer to coccyx (buttock) and potential for pressure ulcer development related to history of ulcers and immobility. Follow facility policies/protocols for the prevention/treatment of skin breakdown. The resident is on Pressure relieving/reducing device) on bed/cushion in chair.</p> <p>The MDS (Minimum Data Set) dated 11/2/24 showed partial/moderate assist rolling in bed, moving from sitting to lying, sit to stand, chair/bed transfer, and toilet transfer. Walk 10 feet with supervision.</p> <p>The facility's Pressure Injury Prevention policy (1/10/24) showed a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The wound team will manage wound care, implement prevention interventions, and monitor compliance with documentation. Residents with pressure injury whether facility acquired or present on admission will have specialized mattress and wheelchair cushion appropriate to the resident's need. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc).</p> <p>39543</p> <p>3. R466's Admission Record (Face Sheet) showed he was admitted on [DATE] with diagnoses to include but not limited to dementia, Parkinson's disease, and weakness.</p> <p>R466's 11/11/24 Admission Minimum Data Set (MDS) showed he had short-term and long-term memory problems. (Brief Interview for Mental Status was not able to be done.)</p> <p>R466's 11/14/24 Physician wound care note showed he had a stage 3 pressure wound to the sacrum which was identified on admission.</p> <p>R466's Order Summary Report (as of 11/20/24) showed he had an active order, started on 11/7/24, for a low air loss mattress (commonly referred to as an air mattress). The order showed the mattress should be verified every shift.</p> <p>R466's November 2024 Treatment Administration Record (TAR) showed a treatment for Low air loss mattress every shift (twice daily) with an 11/7/24 start date. The TAR showed the 11/19/24 day shift, night shift, and 11/20/24 day shift air mattress checks were documented as being completed.</p> <p>On 11/19/24 at 3:05 PM, R466 was laying on his back in bed. At the foot of his bed was an air mattress pump/control unit, which was running. The air mattress was set to the highest weight setting which was 400 pounds. R466 appeared thin, frail, malnourished, and weighing less than 150 pounds. The air mattress control unit showed an applied label stating, in capital letters, KEEP DIAL AT RESIDENT WEIGHT.</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>On 11/20/24 at 9:00 AM, R466's air mattress was set at the maximum weight of 400 pounds.</p> <p>On 11/20/24 at 2:07 PM, R466's air mattress remained at the 400-pound setting.</p> <p>R466's Weights and Vitals Summary showed, on 11/11/24, he weighed 110. (Nearly 300 pounds less than the air mattress setting.)</p> <p>On 11/20/24 at 3:00 PM, V3 Assistant Director of Nursing stated the purpose of an air mattress, for a resident with pressure ulcers, is to promote healing and to prevent further skin breakdown. V3 stated the air mattress should be set to the resident's weight, which alters the pressure in the air mattress to match an optimal pressure for the resident. V3 stated low air loss entry in the TAR is when the nursing staff should be verifying the air mattress pressure.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891</p> <p>Based on observation, interview, and record review the facility failed to supervise a resident with difficulty swallowing while eating for 1 of 6 residents (R8) reviewed for safety in the sample of 35.</p> <p>The findings include:</p> <p>R8's face sheet printed on 11/21/24 showed diagnoses including but not limited to multiple sclerosis, dementia, psychotic disturbance, bipolar disorder, and dysphagia (difficulty swallowing). R8's facility assessment dated [DATE] showed moderate cognitive impairment and staff assistance of setup for eating meals.</p> <p>R8's physician orders showed an order start dated 6/21/24 for: Regular diet, pureed texture, regular/thin consistency, please feed for Multiple Sclerosis, Dysphagia, Oropharyngeal Phase.</p> <p>R8's care plan showed an intervention initiated on 9/20/24 to assist/feed at mealtimes.</p> <p>On 11/19/24 at 12:35 PM, R8 was seated in a wheelchair in the unit dining room. R8's lunch was a pureed consistency and approximately 50% of the food had been consumed. Another resident was seated next to R8 and eating a regular texture meal. A third resident was across the room with her private caregiver who was talking on the phone. There was a dietary aide at the serving counter across the room and R8's back was facing her. There were no facility nursing staff present in the dining room supervising.</p> <p>On 11/20/24 at 8:57 AM, R8 was in his wheelchair in his room and alone. A pureed texture breakfast tray was in front of him. R8 was feeding himself and there were no staff present. At 12:36 PM, R8 was in his room eating his pureed lunch and alone.</p> <p>On 11/21/24 at 9:24 AM, R8 was in his wheelchair in his room and alone. A pureed texture breakfast was in front of him.