STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	C 12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S 000	Initial Comments Complaint Investigation: 2399057/IL166111 - 330.710, 330.785, 330.911	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 330.710a)3) 330.785b)5) 330.785c)4) SECTION 330.710 RESIDENT CARE POLICIES a) The facility shall have written policies and procedures governing all services provided by the facility. 3) A policy to identify, assess, and strategies to control the risk of injury to residents Section 330.785 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 5) When a resident death has occurred other than by disease processes. c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 4) Seeking advice concerning preservation of a potential crime scene;	S9999	Attachment A Statement of Licensure Violations	

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These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to notify the local police for over four hours after observing (R1) who was a hospice resident with a curtain around her neck and hanging from her closet. This failure resulted in V6 moving R1's body from the closet and placing R1 in the bed and not preserving the potential crime scene.

Finding Includes:

R1 had a diagnosis of Dementia with behavioral disturbance. Hospice paperwork dated 1/17/23 documents: progressive dementia-invoke R1's hospice benefits. Vascular Dementia which will qualify R1 for hospice at this time.

On 10/21/23 at 1:30pm, V5 (care giver) said he found R1 dead at 4AM and notified the other staff member (V6) who was assisting a resident in the room next to R1's. V6 worked that night but he had to work in house one, two and three. V5 said he was a new employee and V6 knew more staff, V6 called staff and emergency services. The oncoming nurse (V9) came in. V9 arrived before the police.

On 11/01/23 at 11:12AM, V6 (care giver) said he went back to R1's house around 4:00AM. V6 said, he was in another resident's room providing care when he heard V5 call for him. V6 said, V5 was frantically waving his hand and saying something that V6 could not understand. V6 said, he followed V5 into R1's room. V6 said, upon entering R1's room he saw R1 hanging from the closet with the closet curtain around R1's neck. V6 said, he started to loosen the curtain from

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R1's neck to save her life but he realized R1 was dead. V6 said, he informed V12 (Director of Nursing/DON) who instructed him to call hospice. V6 said, it took an hour to get the correct hospice number. V6 said, he called the hospice company that provided care in R1's house but it took that company a long time to check if R1 was their resident, which R1 was not. V6 said, he called V12 back, updated him about the hospice company and was told by V12, R1's hospice phone number was in the kitchen. V6 said, he called the correct number, informed the person on the phone about R1's death and that R1 was on the floor in her room. V6 said, the hospice staff instructed him to pick R1 up off the floor, place R1 in her bed and call 911. V6 said, he spoke to the hospice nursing assistant but was unable to report the hospice nursing assistant's name.

On 11/15/23 at 1:42PM, V12 said, he was called around 4:38AM by V6 who reported R1's death. V12 said, he was awakened by V6's phone call. V12 said, he instructed V6 to call R1's hospice company. V12 said, he received a texted picture of R1 around the same time V6 placed the call but V12 said, he did not look at R1's picture until thirty to forty-five minutes after the initial call (5:08AM - 5:53AM). In between the thirty to forty-five minutes, V12 said, he received multiple calls from V9 (nurse) and hospice personnel. V12 was unable to report who he spoke to from hospice. V12 said, the hospice personnel told him, R1 did not die in her sleep, hospice will not be coming out to the facility and 911 should be called. V12 said, V9 (Nurse) informed him that, R1 passed away. R1's death was unusual. V12 said, it was at the time of the call from V9 that he looked at R1's picture which was sent via text at 4:38AM. V12 said, he expects staff to call 911

