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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations State Licensure Violations: 1) 300.615 f) 300.615 j) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to check the Illinois Department of Corrections search page for new admissions and failed to ensure residents were safe while	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 background checks were pending. This applies to all facility residents. The findings include: The Facility Data Sheet dated October 17, 2018 shows there were 80 residents in the facility. On October 18, 2018 at 10:00 AM, V17 Business Office Manager said background checks on new admissions are part of the facility's abuse prevention program and they are done to make sure the residents are safe. At 3:45 PM, V17 said she does the background checks and cannot provide any evidence that Illinois Department of Corrections (IDOC) searches were done on R10-19 prior to today. R10 was discharged to home from the facility on August 24, 2018 and readmitted on September 22, 2018. No background checks were done on R10 with her readmission. The facility does not take any special precautions to protect residents while awaiting the results of background checks on new admissions. The facility's last 10 admissions (R10-19) were reviewed for compliance with identified offender regulations. R10-19 were admitted between September1 and October 15, 2018. R10-19's IDOC checks were dated October 18, 2018. R10-19's Illinois Sex Offender searches were limited to a single city and statewide searches were not completed: R10-searched the city of Bradley, R11-searched the city of Herscher, R12-searched the city of Momence, R13-searched the city of Kankakee, R14-searched the city of Bradley, R15- searched the city of Bourbonnais.	S9999		

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S9999	Continued From page 2 R10 was admitted to the facility on September 22, 2018. R10's Illinois State Police (ISP) background search was dated November 27, 2017. R10's Illinois Sex Offender search was dated November 27, 2017. R11 was admitted to the facility on October 15, 2018. R11's ISP background search has the last name misspelled. There was no ISP search provided with the correct spelling of R11's last name. R13 was admitted to the facility on October 2, 2018. R13's ISP background check shows a HIT for reckless driving, unlawful use of a weapon, and contributing to the sex delinquency of a child. R15 was admitted on September 28, 2018. R15's Illinois Sex Offender search was done on October 2, 2018. The facility's Abuse Prevention Policy dated January 2017 shows the purpose of the policy is to ensure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of the residents. Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility identification of residents, whose personal histories render them at risk for abusing other residents, and development of interventions strategies to prevent occurrences. As part of the admission process a state police background check, identified offender check, and a background check will be completed. (C)	S9999		

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S9999	Continued From page 3 2) 300.680 a) Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility have a written policy for physical restraints and failed to identify a lap tray as a physical restraint. This applies to 1 of 1 resident (R5) reviewed for restraints in the sample of 7.	S9999		

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The findings include:

On October 17-18, 2018, R5 was observed with a lap tray secured to her wheelchair at all times when out of bed.

On October 17, 2018 at 2:00 PM, a certified nursing assistant demonstrated how R5's lap tray works. The tray slides over both arms of the wheelchair and attaches to the arm with a metal clasp mounted underneath the tray. To release the tray, the metal clasp is pushed to release it.

On October 19, 2018 at 9:20 AM, V2 Director of Nursing said R5 cannot remove her lap tray by herself and it would meet the definition of a restraint.

R5's care plan shows a history of cerebral palsy with spastic uncoordinated movements. R5's electronic health record does not include a consent for the restraint, there is no care plan for a restraint, no physician order for a restraint and no plan to decrease the restraint.

A facility policy for physical restraints was requested and none was received. The facility's Proper Use of Side Rails Policy dated November 2015 shows physical restraints are defined as any physical or mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a

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S9999	Continued From page 5 restraint. (AW) 3) 300.1210 b)2)5) 300.1210 d)2)5) 300.1210 d)5)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 5) All nursing personnel shall assist and	S9999		

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S9999	Continued From page 6 encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received restorative services to increase resident range of motion and prevent further decrease in range of motion, failed to ensure a resident was	S9999		

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transferred and ambulated using a gait belt to maintain their highest practicable level of functioning, failed to ensure a resident dependent on enteral nutritional feedings received his prescribed daily feeding, failed to reposition a resident with a facility-acquired unstageable pressure injury, and failed to investigate an alarming door to ensure a confused resident did not leave the facility unsupervised.