</p> <p>On 11/21/24 at 9:30 AM, V31 (Licensed Practical Nurse) stated R8 has dysphagia due to his multiple sclerosis. He has trouble swallowing and has been on a puree texture diet since he was admitted . The texture helps him swallow more easily.</p> <p>On 11/21/24 at 9:36 AM, V32 (Diet Technician) stated R8 needs a pureed diet because of swallowing difficulties. He has the potential to choke if he isn't supervised while eating. He should be eating meals in the dining room so staff can supervise him. The nursing department would be the ones to determine if it is safe for him to eat alone in his room.</p> <p>On 11/21/24 at 9:51 AM, V3 (Assistant Director of Nurses) said R8 needs to eat meals in the dining room so that staff can supervise him. He has the potential to choke if he is eating alone. It is not safe for him to be eating alone in his room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was unable to provide any policy related to the supervision of residents with dysphagia or difficulty swallowing.</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>20042</p> <p>Based on observation, interview, and Record Review the facility failed to ensure a resident's indwelling urinary catheter bag was not on the floor or stepped on for 1 of 1 residents (R291) reviewed for catheters in the sample of 35.</p> <p>The findings include:</p> <p>On 11/20/24 at 9:32 AM, R291 was sitting on the toilet in her bathroom with the catheter drainage bag laying on the floor. V13 CNA (Certified Nursing Assistant) picked the drainage bag up from the floor, treaded it through R291's pants and put the drainage bag back on the floor. R291 scooted forward on the toilet and her right foot was stepping on the catheter drainage bag. V13 counted to three and had R291 stand and she cleaned R291's buttocks. V13 put an incontinence brief on the resident and pulled up her pants. R291 sat in her wheelchair and her drainage bag continued to lay on the floor. V13 moved the drainage bag over next to the outside of R291's leg, went to the back of her chair, grabbed the bag and placed it in the dignity bag under the wheelchair. V13 stated the catheter bag should be below the bladder so it can drain. V13 stated the drainage bag shouldn't be on floor because a lot of things can happen to the bag.</p> <p>On 11/20/24 at 12:59 PM, V14 RN (Registered Nurse) stated the catheter drainage bag should not be on the floor because it can cause an infection.</p> <p>On 11/20/24 at 2:20 PM, V5 RN (Registered Nurse/Nurse Educator) stated the catheter bag should not be on the floor for infection control. The floor is not the cleanest; we want to prevent an infection from happening.</p> <p>The Face Sheet dated 11/20/24 for R291 showed diagnoses including congestive heart failure, low back pain, neuropathy, pleural effusion, hypertension, generalized edema, muscle weakness, cellulitis of right lower limb, atrial fibrillation, hyperlipidemia, gastroesophageal reflux disease, venous insufficiency, retention of urine, and peripheral vascular disease.</p> <p>The Care Plan dated 11/5/24 for R291 showed resident requires enhanced barrier precautions related to indwelling catheter. Make sure PPE, including gown and gloves are available. Post clear sign on wall outside room indicating type of precautions and required PPE. The resident has and indwelling urinary catheter for urinary retention. The resident has 16 french indwelling catheter. Position catheter bag and tubing below the level of the bladder and away from entrance door.</p> <p>The facility's Catheter Care, Urinary policy (7/6/23) showed, Infection Control: b. Be sure the catheter and tubing are kept off the floor.</p>

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>39537</p> <p>Based on observation, interview, and record review the facility failed to communicate and effectively treat a resident's pain; and failed to verify and obtain a resident's ordered pain medication in a timely manner for 1 of 1 resident (R425) reviewed for pain in the sample of 35. These failures resulted in R425 experiencing continued pain and emotional anguish.</p> <p>The findings include:</p> <p>On 11/19/24 at 11:46 AM, R425 was lying in bed, on his left side. R425 had a catheter drainage bag on each side of the bed frame. R425 said he's been sick since March and was in the hospital. R425 said the hospital found out that he had urine draining into his right upper leg area (fistula - an abnormal opening in the urinary tract). R425 said that caused him to develop an abscess in his right upper leg. R425 said they had to drain out the fluid from his leg and now he has a catheter in his penis to protect the fistula and a suprapubic catheter (directly through the abdominal wall, into the bladder) to empty most of his urine. R425 said his pain seemed to be getting worse. R425 said in the hospital he was getting 2 Norcos (opiate pain medication), but when he was transferred to the facility it