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S9999	Continued From page 3 immediately after seeing R1 hanging with a curtain around her neck. On 11/15/23 at 3:17PM, V13 (Hospice CNA) said, she missed a call from R1's facility at 4:43AM. V13 said, she was sleeping and not on call. V13 said, she received a second call from R1's facility at 6:09AM. V13 said, she was informed by V6 that, R1 was found in the closet with the curtain wrapped around R1's neck. V13 said, she instructed V6, to leave R1's body where it was, not to touch R1, and call 911 due to R1's death not being medical but incidental. As an aide, we are supposed to notify the nursing supervisor for any incidental deaths and not touch any residents observed in an incidental situation/non-medical deaths. On 12/01/23 at 1:30PM V1 (Executive Director) said, R1's death was unnatural. 911 should have be called immediately. Once it was determined that R1 was dead, staff should have stepped back and not touched R1. Health note dated 10/22/23 written by V9 documents: Received a call around 4:30AM from caregivers that resident (R1) died this AM. They found resident hanging by the closet cotton (curtain). They immediately checked resident and put her in her bed. Caregiver (V6) called DON (V12) and hospice nurse. NOD (nurse on duty/V9) made it to facility around 6:15AM and called 911. ED (V1) and NP notified and ED made it to the facility. 911 and hospice nurse arrived the facility. Health note dated 10/22/23 written by V12 documents: At 4:37AM, writer received a call from float night caregivers (V6) that a resident (R1) was found dead in her room. Per care giver	S9999		

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S9999	Continued From page 4 (V6) he was notified by the scheduled house three (3) caregiver (V5) the resident was found hanging from her closet curtain with the curtain wrapped around her neck. Caregiver (V6) stated they released the resident from the curtain and laid her on the bed. Resident was under hospice care so writer asked the caregiver to call hospice per policy. Writer also called ED (V1) and notified her of the incident. Hospice later called writer and notify writer that hospice will not be coming since it was an unnatural death. That 911 should be called. Writer than called caregivers to call 911. Schedule nurse (V9) on duty was already at the facility so writer instructed NOD to call 911. Paramedics and police arrived at the facility. Facility reported incidents dated 10/22/23 documents: At approximately 5AM, writer (V1) notified by DON (V12) that hospice resident (R1) was found nonresponsive. DON (V12) advised caregiver to call Hospice Company. Hospice advised caregiver to call 911. Police Incident/Offense Report dated 10/22/23 documents: On 10/22/23 at 0643 (6:43AM) officer was dispatched reference death investigation. Upon arrival, officer spoke to V6 and he related the following in summary: V6 is an employee at this facility and was doing his rounds at approximately 0200 (2AM) hours. When he entered R1's room, he observed the victim (R1) who had a white closet curtain tied around her neck and was hanging in the closet of her room. She (R1) was unresponsive. V6 untied the curtain and put R1 on the floor of the room in order to see if he could help her. V6 then called his boss (V12) and asked what he should do, V6 was advised to call her (R1) hospice. After calling the hospice at approximately 0330 (3:30am), V6 moved R1 to her bed and covered her with her	S9999		

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blanket. At approximately 0640 (6:40am), V6 contacted police department to report the death. When asked why he waited so long to report the death to the police, V6 said, that he was not sure what to do which is why he called his boss to get clarification. The staff at the facility advised that R1 had a DNR (do not resuscitate) and gave me (officer) a copy of the form. Upon entering R1's room, I (officer) observed R1 in her bed with her blanket covering her entire body. When the blanket was lifted I observed a deep red mark around the circumference of her neck. I also observed a white curtain which was hanging from a metal bar above the closet and there was a red substance (suspected blood) on the blanket and the floor nearby.

Fire Department Pre Hospital Care Report dated 10/22/23 at 06:45:40 (6:45AM) documents: Wheeling engine E42. Ambulance A23 WPD (Wheeling Police Department) was dispatched to the location (R1's facility) for the unresponsive. Upon arrival, health care staff on scene escorted crew to the patient (R1) who was laying supine in bed, under a blanket. Upon arrival to patient, crew removed blanket from patient and noted patient tongue was swollen and she had a ligature around her neck. Sixty-five year old female was alert and oriented times zero out of four (A0x0/4), unresponsive. Patient was pulseless, apneic. According to health care staff, they found the patient hanging from the closet drapes around 2:00AM. Staff stated, they assisted patient onto the floor and notice no pulse. Staff conveyed they then called their boss and then called hospice. Staff stated, "I moved her from the floor to her bed around 3:30AM. Patient hx (history), vitals and interventions performed and noted. Cardiac monitors lead were applied and uploaded to report. Medical history:

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behavior- Dementia (w/o -without behavior disturbance). Skin description: cold, cyanotic, lividity, mottled. Mental status: unresponsive. Neck: abrasion. Chest/Lungs: breath-sound-absent-left, breath-sound-absent-right. Complaint: DOA (dead on arrival). Duration: 4 (four) hours. Primary symptoms: obvious death. Call type: unconscious/fainting/near-fainting. Resp Mode: emergent (immediate response). Response: 911. Disposition: Patient dead at scene-no resuscitation attempted (without transport). Response delay: none/no delay. PSAP: 10/22/2023 06:42:53. Disp notified: 10/22/2023 -06:45:38. Unit Disp: 10/22/23. Unit notified: 10/22/2023 - 06:45:40. Enroute: 10/22/23 - 06:46:32, At scene 10/22/23 - 06:51:18, At patient 10/22/2023 - 06:53:41.

Long-Term Care Facility and IID- Serious Injury Incident and Communicable Disease Report documents: Incident date: 10/22/23. Time of Incident: 06:58. Report dated 10/22/23 documents: R1, deceased. Staff involved: V5 and V6.

Resident Operations-action steps serious illness/accident or death policy Revised: 6/7/2023 documents: Purpose: To provide residents with prompt evaluation and medical attention. Prompt and adequate treatment will be given to all resident in the occurrence of an accident, sudden illness, or death. If a resident is followed by hospice, please follow protocol indicated in policy titled Resident Operations-Terminal Resident & Hospice Best Practice Policy. Unresponsive or Possible Death of a Resident: 7p-7a, call 911.

Resident Operation- Terminal Residents & Hospice Best Practice Policy dated 6/4/22

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S9999	Continued From page 7 documents: upon death: if the occurred due to an incident with psychotropic medications, or suicide, the death must be reported immediately to the executive director. 2.) Based on interview and record review, the facility failed to follow their frequent check policy by not rounding or monitoring 1 of 1 (R1) who was diagnosis with Dementia and identified as cognitively impaired every thirty minutes. This failure resulted in R1 being found hanging with the closet curtain wrapped around her neck which resulted in R1's death. Findings Include: R1 was diagnosis with Dementia, Anxiety and Insomnia. On 11/1/23 at 11:00am, V8 (Director of Hospice) said, R1 did not exhibit anxiety or depression. R1 did have a behavior of walking/pacing which was R1's comfort measure. On 11/1/23 at 11:12am, V6 (care giver) said, he was in another resident's room when he heard V5 (CNA) call for him. V6 said, V5 was frantically waving his hand and saying something V6 could not understand. V6 said, he followed V5 into R1's room. V6 said, upon entering R1's room he saw R1 hanging from the closet with the curtain around R1's neck. V6 said, he started to loosen the curtain from R1's neck to save her life but he realized R1 was dead. On 11/01/23 at 2:00pm, V11 (Nurse) said, R1 wandered and paced all day, care givers were monitoring R1 every two hours. When questioned	S9999		

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about R1' black eye she sustained after entering another resident's room. V11 said, R1 should have been monitored every thirty minutes.

On 11/2/23 at 9:30am, V9 (Nurse) said, R1 was non-verbal, mumbled, had insomnia, does not sleep very well and is up at night pacing. R1 did not sit down for long periods of time. R1 did don't exhibit any signs of depression. R1 was not alert. R1 had an incident with a resident prior to R1's death where she sustained a black eye after entering a resident's room. After that incident, R1 should have been monitored every thirty minutes.

On 11/2/23 at 1:30pm, V5 (care giver) who was R1's assigned care giver said he founded R1 dead at 4AM and notified V6 (care giver). V5 said, he rounded on all the residents at 7pm, 12am and 4am. V5 said, he did not see any resident's awake between 7pm and 4am.

On 12/1/23 at 1:30pm, V1 (Executive Director) said, R1 was not alert to person, place or time, was unable to advocate for herself and should have been monitored every thirty minutes to ensure her safety.