This applies to 2 of 3 residents (R2, R3) reviewed for restorative services, 1 of 7 residents (R3) reviewed for assistance with activities of daily living, 1 of 3 residents (R3) reviewed for specialty care services, and 1 of 2 residents (R4) reviewed for pressure ulcers, all in the sample of 7; and 1 resident (R20) reviewed for safety outside the sample.

The findings include:

1. On October 18, 2018 at 10:50 AM, V12 (Physical Therapy Program Director) stated R3 was discharged from physical therapy on August 30, 2018. At the time of discharge from therapy, R3 was able to transfer with minimal assistance, using stand by assistance and supervision. V12 reviewed the therapy discharge summary and stated R3 could have benefited from a restorative program, but therapy did not make a recommendation. R3 should be transferred with a gait belt.

On October 18, 2018 at 8:20 AM, V6 (Certified Nursing Assistant - CNA) assisted R3 to a sitting position on the edge of his bed. V6 grabbed the back of R3's pants and assisted R3 to a standing position. A gait belt was not used. V6 encouraged R3 to take a few steps with his walker to the wheelchair. R3 was able to shuffle

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step toward the wheelchair, but his body was very shaky, appeared weak and unsure of his ability to walk.

On October 18, 2018 at 11:45 AM, R3 stated, "Sometimes they use a belt and sometimes they don't (when I am transferring out of bed). I like it better when they use the belt to hang on to me." R3 stated after he had the gastrostomy tube surgery, he was very sore and had a hard time moving. R3 stated he got a blood clot in his leg from lying too much in bed.

The admission notes written by V4 (Family Nurse Practitioner - FNP) show R3 was admitted to the facility on June 26, 2018 from the hospital after treatment for pneumonia, congestive heart failure, and cardiovascular accident with dysphagia. V4 assessed R3 on July 16, 2018 after insertion of the gastrostomy tube.

R3's undated care plan does not include interventions to assist R3 with ambulation, range of motion exercises or a restorative program. The minimum data set of September 26, 2018 shows R3 is not steady and able to stabilize only with staff assistance for moving from a seated to standing position, with walking, turning around, moving on and off the toilet and with surface to surface transfers.

On October 18, 2018 at 2:30 PM, V4 stated there is a gap in program referrals to restorative after residents complete physical therapy. V4 felt residents can gain continued therapy benefits with restorative therapy.

The facility therapy screening and discharge policy effective June 2013, states all residents will be screened upon admission or readmission to

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the facility. The policy shows all resident being discharged from therapy to the facility, unless discharged to hospice, will receive a written restorative program and training will be clearly defined in all discharge evaluations.

2. On October 17, 2018 at 11:10 AM, R2 was seated in a wheelchair in his room watching TV. R2's bilateral hands laid in a contracted position at rest. No splints were in place. (Splints were observed lying on the bedside table.) R2 was able to wiggle the fingers, but to extend his fingers, he had to manually stretch them out. R2 stated he does not get much exercise since his (physical) therapy has ended due to lack of money. R2 was able to move his swollen feet, demonstrating he could lift his feet 4-6 inches off the floor. R2 could slowly self-propel his wheelchair. R2 stated he was living at home, and was ambulatory prior to his fall. R2 stated the staff use a stand lift to transfer him out of bed. R2 stated he is able to bear weight "pretty good" when transferring the stand lift.

On October 18, 2018 at 9:15 AM, V11 (Restorative CNA) stated the restorative nurse makes the plan for residents, and the restorative CNA staff work with the residents. V11 stated, "R2 has problems with his hands, he can't grip things. We are working on building strength on his arms and hands". V11 stated R2 does not have any restorative exercises for ambulation, and was not sure why he didn't. R2 stated she did not know anything about R2 wearing arm splints, but they do active range of motion to his arms and provide assistance with dressing, but there is no ambulation plan.

