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(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	Final Observations Statement of Licensure Violations: 2 of 2 Violations Complaint 2087824/IL127392 300.610a) 300.1010h) 300.1010i) 300.1210b) 300.1210d)3)6) 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 300.1010 Medical Care Policies	S9999	**Attachment A** **Statement of Licensure Violations**	

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h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B)

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.

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:

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3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 300.3240 Abuse and Neglect

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

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to provide a thorough and accurate assessment of a resident injury post fall for 1 of 4 residents (R1) reviewed for falls. Facility failed to provde emergency care in a timely manner and provide appropriate services related to pain post fall. This failure resulted in R1 experiencing

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S9999	Continued From page 3 unrelieved pain, and a delay in emergency treatment for seven and a half hours for an open fracture of right femur, requiring surgical repair, potential for shock, excruciating pain and blood loss due to significant delay in treatment. Findings include: On 10/5/20, R1's medical record and face Sheet showed that R1 was originally admitted to the facility on 5/20/20 and latest admission was 9/9/20, with diagnoses that includes but not limited to Contracture, Epilepsy Unspecified, Seizure Disorder, Pressure Ulcer stage 4 sacral region, Right hip, Left hip, Right ankle, Left Ankle, and of other sites, long use of anticoagulants, Anemia. R1 is a 60 year old quadriplegic with severe contractures. R1 was sent to local hospital seven and half hours post fall incident. R1's hospital record showed that R1 had "Type 3 open fracture of shaft of right femur unspecified fracture, with 5-6 inches of protruding right proximal femur through the lateral soft tissue ulceration." R1 was hospitalized, had a surgery Femoral Osteotomy to allow closure. R1 received three units of packed red blood cells on 9/29/20 at the hospital." On 10/05/20, R1's medical record progress note dated 9/29/20 timed 5:50am, V15 RN (Registered Nurse) documented in part that R1 was observed on the floor next to bed on his right side at 5:30am. V15 documented that R1 was assisted back into the bed by two staff members with the use of mechanical lift device. V15 documented that R1 had ROM (Range of Motion) times four, no rotation /deformity /shortening noted. R1's medical record event report full body	S9999		

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S9999	Continued From page 4 assessment V15 documented that there was no injury. V15 documented "No" under musculoskeletal normality or consistent with pre fall alignment observation. On 10/5/20, review of R1's medical record, progress note dated 9/29/20, both V5 (wound care Nurse) and V9 RN (Registered Nurse) did not document an assessment post fall. No event charting noted. On 10/05/20 at 12:35pm,V5 (Wound Treatment Nurse) stated on 9/29/20 when she tried to perform the wound care for R1, she noted the bed lining was saturated with blood in addition to the wound dressing which was also covered in blood to the sheets and clots of blood. V5 stated R1 was profusely bleeding from the right ischium area. V5 further stated I called the nurse in charge (referring to V9) at the time that R1 needed to be transferred to the hospital. V5 could not present any documentation of what was observed or assessed. V5 explained that she did not document the observation or assessment in R1's chart. On 10/05/20 at 1:40pm, during interview with V9 RN (Registered Nurse), V9 stated R1 was sent to the hospital for evaluation post fall incident. V9 explained that R1 fell during the night shift and when we knew something was very wrong we sent R1 to the hospital. When the surveyor asked what was wrong, V9 stated the treatment nurse (referring to V5) went to do (referring to wound care) R1's treatment, there was bleeding and red drainage from the wound site on the right hip so R1 was sent out to the hospital. When the surveyor asked V9 about his assessment of R1 site of injury, V9 replied I did not see the site like I wrote in my note it was the wound care nurse that	S9999		

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informed me that there was heavy bleeding at the wound site. V9 stated falls are documented under events in the resident record but in this case no facility event, incident accident form was created because the fall happened on the night shift. V9 stated that he does not normally work on the floor because he is the facility psychotropic nurse.

