IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 19, 2019

Aaron Rokach, Registered Agent
Pearl Pavilion, LLC
4711 Golf Road, Suite 200
Skokie, Illinois 60076

RE: Complaint #: IL 107750
Survey Date: December 19, 2018
Docket #: 19-C0064
Violation Type: 2-B Violations with Fines

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Pearl Pavilion.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Pearl Pavilion/December 19, 2018/19-C0064/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: PEARL PAVILION COMPLAINT #: 0107750
LIC. ID #: 0053603
DATE COMPLAINT RECEIVED: 12/04/18 09:09:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
117	THEFT	2
130	MENTAL ABUSE	1
206	HOUSEKEEPING	2
409	POLICY AND PROCEDURES	2

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. PEARL PAVILION, LLC, D/B/A, PEARL PAVILION, Respondent.	)))))))))	Docket No. NH19-C0064

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 19, 2018, at Pearl Pavilion, 900 South Kiwanis Drive, Freeport, Illinois 61032. On February 14, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$4,400.00**, as follows:

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1220b)2), 300.3240a), 300.3240d)and 300.3240e). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.3240a), 300.3240d) and 300.3240e).

  Fine = $2,200

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1010h), 300.1210a), 300.1210b), 300.1210d)5), 300.1220b)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)5) and 300.3240a).

  Fine = $2,200

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 19th day of February ,2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. PEARL PAVILION, LLC, D/B/A, PEARL PAVILION , Respondent.	)))))))))	Docket No. NH 19-C0064

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Aaron Rokach
Licensee Info:	Pearl Pavilion, LLC
Address:	4711 Golf Road, Suite 200 Skokie, Illinois 60076

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 19th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

BF300/19-C0064/Pearl Pavilion/December 19, 2018/kk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	C 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

(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
S 000	Initial Comments Complaint Investigation: 1817831/IL107750	S 000		
S9999	Final Observations Statement of Licensure Violations: Licensure 1 of 2: 300.610a) 300.1210 b) 300.1220 b)2) 300.3240 a) 300.3240d) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

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)

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These requirements are not met as evidenced by:

Based on Observation, Interview and Record Review the facility failed to ensure residents were not mistreated or abused by staff. This failure contributed to R1 being taunted and teased and R8 struggling with staff, resulting in a fall.

This applies to 2 of 4 residents (R1, and R8) reviewed for abuse in the sample of twelve.

The findings include:

1. The Medical Diagnoses Sheet dated 12/12/18 for R1 showed diagnosis including Dementia without behavioral disturbance, Alzheimer's Disease, Heart Failure, Unsteadiness on Feet, Hypertension, Hypothyroidism and Hyperlipidemia.
R1's Care Plan dated 11/23/18 showed, "Behavioral distress related to being challenged by dementia-related illness. Problems are manifested by physically abusive behavior when agitated. Intervene by speaking calmly and professionally in a soft voice. Staff should avoid raising own voice since this tends to make the resident more upset. This may cause the situation to escalate."
R1's MDS (Minimum Data Set) dated 11/21/18 showed a BIMS (brief interview for mental status) score of 3, severe cognitive impairment.

On 12/12/18 at 12:23PM V17 (R1's daughter) stated, "I put the camera in, because things were turning up missing and all of a sudden, dad was not acting like dad. The camera was where his recliner is now. There is a plug in there and the night stand was there before. The camera was on the side closest to the bathroom. It looks like a

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phone charger. You can't tell it is a camera. I never set the time and date on it because we did it for us. The camera was put in his room in June 2018 or July 2018 and removed in September or October 2018. I blew up at V1 (Administrator) in September or October 2018. I told him that my dad's treatment is sickening. He viewed the video of the hands in dad's face and he was sickened by it and couldn't believe what was going on. He acted like something was going to happen. V1 response was "All I can say is I am sorry, something will be done." He knew the staff in the video and mentioned her by name. I felt he was going to investigate. V1 said they were going to do classes. V28,CNA, is the one waving her hands. She has the long nails. V1's assistant said right away it was V28. The assistant quit. V18 is the one swearing. R1 doesn't swear unless he is extremely p***** off. He is quiet, keeps to himself and is clean cut." V17 stated she felt that a staff member waving their hands in her dad's face was abuse. V17 stated, "It feels like mental abuse has occurred." V17 was asked how she felt about staff swearing in front of R1? V17 stated, "It was sickening and unprofessional. She said just tell them to f*** off! Really? My dad is not that kind of person. He would laugh but laughs when he is uncomfortable. He is not the kind of person to swear."