was changed to 1 Norco. R425 started crying and plead, I'm just so miserable and I can't get anyone to listen to me. R425 shook his head then became irritable. R425 stated, I just don't feel like anyone communicates with each other. I'm tired of being in pain. I tell them and no one listens. This position (left side lying) is the only position that is even the slightest bit comfortable for me. Any movement of my right leg is excruciating. I can't do therapy because my right leg hurts so bad when it's moved. I'm so f***** frustrated! I'm sorry I'm cussing, but that's how I feel. (R425 began crying again). Most days I just lay here, grip the side rail and cry. This pain is awful, and no one is doing anything about it. V20 (R425's spouse) was seated in a chair at the bedside. V20 said the facility wasn't managing his pain, but they had a tele-visit with R425's pain doctor at 1:30 PM today. V20 reminded R425 of the appointment and attempted to reassure him.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/20/24 at 12:47 PM, R425 was sitting up in the wheelchair in his room. R425 and V20 (R425's spouse) were discussing nutritional supplements with V15 (RN - Registered Nurse). After V15 left the room, the surveyor asked R425 how he was feeling today. R425 reported, I'm miserable! (and began crying). R425 became agitated and said they had the tele-visit with V22 (Pain Nurse Practitioner) at 1:30 PM yesterday. R425 said about an hour later V22 called V20 (R425's spouse) to provide an order for Fentanyl patch 12 mcg. R425 said he was supposed to continue the Norco scheduled every 4 hours and start the Fentanyl patch. R425 said V22 (Pain NP) would follow-up with them in a few days to see if his pain was improving. R425 yelled, I still don't have the damn patch! I guess they don't have the order or something like that! How can that be, it's almost been 24 hours! See what I mean. The communication sucks! R425 was becoming agitated and crying. V20 (R425's spouse) rubbed his shoulders and tried to calm him. V20 said when V22 (Pain NP) called with the order for Fentanyl, she couldn't find the nurse. V20 said she went to the desk; the nurse wasn't there. V20 said the receptionist was there and said she would make sure the order was put in right away. V20 said she's not sure what the receptionist's credentials were, but she trusted that the information would be communicated. V20 said the receptionist provided the facility's pharmacy information to her. V20 said she provided the pharmacy information to V22 (Pain NP), and she said that she would send the Fentanyl patch prescription directly to the pharmacy. V20 said the nurse did not come in the room to discuss it with her later. V20 stated, I expected the pain patch to be delivered by this morning (at the latest), but it's still not here. They don't even have an order for it here. R425 stated, I'm so disgusted, miserable, and frustrated! They need to communicate and control my pain. R425 started crying and placed his face into his hands. At 12:55 PM, V16 (NP) entered the room. V16 asked R425 how are you? R425 replied, Don't even ask! R425 reported his frustrations to V16. V16 stated, This is my first time seeing you. I'll have to take a look at your notes. There is no Fentanyl order in the computer at this time. The surveyor walked to the nurses' station where V15 (RN) was on the phone with pharmacy. V15 said there was a prescription for a Fentanyl patch sent yesterday and the family is asking me about it. V15 said he reviewed the chart and R425 did not have an order for Fentanyl and there were no progress notes. V15 said the pharmacy said they received a prescription from V22 (Pain NP), but the prescription was for 30 patches, and they will not accept it. V15 stated, I don't know why the pharmacy didn't call [V22 - Pain NP] to verify the order. They are the ones that gave the phone number for [V22]. V16 (NP) walked up to V15 and stated, I'll give you a one-time order (for Fentanyl patch) now, so the resident can get it right away. He's in pain. Then we can make follow-up appointments to get an order (for ongoing treatment). Don't even bother to call this office [V22]. I'll give the Fentanyl order and [V23 - Pain MD] will follow-up. V16 asked V15 to call the nursing supervisor and see if they can get the Fentanyl patch from the emergency box, so he (R425) doesn't have to wait any longer. V15 said R425's Fentanyl patch prescription was sent directly to the pharmacy, but they didn't call the doctor's office to get the quantity changed. V15 stated, They should have done that. They gave me the number. Why didn't they call? I'm putting the orders in now. Hopefully they can get the Fentanyl patch from the emergency box. This is the first time I've experienced Pharmacy not liking a quantity. They (Pharmacy) didn't call us to check. The previous nurse would have told me that. The pharmacy should have sent at least 1 Fentanyl patch to get the resident's pain controlled, then got the clarification. It's important to control the resident's pain. That's why I was surprised someone came to me and said he was asking for his pain medication. I didn't know anything about the Fentanyl. I checked the orders and progress notes and there wasn't anything. It's true that there was a communication break down and I'm sorry this happened to them. V15 said R425 has prostate cancer and had pain to his lower back and right hip area. V15 said R425 had therapy in the gym and that may have triggered more pain again. V15 said V23 (Pain MD) is at the facility 1-2 times per week and will see R425 tomorrow.