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S 000	Initial Comments Complaints 2226070/IL149690, 2226264/IL149915 & 2226311/IL149982	S 000		
S9999	Final Observations #1 Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)3) 300.1220b)1)2) 300.1810f)1) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. Section 300.1220 Supervision of Nursing Services	S9999		

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S9999	Continued From page 2 b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 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 300.1810 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. 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 Regulations were not met as evidenced by: Based on interview, observation and record review, the facility 1) neglected to identify,	S9999		

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assess, and contact the physician of an acute change in a resident condition, and neglected to ensure a resident was checked every two hours as directed by the facility's policy. R1 displayed a change in condition on the afternoon of 7/31/22 that continued to decline into the evening. R1 was put to bed around 8:30 PM, did not checked by staff for nearly 12 hours, and was subsequently found deceased in bed the following morning. R1 was found in a state of rigor mortis (stiffening of the joints and muscles of a body after death) on discovery.

2) the facility failed to ensure that emotional support was provided to a resident who became emotionally distressed after witnessing a resident's change in condition who later passed away. R2 observed R1 display a change in condition on the afternoon of 7/31/22 that continued to decline into the evening. R2 was made aware that R1 was found deceased in bed the following morning, which caused R2 emotional distress that continues.

Findings include:

1) The facility's Family and Physician Notification policy (undated) documents the following: "Policy: To provide notification to family and physician of changes, resident needs. Procedure: Attending physician as well as Power of Attorney/representative shall be notified of health status changes in a timely manner. ie: falls, injuries, abnormal labs, continuous nausea/vomiting, unconsciousness, seizures, unusual bleeding, new or unmanaged pain, SOB (shortness of breath), chest pain, significant mental status changes, unmanageable behavior, medication errors, and all other conditions deemed necessary. Document time of call and

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S9999	Continued From page 4 results in chart. Notify POA (power of attorney) of any new orders obtained from physician." The facility's Repositioning and Check/Change policy (undated) documents the following: "Repositioning and frequent changing is a common, effective intervention for prevention skin breakdown, promoting circulation, and providing pressure relief. Reposition and check or change residents every two hours or as needed." R1's Progress Notes document the following: On 7/15/22, R1 was sent to a local hospital after staff witnessed her have a grand mal seizure, was admitted to the hospital for care of a subdural hematoma and returned to facility on 7/22/22. R1's Minimum Data Set Assessment (dated 7/29/22) Section C, Cognitive Patterns, documents a Brief Interview for Mental Status could not be conducted due to R1 being rarely/never understood. This same section also documents the Staff Assessment of R1's Mental Status indicating a short-term and long-term memory problem, and R1 is severely impaired (never/rarely made decisions) in cognitive skills for daily decision making. On 8/8/22 at 1:55 PM, V9 (Housekeeping Supervisor) stated the following: "On the morning of 8/01/22, I was delivering newspapers. I was on the second floor and was walking past (R1's) room. I always glance in the resident's rooms as I pass by. I stopped at (R1's) room because she didn't look right. You could tell that something was wrong. Her color was gray, her head was back, and her eyes and mouth were open. I went in and felt her. She was cold. I tried to find a pulse and one was not present. She was as stiff as a board. So, I went to (V5, Registered Nurse) and made	S9999		

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S9999	Continued From page 5 him aware that one of his residents was dead." On 8/8/22 at 12:10 PM, V5 (Agency Registered Nurse) stated he was the nurse working day shift on 08/01/22. V5 stated the following: "Around 8:00 AM, (V9, Housekeeping Supervisor) came and told me that (R1) had passed away. I was passing morning medications and had not yet been in to see (R1). When I went in her room, she was very cold and rigor mortis had already set in. Her eyes were open, her mouth was open, and her head was tilted back. Both of her hands were grasping the bed sheet. I called the Power of Attorney, the doctor's office, the Coroner's office, and then the funeral home after getting the OK from the Coroner's office. V5 stated he was not aware of R1's recent hospitalization for treatment of a subdural hematoma. V5 stated he was not made aware of any concerns regarding R1 when he received report at the beginning of his shift. On 8/08/22 at 12:35 PM, V6 (Licensed Practical Nurse) stated she was called to be the second nurse to confirm R1's time of death. V6 stated, "I was in my office and got a call that they needed a second nurse to verify (R1's) death. V9 (Housekeeping Supervisor) called, and I went down to verify. I listened for a heartbeat and lung sounds and did not hear anything. I also watched for chest rise and fall and did not see any respirations. After doing this, I verified her time of death with (V5, Registered Nurse). Rigor had already set in. It appeared she had been dead for a while. We did not attempt CPR. It was past that point." On 8/8/22 at 2:40 PM, V3 (Assistant Director of Nursing) stated she was the nurse working second shift on 07/31/22. V3 stated the following:	S9999		