The progress note written by V4 (FNP) on October 3, 2018 shows "I did speak with CNAs

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and physical therapy who report he would be very difficult to manage at home as he cannot be left alone and he is a 2 person assist due to generalized weakness and physical deconditioning." The assessment and plan for October 3, 2018 includes to continue physical therapy for weakness and continue to wear bilateral hand splints daily.

The physical therapy notes for R2 show he received physical therapy from July 2, 2018 through September 19, 2018. The discharge summary stated R2 was discharged from therapy because he was hospitalized for a surgical procedure. No other discharge plan was noted. The report shows R2 was receiving training in sit to stand, standing tolerance and functional transfers. The clinical impression for R2 included to say therapeutic exercises to develop strength and range of motion to the lower extremities and trunk. The summary includes, "Complicating factors, including patient hospitalization, prevent the patient from achieving all established goals".

The progress note written by V4 (FNP) show R2 had a cervical fusion on September 20, 2018. The surgery was uneventful with the exception or urinary retention. The assessment and plan includes to continue physical therapy and bilateral upper extremities hand splints daily.

The care plan revised on September 25, 2018 show R2 has potential for decreased range of motion related to generalized weakness and fatigue. The interventions are not specific to the restorative plan for R2 and does not address transfers or ambulation.

The minimum data set of October 4, 2018 shows R2 does not ambulate, and is totally dependent

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on staff for transfer moving from the bed to chair. R2 requires extensive assistance from staff for dressing, toileting and personal hygiene. R2 is not steady only able to stabilize with staff assistance during transfers from seated to standing position.

On October 18, 2018 at 10:50 AM, V12 (Therapy Program Director) stated R2 was first admitted to the facility from March 11, 2018 through March 30, 2018 after a fall and injury at home shoveling snow. R2 was discharged home. R2 was readmitted on April 16, 2018 after another fall at home related to his weakness. R2 received a spinal fusion of the cervical region in September 2018. When R2 returned from the hospital after his surgery, there was no physician order to resume physical therapy or use of his bilateral hand splints. The therapy department did not make a referral for restorative when he was discharged prior to his surgery.

The physician order sheet shows R2 was re-admitted to the facility on April 13, 2018. R2's diagnoses includes spinal stenosis, fracture of nasal bone, diabetes mellitus type 2, chronic kidney disease, convulsions, muscle weakness, generalized osteoarthritis, and fusion of the spine in the cervical regions. There is no order to resume bilateral hand splints or resume therapy or restorative therapy after his return from the hospital.

The facility policy for Rehabilitative nursing care dated November 2013, states rehabilitative nursing care is provided for each resident admitted. The rehabilitative program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence.

3. On October 18, 2018 at 8:20 AM, V6 (CNA)

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assisted R3 to a sitting position on the edge of his bed. V6 grabbed the back of R3's pants and assisted R3 to a standing position. A gait belt was not used. V6 encouraged R3 to take a few steps with his walker to the wheelchair. R3 was able to shuffle step toward the wheelchair, but his body was very shaky.

On October 18, 2018 at 11:45 AM, R3 stated, "Sometimes they use a belt and sometimes they don't (when I am transferring out of bed). I like it better when they use the belt to hang on to me."

On October 18, 2018 at 8:35 AM, V6 stated he did not bring his gait belt with him, "It would probably be a good idea to use one".

On October 18, 2018 at 10:50 AM, V12 (Physical Therapy Program Director) stated when transferring R3, a gait belt should be used for safety.

The care plan for R3 dated June 23, 2018, shows he is at risk for falls. The care plan does not list specific interventions for R3 to prevent falls or specific adaptive equipment or devices needed to transfer R3 in a safe manner.

The facility policy for safe lifting and movement of residents, revised 11/2013, states in order to protect the safety and well-being of staff and resident, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. The policy shows that nursing and restorative staff will assess the resident's individual needs for transfer assistance on an ongoing basis. Staff will document the resident transferring and lifting needs in the care plan.

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4.On October 17, 2018 at 10:55 AM, R3 was not in his room. At the bedside, a partial, unlabeled bottle of tube feeding solution was hanging from the IV pump pole with the tubing attached.

