STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING _____ B. WING _____	C 03/12/2019

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S 000	Initial Comments Complaint investigation 1911579/IL110080	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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.	S9999		

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These regulations are not met as evidence by: Based on observation, interview, and record review the facility failed to safely intervene to a resident's catastrophic reaction to care, this failure resulted in a resident receiving a large skin tear and bruising to the resident's arms. The facility also failed to to follow their abuse policy after the discovery of an injury of unknown origin and failed to suspend an employee identified in an abuse investigation. This applies to 1 of 3 residents (R1) reviewed for abuse in a sample of 3. The findings include: R1 is a resident on a dementia care unit. R1's face sheet shows a diagnosis of Alzheimer's disease. R1's Minimum Data Set assessment (MDS) dated 12/4/2019 shows her to have severe cognitive impairment. R1's behavior analysis report for 1/1/2019 to 3/12/2019 shows she is	S9999		

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being monitored for physical behavior symptoms directed towards others, verbal behavioral symptoms directed toward others, and rejection of care.

R1's care plan shows interventions dated 10/25/2016 to allow R1 to sleep in the morning, until she wakes up naturally. The intervention dated 3/5/2019 shows if R1 is combative or resistive with care, allow time to cool off and let another staff member approach the task.

The final report from the abuse investigation dated 3/7/2019 shows that on 3/6/2019 at approximately 3:50 AM, R1 came to the nurses' station and a large skin was observed on her right arm. V11 Certified Nursing Assistant (CNA) had been the only staff to care for R1 that shift. V6 CNA went to R1's room and there was blood on the floor next to the bed and on the bed sheets. When staff asked R1 what had happened, she said "that man did it". Staff and residents were interviewed about the incident and the conclusion of the investigation was V11 took R1's blood pressure with the lights off and used his cell phone flash light to see. V11 said R1 was refusing the blood pressure and tried to punch him and may have hit her arm on the side rail. The final report does not show at any point that V11 was removed from resident care during the abuse investigation.

The vitals signs report for 3/6/2019 shows R11's documentation of R1's blood pressure.

On 3/12/2019 at 8:35 AM, R1 was resting in bed, with her right forearm wrapped in gauze. R1 said she wasn't sure what had happened but that it still hurt. R1 was calm and pleasant. On 3/13/2019 at 8:48 AM, R1 was asleep in her bed with her

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clothes on. R1 was awakened by the wound care nurse to change the dressing to her right arm. R1 seemed irritated and confused about why she was being woken up. R1 had a skin tear to her right forearm measuring eight centimeters in length. The skin was held together with steri-strips. The top of R1's left forearm had two old looking bruises about the size of a thumb. There was no bruising to the underside of R1's arm. R1 said she did not know how she got the bruises.

On 3/12/2019 at 10:35 AM, V5 Licensed Practical Nurse (LPN) said she had asked V11 to get R1's blood pressure so she could get it documented. V5 said V11 entered the room and then she heard a scream from R1's room. R5 said she did not investigate why R1 screamed because she was busy and thought he only scared her when he woke her up. V5 said she was two doors down on the hallway from R1's room. V5 said V11 came out of R1's room a short time later and V5 heard V11 say to himself, "I hate that lady".V5 said V11 then went and charted the vital signs.V5 said she needed the blood pressure for follow up to a fall R1 had earlier in the week. V5 said the blood pressure was not that important and she could have just charted refused. V5 said if a dementia resident is refusing care the staff should stop and try later. V5 said maybe 20 minutes later she received a call from another CNA on the dementia unit to come back over to the unit because R1 had a large skin tear. V5 said she returned to the unit and saw a large skin tear to R1's right forearm. V5 asked V11 if he knew anything about the skin tear and he denied it. V5 said she did not talk to V11 again about the incident. V5 said on 3/13/2019 at 10:30 AM, that she should have removed him from resident care but thought the other two staff working would

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watch over R1 the rest of the shift.