On 10/07/20 at 11:12am, telephone interview with V18 NP (Nurse Practitioner) conducted. V18 stated the nurse (Referring to V15) called stating that R1 had a fall that was unremarkable with no head trauma or injury. V18 explained that in the morning of the fall another nurse called that there was a prominent injury on (R1)'s hip and that was what prompted the sending of R1 to the hospital. When the surveyor asked V18 as to the description of the injury, V18 stated it was described that there was a deformity in the wound and the pressure ulcer was worse in condition than before.

On 10/8/20 at 10:52am, V20 CNA (Certified Nurse's Aide) stated she was the CNA on duty on 9/29/20 with R1. V20 stated in part that at 4:00am she went to change R1 and then she had to go and attend to another resident so she left the room and about 10 to 15 minutes later when she returned back to R1's room and could not find R1 in bed. V20 stated after looking around for R1, R1 was noted on the floor in a corner near his bed. V20 stated she did not know how R1 got on the floor. V20 stated she called the nurse (identified as V15). V20 stated another CNA was called to help in assisting R1 back to bed because both she and V15 could not put R1 back to bed. V20 stated the dressing to R1's wound site was soaked and V15 changed the dressing. V20 added that there was a big opening on R1's butt. When the surveyor asked V20 how often rounds

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are made, V20 stated she makes rounds during the shift but could not say how often because all the residents are usually sleeping at night. V20 explained that the residents don't need anything and they don't call for nothing so she does not need to disturb them.

On 10/8/20 at 2:40pm, interview conducted over the telephone with V15. Surveyor asked V15 what happened to R1 on 9/29/20. V15 stated, V20 CNA (Certified Nurse's Aide) informed her that R1 was on the floor in the room. V15 stated V20 had been in the room with R1 when another resident tried to elope so V20 went out looking for the resident. V20 came back stating the resident had gone down the street. V15 stated she was on the phone with the police when V20 called her to inform her that R1 was found on the floor. V15 stated R1 did not hit his head because he was noted on the floor holding on to the side of the bed. V15 stated "(I) and the CNA (Referring to V20) tried to get R1 up into the bed and they could not do it, so she called another CNA for help to get him into the bed. V15 stated at this time the police came to the facility, so she went and attended to the police. V15 stated it seems R1 hit his right hip on the floor when he fell. When the surveyor asked V15 whether there was any injury to the right hip, V15 stated when she went back to put the dressing on R1's hip, the right hip was not injured because he already had sores on it. V15 stated I just put another dressing because it was bleeding but (R1) bleeds anyway. It's an unstageable ulcer that was there before and you can see the bone. V15 stated she changed the dressing because it was "nasty". V15 stated she could not remember the name of the resident eloping and could not remember the name of the CNA's that worked with her because that was her first day of working on the floor. V15 stated

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because she was just out of orientation. V15 stated she does not know the facility procedure for falls other than to call the physician and the family. V15 explained she had never been in that kind of situation before.

Review of R1's Physician order sheet and MAR (Medication administration record) showed that R1 is receiving Eliquis 5mg (Milligrams) (Blood Thinner medication) one tablet gastric tube twice daily, scheduled for 6:00am and at 6:00pm.

Review of R1's MDS (Minimum Data Set) facility tool in assessing residents dated 5/20/20 under Section G Functional Status for ADL (Activity of Daily Living) coded R1 3/3 for transfer showing that R1 needed extensive assistance with two + persons physical assistance, 3/2 for dressing and 3/2 for personal hygiene showing that R1 needed extensive assistance with one+ person physical assistance. R1 was coded has having a BIMS (Brief Interview of Mental Status) of 07 (seven).

Review of R1's MDS (Minimum Data Set) facility tool in assessing residents dated 7/10/20 under Section G Functional Status for ADL (Activity of Daily Living) coded R1 3/3 for transfer, dressing and personal hygiene showing that R1 needed extensive assistance with two + persons physical assistance. R1 was coded has having a BIMS (Brief Interview of Mental Status) of 05 (five).

Review of R1's MAR (Medication Administration Record) for September 2020, did not show any documentation that any pain medication was administered. V15 documented that R1 had no pain.