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/20/24 at 1:23 PM, V17 (RN - Registered Nurse/Unit Manager) said she is not sure what happened with R425's Fentanyl. V17 said she called V18 (LPN - Licensed Practical Nurse) because she was R425's nurse yesterday (11/19/24). V17 said V18 didn't know anything about a Fentanyl order sent to the pharmacy. V17 states if an outside physician order's medication, then the facility needs to get approval from an in-house provider and enter an order. V17 said R425 did not have a Fentanyl order entered into the EMR (electronic medical record) yesterday. V17 said the emergency box does not contain Fentanyl patches. V17 said pharmacy was called and a STAT order was placed. V17 said the pain patch should be here in 2-4 hours.</p> <p>On 11/20/24 at 1:34 PM, V19 (Guest Services Associate) said she works at the reception desk on R425's floor. V19 said she works 8 AM to 4 PM. V19 said she answers the phones, assists with scheduling appointments, and orders equipment and supplies for the unit. V19 said she was working 11/19/24 and spoke with V20 (R425's spouse). V19 said the nurse was busy and V20 was asking what pharmacy we used and what their phone number was. V19 said she gave V20 the information because the nurses were busy. V19 said she didn't ask V20 why she needed the pharmacy number.</p> <p>On 11/21/24 at 9:08 AM, V18 (LPN) said she worked 11/19/24 and took care of R425. V18 said she was not aware that R425 had a tele-visit with a pain NP. V18 said V19 (Guest Services Associate) did tell me that V20 (R425's spouse) was asking for the pharmacy we use and for the number. The surveyor asked why V20 would be asking about the pharmacy information. V18 replied, I'm not sure why she would be asking for the pharmacy information. That's a good question. V18 said she didn't follow-up with R425 or V20 regarding their request for the pharmacy information. V18 said she worked until 7 PM on 11/19/24. V18 said they didn't mention they were waiting for a pain patch. V18 said if she knew, then she would have checked to see if there was an order in the EMR. V18 said if there wasn't an order, then she would call the facility provider to obtain an order, enter it into the EMR, and notify pharmacy. V18 said there should have been follow-up to V20's request for the pharmacy information. V18 said she didn't speak to the pharmacy about R425's Fentanyl patch because she didn't know anything about it.</p> <p>On 11/21/24 at 9:26 AM, V21 (Pharmacist) said an electronic order for Fentanyl patch 12 mcg was sent on 11/19/24 at 7:43 PM by V22 (Pain NP). V21 said it looks like there was a discrepancy on the quantity. I see documentation that the pharmacy attempted to contact the facility at 9:11 PM and was not get in contact with facility staff. There was a note in the system that the Fentanyl patch was pending clarification. V21 said there is no further documentation, and he is unsure if the pharmacist made contact with someone at the facility. V21 said on 11/20/24 at 1:13 PM, V16 (NP) entered an order for 1 Fentanyl patch for R425. V21 said the delivery left the pharmacy at 2 PM and arrived at the facility a few hours later. V21 said the pharmacy director will follow-up with more details on 11/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/24 at 9:59 AM, V24 and V25 (Restorative Aides) were donning gowns and gloves to provide R425 incontinence care and get him up to the wheelchair. R425 looked up and started crying and motioned for the surveyor to come talk. R425 stated, This is a f***** mess! The system is broken down. I tell every f***** person that comes in that I'm in pain. I lay here in unbearable pain. One time I laid here crying for what seemed like 5 hours, but only 1 f***** hour had passed. I don't feel like I'm moving forward with pain control. I had that tele-visit on Tuesday at 1:30 PM (11/19/24) with [V22 (Pain NP)]. [V22] called back within an hour to give an order. It took damn near 24 hours to get the pain patch (Fentanyl patch). When I finally got the patch, they started messing with my Norco. I don't like taking narcotics. It scares the s*** out of me, but I need them! I don't like it, but I NEED them. (R425 was lying on his back in bed, speaking loudly, cursing frequently, and his eyes welled up with tears.) I've never not been in pain. I can't even say if this pain