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	IL6007140	A. BUILDING: _____ B. WING _____	C 02/06/2020

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S 000	Initial Comments Complaint Survey # 2080048/ IL/ 00118863 -F689 cited FRI IL/ 00119225- F600 and F689 cited	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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 b) The facility shall provide the necessary care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on observation, interview, and record review, the facility failed to implement appropriate measures to ensure adequate supervision was provided during smoking period for R1 and R2 who had a verbal altercation that escalated into physical abuse. This failure resulted in R2 having a skin tear to left elbow and inner arm and was treated in the facility, failed to develop and implement individualized plan of care according to medical diagnoses, and failed to analyze the circumstances of fall and develop individualized interventions to minimize the risk of recurring falls for one resident R5 reviewed for falls. This failure affected R5 who was found on the floor face down and was sent to the hospital. Also, the facility failed to protect a resident's right to be free of abuse for one of four resident's (R2) reviewed for abuse. This physical abuse has the potential to affect all 69 listed resident's that smokes in the facility.

Findings include:

R1's medical record documented that R1 was admitted to the facility on 7/30/18 with diagnosis that includes but not limited to Tremor, hypokalemia, schizophrenia weakness, Bipolar current episodes hypomanic, Personal history of

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self-harm and unspecified disorder of Adult Personality and behavior.

R2's medical record showed that R2 was admitted to the facility on 12/23/2019 with diagnoses that includes but not limited to Alzheimer's disease, Schizophrenia Auditory hallucinations and suicidal ideations. According to the facility incident report on 2/3/2020 at approximately 10:15am, R2 was noted in the room preparing to go out to the store with V3 (Case Worker). At 2:05pm R2 stated (R1) was his roommate but he was just walking around in the room on his side of the bed, while he (R2) was watching a program he likes on the television. R2 explained that R1 will go out of the room slamming the door. R2 stated during the smoking time both him and R1 got into a verbal altercation and R1 threatened him that he was going to beat him up and before he knew it, R1 started kicking and punching him and his arm started bleeding.

On 2/3/2020 at approximately 10:25am, during the smoking time observation in the patio designated for smoking time. Residents were noted with two activity aides V5 and V6 (Activity Aides). V5 was noted passing the cigarettes to the resident's while V6 was monitoring and helping residents who need help in getting back into the facility. V5 and V6 stated two activity aides are usually assigned to the patio during smoking time.

On 2/3/2020, review of incident report and investigation report showed that R1 and R2 had a verbal altercation that escalated into physical aggression and abuse resulting in R2 sustaining an injury to R2's left arm. Review of both resident's plan of care did not show that plan of

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care was reviewed and revised. R1's care plan showed it was revised on 2/3/2020 28 days after the incident. When this was brought to V15's PRSD (Psychiatrist Rehabilitation Service Director) attention, V15 stated it should have been revised, I guess we forgot to do it. V15 then stated to the surveyor let me check if some of the other staff in the department did it. After checking V15 stated yeah it was not done and I did it on 2/3/2020 when you got here (referring to the facility). V15 acknowledged that the plan of care should have be reviewed and revised immediately within 24 hours. V15 stated physical aggression is treated like an abuse, the facility protocol on abuse and physical altercation is the same.

During this investigation V5 V6, V12 (Activity Aides) and V13 (Activity Director) were interviewed concerning supervision during smoking time. They all stated during smoking time, two activity aides are assigned to monitor the residents. V13 (Activity Director) explained that the two activity aides are needed for safety and elopement issues.

On 2/3/20 at approximately 4:45pm, V12 stated on the day of the incident 1/6/2020 he was the only activity aide/ smoking monitor present distributing the cigarettes and monitoring the residents so, it was hard for him to get to R1 and R2 before the physical fight but he heard them when they first started arguing.

On 2/3/2020, R5's medical record showed that R5 was admitted on 11/27/19 with diagnoses that includes but not limited to Hemiplegia, Hemiparesis following cerebral infarction affecting left non-dominant side, Epilepsy, unspecified, intractable with status epilepticus, lack of coo (referring to Coordination) seizures and stroke.

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R5 was sent to the hospital on 12/19/19 with diagnoses of fall and Supratherapeutic INR. R5 return to the facility same day. Review of R5's care plan did not show that plan of care was revised.

On 2/3/ 20 at approximately 2:26pm, V9 LPN (Licensed Practical Nurse) assigned to R5 on 12/19/19, stated that V10 was the one that found R5 on the floor and alerted her around 10:00am. When the surveyor asked V9 how often she make her rounds and saw R5, V9 replied I'm always on the floor. V10 stated I make rounds 3 to 4 times and I cannot go in the rooms when I'm passing medication. V9 explained that R5 cannot get out of her bed by herself but can reach for things. V9 stated I don't know how she got on the floor.

On 2/3/20 at approximately 2:35pm, V10 CNA (Certified Nurse's aide) stated that she was the aide on duty assisting with R5's care on the day of the fall. V10 explained that she did not know when R5 fell and was busy with getting the breakfast trays out from the rooms and when she got to R5's room she found R5 laying on the floor face down. V10 stated she knew R5 is high risk for fall. V10 stated R5 did not have any alarm to the wheelchair but belief R5 has a safety mat. V10 could not be sure whether R5 had a floor mat.

R5's admission note dated 11/28/2019 timed 2:57am, V19 LPN (Licensed Practical Nurse) documented that R5 has history of seizures, no baseline care plan initiated to address the issue of seizure. After the facility tool use in assessing the residents coded R5 diagnoses that includes but not limited to seizure there was no documented plan of care initiated to address this

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issue.

R5's fall assessment risk observation dated 11/27/19 scored R5 as 18.0 and rated level scored as high risk. Under the contributing factor it showed that R5 was checked for Cardiovascular- cardiac Dysrhythmia and Neuromuscular/ function that includes but not limited to Hemiplegia/ Hemiparesis, seizure disorder and unsteady gait. R5 had recorded fall on 12/19/19 was sent to the hospital. R5 returned the same day, R5's care plan was not reviewed and revised. R5's medical record did not show any cause analysis to show how and why the fall happened, what approaches needed to prevent the fall from happening again.

R5 was found unresponsive in bed on 12/22/19, emergency call made and was transferred to local hospital for emergency treatment. R5's diagnoses includes but not limited to abdominal hematoma.

On 2/5/20 at approximately 3:33pm, V18 (Care Plan Coordinator) stated in part that when she is developing the care plan some diagnoses are group together but in cases of seizure a separate plan of care is normally put in place. V18 explained that for each fall incident, the fall care plan must be reviewed.

As at 2/6/20 4:30pm, the facility was unable to present any documentation that showed that the fall incident was investigated to show how and what was the cause of R5's fall.

The facility policy on Care Plan presented with effective, updated date of April 2015 pointed out that an individual Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing and or

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S9999	Continued From page 7 psychological needs is developed for each resident. Policy specification includes but not limited to developing the Comprehensive Care Plan within 7 days of the completion of the resident's comprehensive assessment MDS (Minimum Data Set). Revising the care plan as changes in the resident's condition dictates. The facility Abuse Prevention Policy dated February 2017 presented indicated that the facility affirms the right of our residents to be free from abuse and prohibits abuse. The facility policy defines abuse that includes but not limited to any physical or mental injury inflicted upon a resident other than by accidental means. The policy further defines physical abuse as the infliction of injury on a resident that occurs other than by accidental means that requires medical attention that includes but not limited to hitting, slapping, and kicking. (B)	S9999		