On 10/13/20 at 11:00am, surveyor presented R1's Emergency room fracture picture to V18 (NP),

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S9999	Continued From page 8 V18 explained that from the last interview with the surveyor, V18 repeated "I was not here (referring to the facility), I was going by what was reported to me." V18 explained that the nurse who actually did the assessment later mentioned that there was a deformity to the wound that was why I ordered for (R1) to be sent out. V18 stated by the time he got to the facility R1 was already on the EMT Cart on his way to the hospital so he was not able to examine the site physically. When the surveyor showed V18 the emergency room picture of the deformity, V18 added, looking at this picture it is definitely a fracture. At 12:50pm, when the surveyor asked what will be V18's expectation concerning the nursing services that should be rendered to R1 post fall, V18 replied it will be for the nurse to have done a comprehensive assessment, full body exam head to toe, reporting the injury instead of saying R1 is okay when in actuality R1 was not. V18 added, and send the resident to the hospital. On 10/05/20 and 10/06/20, the facility was unable to present any thorough fall risk assessment, incident and accident report created, or an individualized plan of care that will meet R1's needs. No follow up with R1's root cause analysis of the fall, no pain assessment form created and no neuro checks documentation can be presented. No pain management follow up documented after fall incident. Review of R1's hospital medical record showed that R1 arrived at the Emergency room moaning in pain and had -6 inches protruding RT (Right) proximal femur through lateral soft tissue ulceration. Concerns for sepsis with WBC 18. Under R1's attending attestation statement dated 9/29/20 timed 2:19pm, the physician statement	S9999		

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includes but not limited to physician documenting that "I saw and physically examined (R1) of risk level high related to Threat to life or Bodily Function."

R1's emergency department record showed sequence of time on 9/29/20 that R1's pain was controlled with Fentanyl 50mcg/ml, 50mcg given IVP (Intravenous Push) at 1:55pm, 2:07pm, 3:36pm, 5:00pm, 6:41pm, and 10:55pm. This showed that R1 was administered pain medication every hour.

R1's hospital record showed that R1 had blood transfusion on 9/9/20 before the fall incident.

R1's fall risk assessment dated 9/10/20 showed that R1 scored 11.0 with a level recorded as level high risk. Braden scale score of 9.0 with a level recorded as severe risk for falls.

On 10/06/20 at 9:09am, V2 presented Incident Packet Direction Sheet with no nurse signature stating this is what I found from yesterday but there was no nurse signature. V2 stated, V15 did not complete any incident accident report, she was due to come back and complete it. V2 stated V15 called off and has been taken off schedule at this time. We are waiting for the nurse (referring to V15) to come back and sign the form. V2 acknowledged that V15 did not perform a through and accurate assessment at the time of fall and both V5 and V9 should have documented in detail assessment done before sending R1 to the hospital.

The facility Accident/Incident Management Meeting IDT (Interdisciplinary Team) form presented documents that "Resident noted on the floor upon entrance of CNA. Seen by wound care,

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red drainage noted, MD notified and sent out for medical evaluation."

R1's medical record progress note dated 9/29/20 timed 11:42am, showed that R1 was not sent to the hospital until after approximately seven and half hours post fall when V5 discovered that R1 was bleeding profusely from injury sustained from the fall incident. This resulted in delay in R1 being identified with a serious injury and receiving emergency care to repair a right femur fracture.

On 10/ 13/20 3:55pm, when the surveyor asked V2 about the facility expectation of staff when a resident falls. V2 replied that they are to assess the resident accurately, thoroughly and document in the Matrix. V3 who was present at the time stated they should document in details in the progress note their assessment, fill out the pain assessessment form. V2 then added they should call the physician giving accurate and precise description of what was observed.

On 10/13/20, the facility is unable to present any documentation of any resident eloping as indicated by V15. V2 and V3 stated there was no record of any resident that eloped.