patch is working because they quit giving my Norco last night. [V22 - Pain NP] knew I was on Norco every 4 hours and said it wasn't effective and added the Fentanyl patch. They were NOT supposed to stop my Norco! I got a couple doses of my scheduled Norco with the Fentanyl patch, but then the nurse last night said she I couldn't have them both together. I told her I was in pain and needed them. (R425 began crying). Why do they keep messing with stuff. I can hardly take this and their poor communication. See what I mean? They don't communicate! It's beyond frustrating and I'm still in pain. V24 and V25 came in the room to assist R425. They provided incontinence care and dressed R425, rolling him side to side. Each time R425 was rolled onto his right side, or his right leg was touched, he groaned in pain and grimaced. R425 told V24 and V25 that it hurt whenever his right leg was moved. They assisted R425 to roll up on his right side to sit up on the edge of bed. R425's right side was on the bed, and he started crying, It hurts, lying on this side hurts. I'm lying on my sore spot. V24 and V25 assisted off his right side and to a sitting position on the edge of the bed.</p> <p>On 11/21/24 at 11:17 AM, V20 (R425's Spouse) said the facility's pain doctor (V23) just left R425's room. V20 said they are going to allow him to take his scheduled Norco every 4 hours and the Fentanyl patch to see if it works. If that doesn't work, then they will come up with a different plan. V20 said R425 seemed to be in better spirits after the visit and he feels like they are finally starting to listen to him. V20 said R425 had been in so much pain every day, so they decided to call his pain doctor because he needed some relief. V20 said she told the receptionist (V19) why she needed the pharmacy number because the nurse wasn't around. V20 said she doesn't know what happened after that because she went back to R425's room. V20 stated, All I know is when I came back yesterday (11/20/24) he still didn't have his pain patch and he was very upset about it. It didn't come until around 4 PM.</p> <p>R425's Facesheet dated 11/20/24 showed he had diagnoses to include, but not limited to: urinary tract infection; sepsis; cutaneous abscess of right lower limb; diabetes; prostate cancer; obstructive and reflux uropathy; other injury of the ureter; chronic kidney disease; and benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>R425's Brief Interview for Mental Status (BIMS) Evaluation dated 11/17/24 showed he was cognitively intact.</p> <p>R425's Physician Order Sheet dated 11/20/24 showed Norco 5-325 mg - Give 1 tablet by mouth every 4 hours for pain was started on 11/15/24. On 11/20/24 an order for Fentanyl 12 mcg transdermally every 72 hours for pain was entered. (The facility did not have an order in the EMR prior to 11/20/24. V20 (R425's spouse) requested the facility's pharmacy information at approximately 2:30 PM. The nurse did not follow-up with V20 and R425 regarding their request for the pharmacy information).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R425's November 2024 MAR (Medication Administration Record) showed he received the Fentanyl patch at 4:09 PM on 11/20/24. This document showed that R425's Norco tablet scheduled for midnight on 11/21/24 was held. The code 5 was documented. This form showed 5 means hold, see progress notes. R425's Progress Notes did not contain an entry explaining why this dose was held.</p> <p>R425's NP Progress Note dated 11/20/24 showed the patient is upset he has not received his Fentanyl patch. The wife relayed it was ordered by his pain MD. Spoke to RN and gave order for Fentanyl patch and V23 (Pain MD) to follow-up with patient for pain control. The patient is complaining of right thigh pain.</p> <p>R425's Nursing Note dated 11/20/24 at 12:50 PM showed, Resident and family asking about the order for Fentanyl patch as from pain MD office. As nurse writer verified today (11/20/24). Pharmacy received order/prescription directly from Pain MD office on 11/19/24 for Fentanyl 12 mcg every 72 hours; but it was not delivered due to questions regarding the prescription. [The pharmacy] did not call [the unit] for verification of order. Upon knowledge, nurse immediately contacted primary attending NP to inform resident circumstance of investigation and approved orders for Fentanyl by outside MD, with current med order on Norco given at 12 PM for pain 8/10 (rated at 8 on 1-10 scale, 10 being worst pain ever experienced) . 4 PM Resident comfortable in bed, left side lying; received from pharmacy and applied Fentanyl patch 12 mcg on right upper chest . 6 PM Resident comfortable in bed, with some relief of pain observed.