Admission paper dated 8/19/22 documents sleep pattern: R1's awake at night, likes to sleep in afternoon.

Home medical group note dated 9/7/23 documents: R1 had progressive Dementia and chronic insomnia. Positive for increased anxiety recently, especially in the afternoon. Poor insight. Poor judgement.

Incident note dated 10/1/23 document: a weight machine fell on the foot of resident. Pressure and ice applied to avoid swelling and bleeding.

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R1's service plan dated 10/3/23 documents: cognition: displays deficits in judgment, has mild to moderate disorientation or difficulty recalling/retaining information, needs cueing and is on safety check every (FREQ) at night. Safety check every two -three hours.

Incident note dated 10/18/23 document: Resident (R1) was struck on the forehead by fellow resident. Resident (R1) walked into another resident room when she was physically hit on the forehead, sustaining a minor bruise to the right forehead. Unusual Occurrence Report dated 10/18/23 documents: two caregivers ran towards room to address verbal aggression and saw male resident hit female (R1) in the left eye. Left eye bruised. Small laceration in female left eyebrow. Resident punched R1 in the upper eyebrow.

Health note dated 10/20/23 documents: writer also notify POA that resident (R1) might need a one-to-one monitoring as resident continues to grab onto other resident.

Schedule dated 10/21/23 documents: Name: V5, Shift: 7p, House assign: R1's --- Name: V6, Shift: 7p, House assign: Float.

R1's house daily task sheet dated 10/21/23 document: 7pm -how many resident are in your house. 10 (ten): 9pm -5am: make rounds every two hours to check resident, Frequent check-initial every ½ hour if form is post near bed. Initial in in bed, CA if in common area. General note: everything is ok.

Health note dated 10/22/23 written by V9 documents: Received a call around 4:30AM from caregivers that resident (R1) died this AM. They

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S9999	Continued From page 10 found resident hanging by the closet cotton (curtain). They immediately check resident and put her in her bed. Rounding Policy revised 6/1/23 documents: purpose: due to the diagnosis of Dementia, residents require cues, reminders and observation throughout the day and night. Plan: To check on, remind, redirect, or cue residents throughout the day and night as needed. Practice: Caregivers and/or their designee will round on each resident approximately every two hours should they not be observed in the common area. Observe if the resident is in a safe space such as sleeping, in the restroom, or resting in their chair. Repeat for each resident (if not in the common area). Frequent Check Policy revised 6/1/23 documents: due to the diagnosis of Dementia, as the disease progresses, some resident may require frequent check when resident is spending time in their room or during bedtime. Plan as assessment warrants, the resident's assessment will be amended and plan of care will include an intervention for frequent checks, which could mean as frequent as every thirty (30) minutes, depending on the assessment, or up to every director of nursing or his/her designee. (A) 2 of 2 330.911 Section 330.911 Healthcare worker background check	S9999		

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S9999	Continued From page 11 A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). This requirement was not met as evidenced by: Based on interview and record review, the facility failed to follow the Illinois Health Care Worker Background Check act by not conducting background checks by not obtaining fingerprints within ten days of employment for 3 of 4 (V4, V5 and V6) employees reviewed for background checks. Findings include: Health care worker registry look up dated 11/3/23 for V4 (caregiver) documents under work eligibility: not yet determined. Under determination of Illinois state police background checks documents: no background checks on record. Last employee verification documents: 3/14/23-active. On 11/3/23 at 12:27PM, V2 (Human Resource Manager) sent an email with the following information: V4 (caregiver) doesn't have a background check due to us waiting on his green card to get here. V4's start date was 3/14/2023. On 12/1/23 at 1:30pm, V1 (Executive Director) said, background checks are done upon hire and annually. Finger prints must be completed within ten (10) days of employment. If they are not completed, the employee cannot work and must be removed from the schedule. We had some billing issue, so fingerprints were not completed between 10/23/23 to 11/27/23. Our account was frozen. V1 said, she created a new onboarding	S9999		