On October 17, 2018 at 3:00 PM, R3 returned to his room. The gastrostomy (G-tube) feeding was not connected to R3. Solution was leaking from the cap of the gastrostomy tube.

On October 17, 2018 at 3:25 PM, V5 (Licensed Practical Nurse - LPN) stated R3's G-tube feeding runs continuous for 22 hours per day. The feeding is shut off between 10 PM and 12:00 AM. V5 did not know why the feedings were scheduled to be off during that time frame. V5 stated she was not aware R3's feeding was not running, "It was reported to me during shift change that the tube feeding is running and has been all day". V5 stated she had not received any report the cap on the G- tube was leaking. At 4:00 PM, V5 proceeded to R3's room and found the G-tube not connected to R3. R3 reported, "I like to sit up front (in the lobby) and I don't like to take the pump, it is too hard to move with the wheelchair. So they disconnect it for me when I go up front." R3 stated he had been sitting up front (in the lobby) since 9:30 AM. There was no documentation of when the tube feeding had been stopped on October 17, 2018 in the progress notes or medication administration record.

On October 18, 2018 at 2:30 PM, V4 (Family Nurse Practitioner - FNP) stated R3 was admitted with aphasia and aspiration pneumonia. V4 stated R3 receives all his nutrition through the G-tube feedings; he does not have any oral consumption of food or fluids. V4 stated, "After I started the anti-depressant, his mood improved

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RIVER NORTH OF BRADLEY H & R	650 NORTH KINZIE BRADLEY, IL 60915

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and he wants to be out of his room more during the day.
The time and amount of feedings could be adjusted. The facility should be a plan in action to adjust his feedings to meet his nutritional needs and his socialization needs".

The care plan for R3 dated June 26, 2018 shows R3 requires a G-tube feeding related to dysphagia (difficulty swallowing). The care plan notes the resident requests at times for the tube feeding to be put on hold so he can ambulate/self-propel throughout the building. The care plan shows R3 has little or no activity involvement. The interventions show to modify R3's daily schedule and treatment plan to accommodate activity participation by the resident.

The Minimum Data set of September 26, 2018 shows R3 receives greater than 51% of his total calories per day and greater than 501 cc per day of his water intake through a tube feeding.
R3's weight record shows on June 18, 2018 his weight was 164.4 pounds. On October 3, 2018, R3's weight was recorded at 157.3 pounds.

The physician order sheet dated September 17, 2018 shows R3's feeding was increased from 60 ml/hour to 75 ml/hour with 35 ml/hour of water for nutrition at continuous feed for 22 hours per day. R3 is NPO (does not take any oral food or fluids).

5. On October 17, 2018, R4 was in bed laying on his back at 10:45 AM, 11:15 AM, and 12:00 PM. At 2:00 PM, R4 was lying on his back with the head of the bed up.

On October 17, 2018 at 10:45 AM R4 said he cannot move or reposition himself in bed. I just

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S9999	Continued From page 15 got out of the hospital yesterday because the pressure ulcer kept getting worse. At 2:00 PM, R4 said they are supposed to reposition me every two hours. It makes it worse when the head of my bed is up. It really puts pressure on my sores. At 4:55 PM, R4 said if they were doing what they were supposed to be doing, I wouldn't be in this condition. I don't get turned every two hours especially on the night shift. On October 18, 2018 at 2:40 PM, V18 R4's spouse said the facility isn't doing anything to prevent pressure wounds or prevent them from worsening. Not until he was recently hospitalized. The surgeon at the hospital told me he had gangrene of the buttock and he had to cut it out. He (R4) had been telling me for a month that his butt burned before his hospitalization. The wound doctor who used to be at the facility told me he was fed up with the staff not doing what he told them to do and that's why he left. At 3:10 PM, V4 Nurse Practitioner said relieving pressure certainly would make a difference in healing R4's pressure wounds. R4 should be repositioned at least every two hours. R4 has not been seen by a wound doctor since August 9, 2018. V4 said she is not certified in wound care and the facility does not currently have a wound doctor. R4's left buttock wound documentation review reveals the following: September 19, 2018: Acquired left buttock pressure wound Stage 3 measures 1 centimeter (cm) X 1 cm X 0.1 cm. October 2, 2018: Acquired left buttock pressure Stage 3 measures 2.0 cm X 3.0 cm X 0.10 cm. October 9, 2018: Acquired left buttock pressure wound Stage 3 measures 15 cm X 6 cm X0.2 cm. October 16, 2018: Acquired left buttock pressure Stage 3 measures 26 cm X 7.0 cm X 0.3 cm. R4's additional wound documentation dated	S9999		