On 3/12/2019 at 10:50 AM, V4 dementia care coordinator said she was called to the facility early in the morning on 3/6/2019 because R1 had a large skin tear and the staff working were not able to get in touch with the administrator. V4 said when she got to the unit the nurse in charge told her R1 had a large skin tear. V4 said she called the administrator and informed him of the skin tear and that only one staff had been in R1's room all night. V4 said she was told to obtain interviews from the staff working and report back to him. V4 said she was not told by the administrator to send V11 home, just to interview him. V4 said V11 worked the rest of his shift on the dementia unit. V4 said she could have sent V11 off the dementia unit but wasn't sure if this was just issues between staff or really a problem.V4 said she assessed R1 and spoke with the staff working that night and was told V11 (CNA) was asked to get R1's blood pressure by the nurse around 3:30 AM and after that was done, R1 walked to the nurse's station and showed the staff her skin tear. V4 said if a resident is becoming agitated with any care the staff are to back away and try again later.

On 3/12/2019 at 10:55 AM, V2 Director of Nursing (DON) said she was never called about the incident, but was told about it when she arrived to work at around 7:30 AM. V2 said V11 should have been sent home as soon as the skin tear was observed.

On 3/12/2019 at 11:15 AM and 11:35 AM, V6 and V7 CNA's said they were working the night of the incident with V11 and R1. V6 and V7 said when R1 came to the nurse's station to show them her arm, V11 walked up to her and R1 "freaked out"

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saying "that man did it". V6 and V7 said R1 calmed down when V11 walked away from her. V6 and V7 said they had not been in R1's room the whole shift and that only V11 had been in there.

On 3/13/2019 at 8:32 AM, V1 administrator said he was notified of the incident around 5:00 AM by V4. V1 said he did not tell V4 to send V11 away from resident care. V1 said he expects the staff to always keep the residents safe and if a staff member is suspected of abuse to send that staff member to the break room. V1 administrator said he expects the staff to walk away from a resident if they are refusing care or become agitated. V1 said a blood pressure is okay to walk away from if the resident refuses.

On 3/13/2019 at 11:15 AM, V2 Director of Nurses (DON) said the staff are expected to back away from the resident if they become resistive with any care including obtaining a blood pressure or incontinence care.

On 3/13/2019 at 2:47 PM, V11 said he was asked to get R1's blood pressure at around 3:30 AM. V11 said he went into R1's room and did not turn on the light, but used the flash light on his cell phone and woke her up. V11 said he did this so he wouldn't frighten R1. V11 said R1 screamed when she saw him. V11 said he then proceeded to get the blood pressure and tried to do incontinence care on R1 but she starting swinging at him and would not calm down. V11 said R1 was too slow at swinging at him and he did not get hit but he did get her blood pressure. V11 said he was not aware that R1 had gotten a skin tear, but V11 felt that maybe she hit her arm on the side rail when she was swinging at him.

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R1's nursing progress notes shows her becoming combative with care on 1/30/2019 where she received a skin tear to her left hand, on 3/4/2019 during a shower, she became combative and she slid down a wall to the floor. The nursing note dated 3/6/2019 shows R1's obtained a large skin tear to her right arm measuring 7 by 2.5 centimeters. The same day a note at 8:20 AM shows, R1 was sent by ambulance to local hospital for evaluation of the skin tear. The investigation into this incident dated 3/7/2019 shows R1 was combative with V11 and tried to strike him while care was trying to be performed.

The hospital records dated 3/6/2019 for R1's shows she was seen in the emergency room for a forearm laceration. R1 was prescribed an antibiotic for five days and an order was received for daily dressing changes.

On 3/14/2019 at 3:55 PM, V2 stated the facility had no specific dementia care policy.

The abuse policy with a revision date of 11/7/2017 shows: B5. If the incident involves alleged abuse and evidence indicates that an employee is the perpetrator of the abuse, then the administrator shall immediately suspend the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident. Section D 1. The nurse shall take all steps necessary to protect the resident from danger. 2. If the incident involves suspected abuse, then the shift nurse shall assure that the suspected abuser has no further contact with the resident involved or with any other resident. 4. If an employee is the suspected perpetrator of the abuse, then the employee shall be kept separate form all residents until further orders. The suspected employee should be sent to an office

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S9999	Continued From page 8 lounge away from all residents to await further instructions. (B)	S9999		