A video from a camera placed in R1's room showed (inaccurate date on video) the following: R1 shut the bathroom door on V20 (housekeeper). R1 then sat in his wheelchair outside of the bathroom door. R1 backed up his wheelchair and picked up a clear bag with food in it from his table. The bathroom door opened and R1 went over and shut the door. R1 backed away from the door. R1 put his foot up to shut the door and keep it shut. V28 ,certified nursing assistant

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(CNA)walked in the room. V28 proceeded to waive her hands in R1's face/personal space. R1 picked up his bag of food and acted as though he would throw it. V28 walked by R1, turned around and waved her hands at R1 again. V28 walked out the door. V20 was present for the interaction between R1 and the CNA. V28 was identified as the CNA in the room.by V20, the housekeeper.

A second video from the camera placed in R1's room showed (inaccurate date on the video) the following: a staff member came into R1's room and told him to come eat. R1 stated he doesn't want to. The staff member stated "Come on" several times. The staff member stated, "Watcha mean you don't want to eat. R1 stated something that was difficult to hear. R1 stated "I don't care for it." The staff member stated, "Me neither but eat your food and tell them f*** you. The staff member laughed and stated she is just joking. R1 stated, "You tell them f*** you." The staff member stated, "Get the f*** out of here. You tell them that. I tell them for you ...." R1 responded, but unable to understand his reply. R1 asked the staff member what time it was and she replied 5:44. The CNA told the resident that they were going to "roll out" and called him homie. In an interview with V17 (R1's daughter) she stated is was V18, CNA, in the room.

On 12/12/18 at 8:35AM , R1's room was observed and from where the camera would have been placed in his room, view of the room is the same as what is observed in the video.

On 12/13/18 at 1:40PM, V20 (Housekeeper) stated, "I was a housekeeper at the facility. I left 1 -2 months ago. I went to clean R1's bathroom

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and he shut the door on me. R1 thought it was the funniest thing ever. R1 shut the door again. I thought he was playing. I turned the call light on and V 28, CNA came in, trying to get R1 out of the door. I believe I was leaving when V28 was coming into the room." V20 denies seeing V28 wave her hands at R1 but is clearly viewed on the video as present in the room.

On 12/14/18 at 10:40AM, V28 (CNA) stated, "I remember hearing about that involving V20 (housekeeper) and V24, (CNA) believed to have been involved by V28. I heard R1 blocked the bathroom door in his bedroom." V28 stated she would not wave her hands at R1 because it would possibly aggravate him.

On 12/12/18 at 9:40AM, V3 (Assistant Director of Nursing - ADON) stated it would not be appropriate for staff to wave their hands in R1's face. V3 stated, "I don't know why they would do it in the first place. I wouldn't do it with anyone. It sounds like tormenting." V3 stated it could be mental abuse but she doesn't know what they were doing.

On 12/12/18 at 10:36AM, V9 (Registered Nurse - RN) was asked if it would be okay to wave your hands in R1's face? V9 stated, "I would need to know if they are playing or not. They shouldn't do that if he is in a bad way. They shouldn't be putting hands in his face. I can't see anyone doing it towards his face. R1 is a nice guy."

On 12/13/18 at 12:49PM, V2 , DON stated, "I wasn't here then. The first time I was aware of this was on 12/11/18. When you came in, they called me and said state was in the building. We provide the abuse policy and procedure to everyone."

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On 12/14/18 at 4:41AM, V14 (CNA) stated it is not appropriate to swear in front of a resident. V14 stated that if a staff member waved their hands in a residents face or towards the resident that the resident would think they are being attacked or belittled. V14 stated she has heard two CNAs swear, V5 and V18.

On 12/14 /18 at 5:15AM, V22 (Licensed Practical Nurse - LPN) stated she has heard of CNAs swearing in front of residents but has not heard it herself . It is not appropriate to swear in the building at all. V22 stated it would not be okay to lunge at a resident or wave hands at a resident because they don't know what is going on and it would be scary to them.

On 12/14/18 at 6:06AM, V24 (CNA) stated it is not appropriate to wave hands or lunge at residents with dementia. V24 stated, "No one would like that; you don't know what their mind is thinking at that time." V24 stated it would be taunting a resident and stated swearing in front of a resident is not appropriate.

On 12/14/18 at 6:29AM, V25 (Licensed Practical Nurse - LPN) was asked if it would be okay to wave hands or lunge into a dementia resident's personal space? V25 replied, "I wouldn't think that is okay, dementia or no dementia. A dementia resident is afraid as it is. They don't remember and can't tell; but it puts fear in them they don't need to have. I would consider it mental abuse definitely. They can't defend themselves at all." V25 stated it is not okay to swear in front of a resident because it is unprofessional and could be verbal abuse.