</p> <p>On 11/21/24 at 11:29 AM, V3 (ADON - Assistant Director of Nursing) said if the pharmacy has questions regarding a medication order, then they usually call the floor nurse of the 24/7 supervisor. V3 said the staff receiving the call should address the clarifications as soon as possible. V3 said the pharmacy makes three scheduled deliveries per day and can make STAT deliveries in between. V3 said STAT deliveries usually arrive to the facility in 2 hours. V3 said if a resident is complaining of pain, then the staff should believe it. The nurse should perform a pain assessment and determine the level of pain. If the resident is already receiving pain medications, then the nurse will need to notify the physician of continued pain. V3 said the resident may need additional pain medications or a different approach to pain control. V3 said as soon a resident is complaining of pain, then the nurse should start working on obtaining orders for pain control. V3 said the R425, and his family shouldn't have felt they needed to call an outside pain clinic. V3 said V23 (Pain MD) rounds at the facility 1-2 times per week and is available for consults when residents complain of pain. V3 said she expects her staff to communicate a resident's complaints of pain to each other and continuity of care should be maintained. V3 said if R425's wife was asking for pharmacy information, then the staff should have followed-up with her. I don't know why the nurse didn't follow up. There isn't a progress note that showed the nurse was aware of the request for pharmacy information. V3 said pain control is important to a resident's healing, rehab, overall health, and resident comfort. V3 said she was not aware that R425 was unhappy and experiencing such pain. The surveyor asked why R425's scheduled Norco was held at midnight 11/21/24. V3 said she didn't know, but 5 stands for hold, see progress notes. The surveyor asked V3 to review R425's progress notes for an entry for the held 11/21/24 midnight dose of Norco. V3 reviewed R425's chart and said there isn't a note, but there should be one. V3 stated, I'm not sure everyone is aware that he is in pain. It's expected that we would do our best to control the resident's pain. We must listen to them. I can't say what happened because the nurse didn't chart anything to explain why the Norco was held. She should have.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/22/24 at 12 PM, V33 (Director of Pharmacy) said he followed up regarding my questions for R425's Fentanyl patch. V33 said the electronic order was received from pharmacy at 7:43 PM on 11/19/24. V33 said there were errors with the prescription regarding the quantity and duration. V33 said the order was not entered as a STAT, so the pharmacist reviewed the orders later in the evening. V33 said pharmacy sent an email to V34 and V35 (Supervisors) regarding the need for order clarifications. V33 said it's the facility's procedure to email V34 and V35. V33 said a new order was entered for Fentanyl on 11/20/24 by V16 (NP) and it was filled STAT. V33 said he would expect the facility staff to communicate effectively to address any pharmacy concerns or resident complaints with pain.</p> <p>The facility's Pain Assessment and Management Policy reviewed 11/27/24 showed, A comprehensive and effective pain management program is provided to residents who require such services to ensure comfort, facilitate independence, and preserve dignity. The purpose of this policy is to provide guidelines for the assessment and identification of the resident's pain with underlying causes, and the development of pain management interventions consistent with professional standards of practice, person-centered care plan, and the resident's goals and preferences. Guidelines: 1. The pain management program is based on professional standards of practice and the resident's preferences related to pain management. 2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessments and recognition of pain. b. Identifying the underlying causes and characteristics of pain; c. Developing and implementing a treatment/pain management plan; d. Monitoring for effectiveness and modifying interventions; and 3. Documentation and reporting . Documentation and Reporting: 1. The following information shall be documented and reported to the physician/medical provider immediately: a. Significant changes in the level of the resident's pain . d. Prolonged, unrelieved pain despite care plan interventions.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34891</p> <p>Based on observation, interview, and record review the facility failed to ensure insulin was refrigerated or dated and failed to ensure controlled medications were double locked for 2 residents in the sample (R8, R172) and 4 residents outside of the sample (R367, R375, R41, R179).</p> <p>The findings include:</p> <p>1. On 11/20/24 at 9:42 AM, the 2B unit medication cart was reviewed with V26 (RN-Registered Nurse) present. The top drawer of the cart contained an insulin pen labeled with R172's name. A multi-dose vial of insulin belonging to R375 was in the drawer. Both items were unopened and inside clear bags stating to keep refrigerated. The drawer had an opened insulin pen belonging to R367 and a multi-dose vial of insulin belonging to R41. Neither of the open insulin containers were labeled with any dates. V26 (RN) stated insulin needs to be refrigerated until it is opened. It maintains the usefulness. Any open insulin needs to be dated to know when it will expire. It needs to be discarded after 28 days. The insulin proteins can breakdown and not work effectively.