On 10/28/20 at 10:25am, during interview with V31 (Physician), V31 stated she could not remember R1. When the surveyor asked V31 about what will be her expectation in regards to resident who had a un-witness fall. V31 stated an assessment should be made before getting them into the bed and if they deem it necessary to send the resident to the hospital then they should. Notifying the physician and send the resident out. V31 stated if they (Nurses) see any injury they should send the resident to the hospital. V31 explained that, if the resident is bleeding from

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S9999	Continued From page 11 external surface the bleeding should be stopped and then send the resident to the hospital. V31 stated it is not appropriate for a resident who is bleeding to be left bleeding. When the surveyor asked is it appropriate to let a bleeding resident stay in the facility for approximately 71/2 hours before being sent to the hospital, V31 replied it is not appropriate. The facility Job Description for both LPN (Licensed Practical Nurse) and RN (Registered Nurse) essential duties and responsibility includes but not limited to charting nurse's notes in an informative and descriptive manner that reflects complete accident/incident reports and submit to Director as required. Perform routine charting duties as required and in accordance with established charting and documentation policies and procedure. The facility policy titled Falls-clinical Protocol presented with revised date August, 2008 pointed out under assessment and recognition that the Nurse shall assess and document/report that includes but not limited to musculoskeletal function, observing for change in normal range of motion. The facility policy on Pain Clinical Control presented with revised date August 2008 documented under Assessment and Recognition that this includes but not limited to identifying individuals who have pain or who are at risk for having pain. Under monitoring for pain the policy listed guidelines that includes the staff reassessing the individual pain and consequences of pain at regular intervals. The facility was unable to present any documentation that this guideline was followed.	S9999		

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S9999	Continued From page 12 The facility policy presented titled Evaluating Falls and Their Causes with revised date August, 2008 pointed out in part that the purpose of this policy is to provide guidelines for evaluating a resident after a fall. Guideline procedure after a resident is observed on the floor without witness includes but not limited to evaluating resident for possible injury to extremities. An incident report must be completed for resident falls. (A) 300.690a) 300.690b) 300.690c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each	S9999		

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S9999	Continued From page 13 reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. (Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013) This regulations was not MET as evidence by: Based on interview and record review, the facility failed to report to State Agency a resident fall with injury. This failure affected R1 and has the potential to affect all the 104 resident in the facility, R1 had a serious fall, R1 was sent to the hospital. R1 had a fall resulting in a Type 3 open fracture of shaft of right femur unspecified fracture, with -6 inches of protruding Right proximal femur through the lateral soft tissue ulceration. Findings include: On 10/5/20, R1's medical record Face Sheet showed that R1 was originally admitted to the facility on 5/20/20 latest admission was 9/9/20, with diagnoses that includes but not limited to Epilepsy Unspecified, Pressure Ulcer stage 4	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004667	A. BUILDING: _____ B. WING _____	C 10/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 14 sacral region, Right hip, Left hip, Right ankle, Left Ankle, and of other sites, long use of anticoagulants, and Anemia. R1 was sent to local hospital on 9/29/20 post fall incident. R1's hospital record showed that R1 had "Type 3 open fracture of shaft of right femur unspecified fracture, with -6 inches of protruding Right proximal femur through the lateral soft tissue ulceration." This was not reported to the State Agency until 10/5/20 during the investigation. On 10/5/20, the facility was unable to present any documentation that showed they follow up on R1's condition after being sent to the hospital. Review of R1's medical record did not show any documentation showing that the local hospital was contacted to get any follow up information. On 10/05/20 at approximately 4:45pm, V1 (Administrator), V2 DON (Director of Nurse's) and V3 (Nurse Consultant) stated they are not aware of R1's fracture. V2 stated the nurses are supposed to follow up on resident's health condition upon admission at the facility unless they return back to the facility same day. The facility Accident/Incident Management Meeting IDT (Interdisciplinary Team) form present documents that "Resident noted on the floor upon entrance of CNA. Seen by wound care red drainage noted, MD notified and sent out for medical evaluation." The check list includes but not notification made to State (referring to State Agency) if needed this was not marked as done. (B)	S9999		