2. On 12/12/18 at 2:28PM R3 stated, "It was the

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stand lift that got me, not the CNA. It was to the left arm. The mark is not there anymore. I use the stand lift and my arm got pinched when they moved me. V18 (CNA) is snotty and she doesn't like me. I am a veteran and I shouldn't be talked to that way. It makes me feel bad the way she talks to me. She has never hurt me. She swears at me and in front of me. I can't say what she says because it is too dirty. I am afraid she will hurt me. Sometimes she is snippy. She is fast with her hands. I want her to leave here and never come back. Every time I see her, I start shaking. I am afraid she will hit me sometime. V18 swears and is rude. I am Catholic and I don't like it. I only cuss if I am really angry. A lot of residents are scared and don't want to say anything." R3 stated he can't read.

On 12/14/18 at 5:27AM, V23 (CNA) stated, "The only resident that has complained about a CNA is R3. He is afraid of V18 and told me he is terrified of her. I told him to tell someone and I told V31 (Registered Nurse - RN). V31 told me it was under investigation. R3 told me that V18 pinched him and no one believed him. I told him to let someone know and he said that he did. I hear that R3 and V18 go back and forth." V23 stated swearing in front of a resident could be verbal abuse. V23 stated that if you wave your hands in front of a resident and/or lunge at the resident it is not okay because the resident may think you are trying to fight and get scared. V23 stated it is mental abuse.

R3's Nurse's Notes showed, "12/1/18 at 8:15AM - Resident reported to me at 8:05AM a bruise to the anterior left upper arm that he states was caused by a CNA pinching him. The bruise is purple in color 2.5cm and non-tender to touch. Text sent to administration regarding this manner;

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PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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5:30PM - Full body assessment of resident shows no previously undocumented skin issues other than bruise reported at 8:05AM. Resident reiterated that this occurred in the early AM of 12/1 while CNA "With the tattoo on her neck" was repositioning resident to facilitate change of brief. CNA placed hand on resident's upper left arm which caused a feeling resident described as a pinch. Resident voices that "he smacked her" and that the CNA's response was to laugh. Resident voices that he did not report this to the nurse at the time. Resident states that he is "scared" of previously mentioned aide."

The Abuse Investigation for R3 dated 12/1/18 showed statement initialed by the resident and a conversation between the resident, administrator and V33 (Assistant Administrator) that was initialed by R3 who cannot read.

The statement dated 12/1/18 by R3 showed, "The girl with the tattoo on her neck pinched me and I hit her for it and now I will probably get kicked out of here. R3 went on to say, "The other aide was nice to me." He showed the bruise and stated, "They were changing me and she grabbed and pinched me and laughed."

In the written Interview done by V1 and V33 with R3 dated 12/3/18 showed, "Yeah I hit her. She pinched me." At the end of the interview the document showed that R3 then told the administrator that V18 did not pinch him. The document was initialed by R3 who cannot read the document.

R3's Care Plan dated 10/24/18 showed, "Patient is at risk for abuse and/or neglect due to mental illness, traumatic brain injury, agitation and suicidal ideation."

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The MDS dated 10/1/18 for R3 showed a BIMS score of 15, cognitively intact.

3. On 12/11/18 at 11:00AM, R8 stated, "I went to the lobby and V18 told me to go back to bed. I wanted a snack. I didn't want to go back to bed. V18 grabbed my wheelchair and started pulling me in it so I stood up. I bumped and fell into the wall. V18 said, "I told you not to stand up because you will fall over." The other one that was with her had her picture up in the lobby but it's gone now. The other one was pushing my chair while V18 was pulling it. I don't think the other one is here."

The MDS dated 10/13/18 for R8 showed a BIMS of 15, cognitively intact and no physical, verbal or other behaviors.

The facility's Abuse Prevention Program Facility Policy and Procedure (1/4/18) showed, "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology."

(B)

Licensure 2 of 2:

300.610a)
300.1010h)

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300.1210a)
300.1210b)
300.1210d)5)
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 300.1010 Medical Care Policies

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.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility,

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with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a 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.

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:

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

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pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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.

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 are not met as evidenced by:

Based on observation, interview and record review the facility failed to implement a pressure relieving device for a resident with a pressure injury and failed to perform admission skin assessments. This failure resulted in a resident being admitted with a pressure injury and not being identified until it was an infected Stage 3 ulcer.

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This applies to 3 of 4 residents (R2,R4& R5) reviewed for pressure injuries in the sample of 12.