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S9999	Continued From page 16 September 19, 2018 show an acquired right buttock pressure wound Stage 3, an acquired scrotum pressure wound Stage 3 and an acquired penis pressure wound Stage 3. R4's left buttock pressure injury care plan shows to reposition every two hours. R4's alteration in skin integrity care plan shows to reposition every two hours and teach the family/resident the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. R4's Minimum Data Set (MDS) dated July 20, 2018 shows he requires extensive assistance of 2 plus person's physical assistance to move in bed and use the toilet. This MDS shows R4 has a Brief Interview for Mental Status score of 15 which indicated he is cognitively intact. R4's physician discharge summary from a local hospital dated October 15, 2018 shows R4 was admitted to the hospital on October 10, 2018 for necrotic decubitus ulcers that required surgery to remove the necrotic (dead) tissue. Wound care information provided by V4 shows ulcers are treated symptomatically as with any type of pressure injury and pressure relief by turning are necessary. The facility's Prevention of Pressure Ulcers Policy dated 2001 shows pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or decrease of circulation (blood flow) to that area and subsequent destruction of tissue. Pressure ulcers are often made worse by continual pressure on the resident's skin. For a person in bed: change position at least every two hours or more frequently if needed.	S9999		

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6. R20's October 2, 2018 Minimum Data Set showed she has a diagnosis of dementia and she is severely cognitively impaired.

On October 18, 2018 at 8:43 AM, R20 opened the door at the end of a hallway and walked outside the facility with her walker. R20 then turned right where she could no longer be seen through the glass. The temperature showing on the local TV news showed 35 degrees Fahrenheit.

At 8:44 AM, V13 (CNA) walked down the hall to respond to the alarm. V13 handled the alarm pad near the door and did not look through the glass door to see if anyone was outside. V13 walked into the room at the end of the hall and was heard asking someone in the room if they needed anything. At 8:45 AM, the receptionist came down the hall and alerted V8 (RN) that the alarm was still sounding. The V8 and the surveyor went to the end of the hall and R20 was standing down in sloped grass area by a light pole, approximately 30 feet from the facility.

On October 18, 2018 at 9:05 AM, V8 stated he saw V13 go down the hall and he took it for granted that V13 was handling the situation. V8 stated staff has to respond to alarms and check to ensure everything is ok.

The facility's Safety and Supervision of Residents policy (revised December 2007) showed "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities ..." The policy further showed "4. Employees shall be trained and inserviced on potential accident hazards ..."

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S9999	Continued From page 18 (A) 4) 300.1610 a)1) Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident medications were available for administration. This applies to 2 of 7 residents (R2, R7) reviewed for medications in the sample of 7, and 2 residents (R12, R21) outside the sample. The findings include: 1. R2 was admitted on April 13, 2018 with diagnoses to spinal stenosis, diabetes mellitus type 2, chronic kidney disease, obesity, unspecified convulsions, obstructive sleep apnea, and essential hypertension. The physician order	S9999		

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sheet lists the order for a Clonidine patch to be applied transdermally every Thursday for hypertension. The medication administration record (MAR) shows the clonidine patch was started on September 27, 2018. On October 11, 2018, the dose was not given and coded as, "other/see progress notes".

The nursing progress notes on October 11, 2018 recorded by V4 (Family Nurse Practitioner - FNP), "R2's blood pressure is elevated this AM, but he has not received his AM medications. Is due for a patch change today, however no patch available. Pharmacy made aware and will be sending patch. Plan to continue other anti-hypertensive medications and to monitor R2's blood pressure".