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S9999	Continued From page 12 checklist to ensure background checks are not missed. Health care worker registry look up dated 11/3/23 for V5 (caregiver) documents under work eligibility: not yet determined. Under determination of Illinois state police background checks documents: no background checks on record. Last employee verification documents: Blank V5's health care worker background check authorization form was signed and dated 9/21/2023. On 11/3/23 at 12:27PM, V2 (Human resource manager) sent an email with the following information: V5 (Caregiver) had gone last week to get his finger print done but due to a balance due on the account they turned him away. V5's start date was 9/25/2023. On 12/1/23 at 1:30pm, V1 (Executive Director) said, background checks are done upon hire and annually. Finger prints must be completed within ten (10) days of employment. If they are not completed, the employee cannot work and must be removed from the schedule. We had some billing issue, so fingerprints were not completed between 10/23/23 to 11/27/23. Our account was frozen. V1 said, she created a new onboarding checklist to ensure background checks are not missed. Health care worker registry look up dated 11/3/23 for V6 (caregiver) documents under work eligibility: not yet determined. Under determination of Illinois state police background checks documents no background checks on record. Last employee verification documents:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	C 12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 1/18/23. V6's health care worker background check authorization form was sign and dated 1/18/2023. On 11/3/23 at 12:27PM, V2 (Human Resource Manager) sent an email with the following information: V6 (caregiver) has a background done from when he was hired but not exactly sure why it was not finished, I just now processed him to get his fingerprints done. V6's start date was 1/18/2023. On 12/1/23 at 1:30pm, V1 (Executive Director) said, background checks are done upon hire and annually. Finger prints must be completed within ten (10) days of employment. If they are not completed, the employee cannot work and must be removed from the schedule. We had some billing issue, so fingerprints were not completed between 10/23/23 to 11/27/23. Our account was frozen. V1 said, she created a new onboarding checklist to ensure background checks are not missed. According to the Illinois department of public health the health care worker registry lists individuals with a background check conducted pursuant to the health care worker background check act (225 ILCS 46. The health care worker background check act applies to all unlicensed individuals employed or retained by health care employer as home health care aides, nurse's aides, personal care assistants or an individual working in a similar health-related occupation where he or she provides direct care or has access to long term care residents or the living quarters or financial, medical or personal records of long term care residents. A health care employer must verify registry status of an	S9999		

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	IL6013601	A. BUILDING _____ B. WING _____	C 12/27/2023

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S9999	Continued From page 14 individual applying for the above positions of employment. The health care worker registry profile now includes a determination of "work eligibility"; The Work Eligibility will be one of the following: "Eligible" (highlighted in green), "Ineligible" (highlighted in red), or "Not Yet Determined" (highlighted in orange/yellow). "Not Yet Determined" (with orange/yellow highlighting) means an employee has not had a fingerprint-based background check (either a FEE_APP or a CAAPP). It might mean the employee has never had a background check, or it might mean he/she had only a UCIA background check. An employer wishing to hire such an employee must initiate a Livescan request and send the employee to have his/her fingerprints scanned for a FEE_APP background check. Once the health care worker registry receives the background check results and makes a determination on those results, that employee's "Work Eligibility" will change to either "Eligible" or "Ineligible." "Work Eligibility" indicates only whether someone is generally eligible to work in the health care field. According to the Illinois health care worker background check act under (225 ILCS 46/) Sec. 5. Purpose. The General Assembly finds that it is in the public interest to protect the citizens of the State of Illinois who are the most frail and who are persons with disabilities from possible harm through a criminal background check of certain health care workers and all employees of licensed and certified long-term care facilities who have or may have contact with residents or have access to the living quarters or the financial, medical, or personal records of residents. Health care employers shall check the Health Care Worker Registry before hiring an employee to determine that the individual has had a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	C 12/27/2023

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S9999	Continued From page 15 fingerprint-based record check required by this Act and has no disqualifying convictions or has been granted a waiver pursuant to Section 40 of this Act. If the individual has not had such a background check or is not active on the Health Care Worker Registry, then the health care employer shall initiate a fingerprint-based record check requested by the Department of Public Health. (C)	S9999		