The findings include:

1. The computer face sheet for R5 shows he was admitted to the facility on 1/30/18. R5's admission Braden scale for predicting pressure injury risk documents R5 was at a low risk for pressure injuries.

The 2/13/18 MDS (Minimum Data Set) section M (skin conditions) documents R5 was not at risk for pressure ulcers and had no documented unhealed pressure injuries. His BIMS (Brief Interview for Mental Status) score was 15, cognitively intact. R5's functional status for ADL (Activities for Daily Living) assistance showed he required physical help with one staff for bathing.

The physician orders for R5 show on 1/30/18, he was to have a skin assessment weekly on shower day.

R5's nursing progress notes show on 2/26/18, two open areas are noted to the coccyx. One open area was 8cm x 5cm, and the other measured 6cm x 5cm, and the NP (Nurse Practioner) was aware and protective cream was ordered.

R5's progress notes for 3/3/18 document he was seen by the physician and no new orders. The physician note had no documentation of new or current pressure injuries. The progress notes show on 3/5/18, R5 was seen by the dietitian, and she documented R5 had no reported open areas.

R5's nursing progress note of 3/8/18 shows the

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nurse was notified of open areas to coccyx. The notes document two open areas measuring 3cm by 3cm to the right side of the gluteal fold. The weekly wound measurements and assessments were not documented in the progress notes, and were requested from V2, Director of Nursing (DON). None were provided.

On 12/14/18 at 10:00 AM, V2, DON, said R5 goes to the wound clinic for his Stage 3 pressure injury. V2 said R5's wound was stubborn to heal, and he had the wound when he was admitted to the facility in January. V2 said the wounds were stage 3 and had always been a stage 3.

On 12/12/18 at 2:45 PM, R12 (R5's wife) said (R5) had the sore (pressure injury) before he was admitted to the facility (in January).

On 12/14/18 at 2:45 PM, V2 said R5 came to the facility from assisted living, and believed he was going to the wound clinic at that time for the same wound. V2 said on the wound clinic documents a date is put for the date the wound was acquired, and R5's was 1/23/18, one week before his admission. V2 said upon admission, the nurse should have performed a head to toe assessment and documented the wound. V2 said R5 is very independent with all care, but will tell you the wound was there before admission to the facility.

The 1/30/18 unit nurse skin review showed upon admission, R5 had no noted skin problems. The 1/30/18 nursing admission screening for skin integrity documents skin is normal color, warm with normal turgor. The assessment documents R5 had no impaired skin integrity upon admission.

On 12/14/18 at 2:00 PM, V9 Registered Nurse

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(RN), said any new admission has a head to toe assessment and any findings are documented on the unit skin review or the skin integrity review. If a new admission is admitted with a pressure ulcer, the wound nurse is notified along with the NP. V9 said not everyone is automatically placed on the weekly skin check list, there needs to be an order. V9 said with every shower a skin check is done and the aides will document any findings in the computer, but will also verbally report any open skin issues directly to the nurse.

On 12/18/18 at 11:30 AM, V32 RN,(Wound clinic nurse) said R5 initially came to the clinic on 4/23/18. V32 said the initial wound assessment was documented as a Stage 3 measuring 5.7cm x 4.2cm x 0.7cm. V32 said the nursing notes at the clinic show R5 and his daughter explained the wound was approximately 3 months old. R5 was not sure the date it started, but it was before he entered the nursing home. V32 explained that was why the wound documentation lists the date acquired as 1/23/18. V32 said R5 has no feeling in buttocks, and would not know if wound was present or not, which is why he needs a skin check at least weekly. V32 said a nursing skin assessment should have been done when he was admitted and the wound should have been documented. R32 said R5 had no visits to the wound clinic prior to 4/23/18.

On 12/19/18 at 9:15 AM, V34 ,Nurse Practioner (NP) said she performed the initial assessment of R5's pressure injuries at the wound clinic. V34 said the 4/23/18 assessment was the first time R5 had been to the clinic for his wounds. V34 said R5 estimated he had the pressure injury for at least 3 months, but was not sure because he had no feeling in his buttocks. V34 said based on his neuropathy and incontinence, it is likely he

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had this wound longer than he had reported. V34 said he should have had a physical/skin assessment upon admission to the nursing home, it would verify any open areas at the time of admission, it would be the prudent thing to do. V34 said any wound without attention or treatment would decline. Any time a wound is open and exposed it can become infected. R5's wound left unattended in combination with his sitting in the recliner, neuropathy and incontinence would have contributed to his infection. R5 would be at a higher risk for skin breakdown because he can not feel anything in his buttocks. V34 said R5 on his initial visit, had an infection in his wound that was positive for Staphylococcus Aureus and he was placed on antibiotics.