On October 17, 2018 at 3:35 PM, V5 (Licensed Practical Nurse - LPN) reviewed the medication administration record for R2 and found the clonidine patch was omitted on October 11th and had not been applied since October 4, 2018. V5 stated the computer system does not flag the next shift when a medication was not available. V5 went to R2 and checked to see if clonidine patch was on the resident and no patch was found. V5 stated she was unsure of the last patch location as the facility does not document the location where the patch was applied.

On October 18, 2018 at 2:40 PM, V4 (FNP) stated, "I reviewed R2's blood pressure readings for the past week, and there was a problem with a missed (medication) patch for R2. It was reported it was not available; had not been sent by pharmacy. R2 always has high blood pressure, and he receives multiple anti-hypertensive medications to keep his blood pressure in control. The facility should be

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checking for the patch location and recording that it is in place. His blood pressure today is still high, today was high 150's (for systolic)".
R2's care plan initiated on April 13, 2018 shows he has hypertension and to give anti hypertensive medications as ordered. The frequency of monitoring R2's blood pressure is not identified. The blood pressure summary in the computer system for R2 shows his blood pressure was measured on September 23, 2018 at 134/74. The next blood pressure recorded was on October 14, 2018 at 147/81.

The facility policy for accepting delivery of medications revised on November 2013, shows if an error is identified when receiving medications form the pharmacy, the nurse verifying the order shall, inform the delivery agent of any discrepancies and note them on the delivery ticket. Return incorrect medications to the dispensing pharmacy and reorder the correct medication.

2. R12's October Physician Order Sheet (POS) showed an order to receive 35 units of a long-acting insulin twice daily. On October 19, 2018 at 9:15 AM after V3 RN (Registered Nurse) prepared R12's medications, she was unable to locate R12's insulin. R12 left the facility for an appointment and did not receive his insulin before he left.

On October 19, 2018 at 10:35 AM, V3 stated R12's insulin was not available in the medication cart to administer, and there was none of R12's type of insulin available in the house stock.

On October 19, 2018 at 12:00 PM, V3 stated medications have to be given as ordered because the orders are what the physicians want for their

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S9999	Continued From page 21 patients. 3. On October 19, 2018 at 9:35 AM, R21 was lying in bed with her feeding tube running. R21's POS showed an order for 5000 units of vitamin A to be administered through her feeding tube once daily for supplementation. On October 19, 2018 at 10:35 AM, V3 stated there was no liquid form of vitamin A to administer R21 through her feeding tube. 4. R7's August 5, 2018 Minimum Data Set showed she is cognitively intact. R7's October 2018 POS showed an order for methadone 10 mg every six hours. On October 19, 2018 at 10:50 AM, R7 stated her biggest concern with the facility is her medications. R7 stated she is "a little angry" that the facility ran out of her medications recently. R7 stated it is the second time it has happened and she feels like she gets to the beginning stages of withdrawals. R7 stated she feels with the agency staff, "they don't seem to have anybody that watches that stuff .... as though there is nobody on top of it." R7 stated she has heard from others that the facility runs out of their pain medications, too. R7 stated "I don't like the fact they run out of medication- that should be a given." On October 19, 2018 at 12:40 PM, V2 (RN, Director of Nursing) stated residents should have the medications that are prescribed for them. The facility's Administering Medications policy (revised November 2013) showed "Medications shall be administered in a safe and timely manner, and as prescribed ..." A policy for ensuring medications are available to residents was requested and a policy was not provided.	S9999		

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S9999	Continued From page 22 (B) 5) 300.1620 a) Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer medications at ordered times. There were 33 opportunities with 4 errors, resulting in a 12% error rate. This applies to 2 of 2 residents (R12, R21) observed during the medication pass. The findings include: 1. On October 19, 2018 at 9:15 AM, V3 RN (Registered Nurse) prepared medications to administer to R12. V3 administered 10 different	S9999		

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oral medications to R12, including a 50 mg tablet of metoprolol, a blood pressure medication. The card of medication V3 took the medication from showed to give one tablet "in the evening." R12's October Physician Order Sheet (POS) showed R12's order is to receive 100 mg of the medication in the morning and 50 mg in the evening.