</p> <p>2. On 11/20/24 at 10:01 AM, the 2B unit medication room was reviewed with V26 (RN). The medication refrigerator was unlocked and contained two multi-dose vials of lorazepam (anti-anxiety medication). The vials were labeled with R8 and R179's names. V26 stated the lock is needed for safe keeping of the medications. V26 said the refrigerator is always kept unlocked and he was not even sure if he had keys to the lock. V26 did locate the key in his possession and stated the refrigerator is normally kept open from shift to shift. V26 and this surveyor exited the medication room with the refrigerator left unlocked.</p> <p>On 11/21/24 at 11:20 AM, V3 (Assistant Director of Nurses) stated insulin needs to be refrigerated until it is opened. Any open insulin should be dated with the day opened and day it will expire. It is necessary so staff know how long it is good for. There is the potential for less efficacy if it is not stored correctly or used after 28 days. V3 said controlled medications should always be under a two-lock system. It ensures it is in a safe place and prevents unauthorized people from taking the medication.</p> <p>The facility's Medication Storage policy dated 1/24 states under the procedures section: 2. Controlled substances stored in refrigerator should be secured such as a separately locked, permanently affixed compartment. 12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891</p> <p>Based on observation, interview, and record review the facility failed to ensure enhanced barrier precautions were implemented for residents with surgical wounds (R371, R197) and failed to ensure personal protective equipment was worn during catheter care (R291) for 3 of 8 residents reviewed for infection control in the sample of 35.</p> <p>The findings include:</p> <p>1. R371's face sheet printed on 11/20/24 showed an admitted [DATE] and diagnoses including but not limited to aftercare following joint replacement, displaced fracture of the left femur, and the presence of left artificial hip joint. R371's brief interview of mental status report dated 11/15/24 showed cognitively intact.</p> <p>On 11/19/24 at 12:09 PM, R371 was seated in an upright recliner in her room and stated she had left hip surgery a week ago. R371 said she was wet underneath her left buttocks and the aide was on her way to get her cleaned up. A wound vacuum was lying on her bed and the tubing was running under her clothing, to the left side of her body. R371 did not have any type of signage on her door and there was no PPE bin (personal protective equipment) outside the doorway.</p> <p>On 11/19/24 at 12:21 PM, V28 (CNA-Certified Nurse Aide) entered the room and assisted R371 to stand to change her wet pants. R371's left side and buttocks were observed. A large wound sponge was on the side of her left hip, a white dressing was on top of her left hip, and a white dressing was near her left knee. V28 removed R371's brief and provided pericare to the groin and buttock areas. V28 was only wearing gloves. At 1:33 PM, V27(Registered Nurse) examined R371's wound vacuum and said it was not working. V27 examined the surgical site and said fluid has been leaking out of the site. V27 wore only gloves. At 1:47 PM, V28 (CNA) transferred R371 from her recliner to the bed. V28 handled the wound vacuum and wore only gloves.</p> <p>On 11/20/24 at 1:03 PM, V30 (RN/Infection Control Preventionist) stated residents with any draining wound need to be on (EBP) enhanced barrier precautions. V30 said residents with wound vacuums indicate the wound is draining and need to be on EBP. Staff should be wearing gowns and gloves during all resident care. Face shields are needed if there is a chance of any splashing during care. The PPE needs to be worn during all high contact activities. V30 said there is the risk of spreading germs to other residents if it is not worn. EBP rooms should have signs posted on the door and PPE bins in the hall.</p> <p>The facility's Enhanced Barrier Precautions policy last revision dated 1/1/2024 states 2. EBPs employ targeted gown and glove use during high contact resident care activities . The policy listed examples of high contact care activities which require the use of gown and gloves. The list included dressing, providing hygiene, changing briefs, and wound care. The policy further stated: 9. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 10. PPE is available outside of the resident room.