The weekly measurements beginning 10/29/18 show R5's wound to have an onset date of 3/8/18 and it was facility acquired, and on the 11/19/18 assessment, the place acquired was changed to community acquired.

On 12/19/18 at 11:20 AM, V2 said, during the facility's annual survey, she had to locate information for R5's pressure injury for the surveyors. When she received information from the wound clinic it had identified the acquired date of the wounds as 1/23/18, prior to his admission, so she changed the status of the wound to community acquired.

The 11/21/18 MDS shows R5 to have a Stage 3 pressure injury, and it was present upon admission, the admission MDS of 2/13/18 documented R5 had no pressure injuries.

R5's current care plan for alteration in skin integrity documents the wound as a facility

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S9999	Continued From page 17 acquired Stage 3 pressure injuries. 2. The weekly pressure injury report of 12/10/18 shows R4 was admitted with a stage 2 pressure ulcer to his right gluteal fold on 11/20/18. On 12/14/18 at 8:45 AM, R4 said he was admitted to the facility after a couple of days in the hospital. R4 said he came into the facility with a sore on his buttocks. R4 denied any pain to the area. R4 said the nurse had put a dressing on it every day. R4 said he can move himself in and out of bed and can do most things for himself, like getting dressed and brushing his teeth. R4's admission Braden score was a 22, low risk for pressure injuries. The admission skin integrity review shows no documentation of a pressure injury to the buttocks. The admission MDS of 12/4/18 showed R4 to have no current or unhealed pressure injuries. R4's 11/21/18 care plans show he is at increased risk for alteration in skin integrity related to stage 2 open area to the right buttocks. The wound measures 1.7cm by 1.0 cm. On 12/14/18 at 2:45 PM, V2 , DON, said R4 came into the facility with a pressure injury, and it should have been identified on his admission skin assessment. V2 stated,on the evening of his admission, she was in R4's room addressing his leg wounds when R4 complained of soreness to his buttocks. V2 said she assessed R4's buttocks at that time and found him to have an open area, a Stage 2 pressure injury. V2 said the nurse should be conducting an assessment of the buttocks, and not asking the resident about sores on their buttocks.	S9999		

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The facility's undated policy for admission of a resident showed 8. Conduct a head to toe nursing assessment of body systems, parts, and surfaces identifying functional status abilities, needs or problems. Be sure to measure any areas of redness or skin breakdown on extremities or other skin surfaces.

The facility's policy for wound care documents Risk Identification and assessment: 5: Residents should be examined thoroughly at lest weekly by a licensed nurse to identify existing pressure ulcers. a. Findings from the weekly skin assessment should be documented by the licensed nurse.

3. On 12/14/18 at 9:46AM, R2 was sitting in a wheelchair in the hallway. R2 has a sock on her right foot and off loading boot to the left foot. R2's right heel was touching the floor.

On 12/14/18 at 2:00PM, R2 was sitting in her wheelchair by the nurse's medication cart with her right foot rubbing on the foot rest.

On 12/14 18 at 10:15AM, V2 (Director of Nursing - DON) stated, "R2 has a stage I pressure injury to the left heel and has a blister forming to the right heel which is a stage II pressure injury. R2 has the boot to her left heel because it is tender. They had a boot on the left heel and I staged it at a I, not blanchable. The right heel is flat but has a blister forming. We kept her shoe off and it has skin prep on it. R2 has had problems with her heels in the past." V2 stated the pressure injury to R2's right heel was not identified until it was a stage II.

On 12/14/18 at 9:36AM, V9, Registered Nurse (RN) stated, "R2's left heel has a reddish purple

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area that was identified on 12/7/18. We put skin prep on it. It is done on nights. It must be getting done two times per day. There is a blister.."

A physician Notification Form dated 12/8/18 for R2 showed, "Left heel has a 3 x 3 purple area. Right heel has a 2 x 4 red blister.

The Weekly Wound Rounds form dated 12/10/18 for R2 showed her right heel has a stage II pressure injury with a blister that measured 2.0cm x 4.0cm with instructions to keep her shoe off and off load the heel when in bed.

R2's Care Plan updated 12/7/18 showed she is at increased risk for alteration in skin integrity related to impaired cognition, impaired mobility status. A "non blanchable dark red left heel; boot applied. Right heel outer aspect has an area measuring 2 cm by 4cm and is red with a blister forming. Treatment in place."

The Minimum Data Set (MDS) dated 10/26/18 for R2 showed a Brief Interview for Mental Status Score of 4, severe cognitive impairment; she requires extensive assistance for bed mobility and transfers.

(B)