The facility's Administering Medications policy (revised November 2013) showed "Medications shall be administered in a safe and timely manner, and as prescribed ..." The policy further showed "7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage ..."

2. R12's October POS showed an order to receive 35 units of a long-acting insulin twice daily. On October 19, 2018 at 9:15 AM after V3 prepared R12's medications, she was unable to locate R12's insulin. R12 left the facility for an appointment and did not receive his insulin.

On October 19, 2018 at 10:35 AM, V3 stated R12's insulin was not available in the medication cart to administer, and there was none of R12's type of insulin available in the house stock.

On October 19, 2018 at 12:00 PM, V3 stated medications have to be given as ordered because the orders are what the physicians want for their patients.

3. On October 19, 2018 at 9:35 AM, R21 was lying in bed with her feeding tube running. R21's October POS showed an order for 5 mg of a thyroid medication to be administered in the morning through her feeding tube. On October

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S9999	Continued From page 24 19, 2018 at 9:35 AM, V3 administered 10 mg of the thyroid medication through R21's feeding tube. 4. R21's POS showed an order for 5000 units of vitamin A to be administered through her feeding tube once daily for supplementation. On October 19, 2018 at 10:35 AM, V3 stated there was no liquid form of vitamin A to give R21 through her feeding tube. (B) 6) 300.2220 d) Section 300.2220 Housekeeping d) All cleaning compounds, insecticides, and all other potentially hazardous compounds or agents shall be stored in locked cabinets or rooms. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure potentially hazardous agents were stored away from resident access. This applies to 19 residents (R15, R20, and R22-38) outside the sample. The findings include: On October 17, 2018 at 11:00 AM, the following items were found in the unlocked restroom and	S9999		

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S9999	Continued From page 25 adjoining shower room on Wing 4: Procare adult wash cloths on top of toilet tank. Label shows to keep out of reach of children. Dawnmist shaving cream, #2 11 ounce containers DermaRite TotalBath skin and hair cleaner #6 7.5 ounce bottles Derma daily moisturizing lotion #1 4 ounce bottle Peri Guard ointment skin protectant #1 3.5 ounce Freshscent antiperspirant deodorant #4 1.5 ounce rolls Olay complete moisturizer #1 4 ounces On October 17, 2018 at 11:20 AM, the following items were found in the open and unlocked maintenance office on Wing 3: 28 paint cans WD 40 #2 10 ounce cans Commercial Soft scrub with bleach 36 ounces Clorox Disinfecting Wipes #3 containers RAID #1 20 ounce spray can On October 17, 2018 at 11:45 AM, the following items were found in the unlocked storage room on Wing 3: Nail polish remover-#1 bottle Dawnmist shaving cream #13 cans Peri Guard ointment- #9 PeriFresh- open case Dermaklenz-open case Derma daily moisturizing lotion- open case On October 17, 2018 at 1:35 PM, an open package of Sani-Cloth Germicidal Wipes was on top of an unattended medication cart on Wing 3. On October 17, 2018 at 11:45 AM, V19 Certified Nursing Assistant said if residents got a hold of the unlocked chemicals it could cause harm. On October 18, 2018 at 4:15 PM, V9	S9999		

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S9999	Continued From page 26 Maintenance Director said chemical storage areas should be locked and the maintenance office door should be shut and locked when nobody is in there so residents don't ingest anything. The facility identified R15, R20 and R22-38 as residents who are confused and/or wanderers on Wing 3 and 4. The Material Safety Data Sheets/Safety Data Sheets (MSDS/SDS) were reviewed: Dawnmist Shave Cream - Avoid breathing vapors. If inhaled move to fresh air. Seek medical advice if cough, shortness of breath or other respiratory problems occur. Avoid contact with eyes. If contact with eyes, rinse immediately with plenty of water for at least 15 minutes. Obtain medical attention if irritation persists. If ingested call a physician or Poison Control Center immediately. May cause nausea or vomiting. Keep out of reach of children. DermaRite TotalBath-Irritating if placed in eyes, or if ingested. Dermadaily lotion- irritating if placed in eyes, or if ingested. Periguard-Irritating if placed in eyes, or if ingested. Fresh scent deodorant-Flush eyes in clear running water. If irritation results and persists, get medical attention. If ingested, seek medical attention. Olay complete moisturizer- causes eye irritation. WD 40-Harmful or fatal if swallowed. If swallowed, may be aspirated enter the lungs and may cause chemical pneumonitis, severe lung damage and death. May cause eye irritation. Commercial Soft Scrub-Irritating to the nose, throat, and lungs. Can cause mild skin irritation and mild to moderate eye irritation. If ingested, may cause nausea, vomiting, abdominal pain,	S9999		