</p> <p>20042</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 - Few</p>	<p>2. On 11/20/24 at 9:32 AM, R291 was sitting on the toilet in her bathroom with the catheter drainage bag laying on the floor. V13 CNA (Certified Nursing Assistant) had gloves on but was not wearing a gown. V13 picked the drainage bag up from the floor, treaded it through R291's pants and put the drainage bag back on the floor. R291 scooted forward on the toilet and her right foot was stepping on the catheter drainage bag. V13 counted to three and had R291 stand and she cleaned R291's buttocks. V13 put and incontinence brief on the resident and pulled up her pants. V13 removed her gloves. R291 sat in her wheelchair and her drainage bag continued to lay on the floor. V13 moved the drainage bag over next to the outside of R291's leg without any gloves on. V13 stood up, put gloves on, went to the back of her chair, grabbed the bag and placed it in the dignity bag under the wheelchair. V13 was asked what EBP (Enhanced Barrier Precautions) was and she stated she believes gloves is the only PPE (Personal Protective Equipment) she should wear. R291 had an EBP sign outside the door that stated what staff should wear for PPE.</p> <p>On 11/20/24 at 2:20 PM, V5 RN (Registered Nurse/Nurse Educator) stated EBP is for people with devices like catheters, picc (peripherally inserted central catheter), feeding tube, wounds, surgical wounds, stage 3 & 4 wounds, and tracheostomy; there is a long list. V5 stated when staff are providing direct care the PPE they should wear is gown and gloves because we dont want to introduce anything to the patient and put them more at risk.</p> <p>The Face Sheet dated 11/20/24 for R291 showed diagnoses including congestive heart failure, low back pain, neuropathy, pleural effusion, hypertension, generalized edema, muscle weakness, cellulitis of right lower limb, atrial fibrillation, hyperlipidemia, gastroesophageal reflux disease, venous insufficiency, retention of urine, and peripheral vascular disease.</p> <p>The Physician Orders for R291 showed an order dated 11/15/25, enhanced barrier precautions related to foley catheter every shift for urinary retention.</p> <p>The Care Plan dated 11/5/24 for R291 showed resident requires enhanced barrier precautions related to foley catheter. Make sure PPE, including gown and gloves are available. Post clear sign on wall outside room indicating type of precautions and required PPE.</p> <p>The Enhanced Barrier Precautions (1/11/24) showed, enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention control intervention to reduce the spread of MDROs to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene; .f. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc); and wound care (stage II skin opening requiring a dressing). Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.</p> <p>3. On 11/20/24 at 8:59 AM, R197 was laying in bed on his back with his heels resting on the bed. R197 had a pillow under his calves that was flat and did not provide any offloading to his heels. R197 had a dressing to his right heel dated 11/20/24. R197 stated his dressing to his right heel was changed this morning. R197 did not have EBP (Enhanced Barrier Precautions) sign posted on his doorway and/or next to his door.</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 - Few</p>	<p>The Face Sheet dated 11/20/24 for R197 showed diagnoses including right femur fracture, type 2 diabetes mellitus, atrial fibrillation, congestive heart failure, hypertension, abnormalities of gait and mobility, muscle weakness, hyperlipidemia, benign prostatic hyperplasia, cardiomegaly, fall, and need for assistance with personal care.</p> <p>The Physician Orders for November 2024 for R197 did not show any orders for EBP (Enhanced Barrier Precautions).</p> <p>The Wound Care Physician's Progress note dated 11/14/24 for R197 showed, stage 3 pressure wound of the right heel; wound size (L x W x D) 2.4 x 4.2 x 0.1 cm; moderate serous exudate. Treatment plan alginate calcium once daily with a gauze island dressing with border.</p> <p>On 11/20/24 at 12:59 PM, V14 RN (Registered Nurse) stated R197 has a dressing change daily and as needed. V14 stated if a resident is on EBP then staff should wear a gown and gloves because they can come in contact with bodily fluids. EBP are put in place to protect the resident and yourself; to prevent any contamination.</p> <p>On 11/20/24 at 1:15 PM, V11 RN (Registered Nurse/Wound Care Nurse) stated, R197 should have EBP in place. V11 walked down to R197's room and confirmed there wasn't a sign up for R197 to show that he was on enhanced barrier precautions.</p> <p>The Care Plan dated 10/3/24 for R197 did not show a plan in place for EBP.</p> <p>The Enhanced Barrier Precautions (1/11/24) showed, enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention control intervention to reduce the spread of MDROs to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene; .f. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc); and wound care (stage II skin opening requiring a dressing). Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.</p>		