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	IL6001085	A. BUILDING: _____ B. WING _____	10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER NORTH OF BRADLEY H & R	650 NORTH KINZIE BRADLEY, IL 60915

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 27 diarrhea, and lethargy. Clorox Disinfecting Wipes- Exposure to vapor or mist may irritate respiratory tract. The liquid may cause irritation to eyes and skin. Ingestion of liquid may cause slight irritation to mucous membranes and gastrointestinal tract. RAID-concentrating and inhaling contents can be harmful or fatal. Excessive exposure may cause respiratory irritation. Nail Polish Remover-May cause skin irritation and eye discomfort. If ingested, may cause vomiting. If inhaled, may cause headache, nausea, narcotic effect. Derma Klenz- Ingestion may cause vomiting and diarrhea. Sani-Cloth Germicidal Wipes- Can cause serious eye damage/eye irritation. Call Poison Control if ingestion occurs. (C) 7) 300.3220 k) Section 300.3220 Medical Care k) A resident shall be permitted respect and privacy in his or her medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVER NORTH OF BRADLEY H & R	650 NORTH KINZIE BRADLEY, IL 60915

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S9999	Continued From page 28 resident's care must have his or her permission to be present. (Section 2-105 of the Act) This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident had visual privacy during incontinence care and dressing. This applies to 2 of 7 residents (R3, R5) reviewed for privacy in the sample of 7. The findings include: 1. On October 18, 2018 at 8:50 AM, V14-16 Certified Nursing Assistants (CNAs) were in R5's room. R5 was in bed which was located next to a window. The window's vertical blinds were open and R5's privacy curtain was not pulled around the bed. R5's roommate was sitting on her bed. The privacy curtain around the roommate's bed was partially closed but had a 12 inch gap which allowed for full view of R5's bed. R5 was in full view of any person entering the room. V14-16 performed incontinence care, assisted with dressing and transferred R5 to her chair without providing privacy. On October 18, 2018 at 11:55 AM, V14 said, "I should have made sure R5 had total privacy during care. I should have closed the blinds and privacy curtain. We want to provide privacy to give a residents dignity and pride and that didn't happen". The facility provided Resident's Rights pamphlet shows residents have the right to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER NORTH OF BRADLEY H & R	650 NORTH KINZIE BRADLEY, IL 60915

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S9999	Continued From page 29 privacy. Medical and personal care are private. 2. On October 17, 2018 at 3:00 PM, V5 and V15 (CNAs) removed R3's pants and soiled incontinence brief while he was lying in bed. The privacy curtain was not pulled around the end of R3's bed. Any person entering R3's room had full visual of R3 in bed. The window blinds were completely open. The groin and buttocks were totally exposed while R3's skin was washed and dried. No privacy cover over his perineal area was provided during care. On October 18, 2018 at 8:10 AM, V6 CNA, removed R3's clothes and soiled incontinence brief while he was lying in bed. The privacy curtain was not pulled around the end of R3's bed giving full visual of R3's naked body when entering the room. The curtain blinds were completely open. Leaving R3 totally naked, V6 turned away from R3 to assemble supplies for providing personal care. No privacy cover over his perineal area was provided during cares. On October 18, 2018 at 11:45 AM, R3 stated, "I feel better if they cover me when washing me up. I get chilly when I don't have any clothes or covers over me". (AW)	S9999		