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S9999	Continued From page 6 "(R1) was her normal self until dinner time. I saw that she had spit on the floor- it appeared to be clear sputum. Around 6:00 PM, one of the CNAs (Certified Nursing Assistant) grabbed a tray table and positioned it in front of (R1) and placed a basin on the table. (R1) was spitting in the basin. The CNA offered (R1) a banana, and she spit it out. (R1) was offered a glass of water. She did take a very small drink." V3 stated she was aware that R1 had a recent diagnosis of a subdural hematoma. V3 stated she did not take vital signs on R1 the evening of 7/31/22 or notify R1's physician because, "I didn't have any real concerns other than she had an upset stomach." V3 stated she reported off to V8 (Licensed Practical Nurse) on 7/31/22. V3 stated, "(R1) was in bed by 9:00 PM." V3 stated R1 did have a bruise present on her forehead, "I asked about it because I didn't know how she got it. No one I asked knew anything about it." On 8/09/22 at 2:25 PM, V14 (Certified Nursing Assistant) stated she worked on the second floor from 7:00 AM - 8:30 PM on 7/31/22. V14 stated, "(R1) was sick from about 1:00 PM that day. I tried feeding her lunch and she spit it out. She kept spitting out a foamy spit substance. I gave her a shower around 4:00 PM that day because she was covered in the secretions she was throwing up. I took care of (R1) often and I've never seen her do anything like this. I am not aware that she has ever spit on the floor. I have never seen her do this or been told she does this. She just kept getting worse. She should have been sent to the hospital after throwing up for that long. I told (V3, Assistant Director of Nursing) that (R1) was ill multiple times. We put her to bed right before I went home. (R1) is usually up at night until at least 9:30 PM due to restlessness and wandering. I think she should have been sent	S9999		

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in to get evaluated. There was clearly something wrong with her. (R1) is cognitively impaired so she couldn't tell you what was wrong. After so many hours of this, I just kept telling (V3) that (R1) was sick."

On 8/10/22 at 10:30 AM, V10 (Certified Nursing Assistant) stated she worked second shift on the second floor on 7/31/22. V10 stated, "First shift said (R1) had not eaten anything and had been drooling. We tried to get her to eat dinner. We tried applesauce, and she just wouldn't take anything. She was drooling quite a bit. It just kept coming out of her mouth. I kept grabbing towels and (R1) would spit into them. After dinner, the drool had color. It was darker. It almost looked like coffee grounds. I told the nurse we should probably get (R1) checked because there is probably something wrong since this had been going on all of my shift. The nurse never sent her out. She didn't really say anything. She just told me to put (R1) in bed. By that time, (R1) had vomited a large amount and had a brownish drool. The nurse just commented on the color and said she needs cleaned up. So, I took (R1) to her room and cleaned her up and then put her in bed. I went back to the nurse and told her (R1) should probably get checked out. The nurse seemed very busy with paperwork. There is a lot of charting and paperwork on the second floor since it is the Medicare floor. The nurse should of at least called and had (R1) sent in to get looked at, but she stayed behind the desk and did paperwork. I never saw her go check on (R1)."

On 8/10/22 at 10:35 AM, V15 (Certified Nursing Assistant) stated she worked the second floor for night shift beginning at 10:00 PM on 7/31/22. V15 stated, "I heard (R1) passed away. I didn't even know she was on the second floor that night. She

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was on the third floor the last I knew. I never even saw her or went in her room that night. I worked by myself that night too. I was the only aide on the second floor."

On 8/10/22 at 2:25 PM, V16 (Licensed Practical Nurse) stated the following: "July 31st was supposed to be my night off. (V3, Assistant Director of Nursing) called and begged me to come in, and I agreed. (V3) had already left the building when I arrived and she had given the nurse's keys to (V17, Licensed Practical Nurse), who was working on the third floor. I did not receive any report when I arrived since (V3) was already gone. There was only one CNA on the floor, and she left early around 5:30 AM. No one came to replace me when I was supposed to be off at 6:00 AM, and no CNAs had come in either. (V5, Agency Registered Nurse) showed up to relieve me at 7:30 AM, and after giving him report, I left. There were still no CNAs that had shown up when I left. Since July 31st was the last day of the month, I had to do changeover of the MARs (medication administration records). This is very time consuming. The second shift nurse on the third floor (V17) stayed over to do the third floor changeover and then she left. (V17) gave me her keys and then I was responsible for covering the second floor and the third floor. I spent the majority of the night doing changeover, so I was not involved in much resident care. I can tell you that (R1) was never looked at. This is the CNA's failure. Bed checks are supposed to be done at least every two hours. A responsible aide would have caught this. The CNAs are taking advantage of the staffing shortage at the facility. They come and go when they please because they know they can get away with it. The facility has been very short staffed, and a lot has been getting missed lately. I know a lot of the residents

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S9999	Continued From page 9 have said they have not been getting showers." On 8/11/22 at 10:12 AM, V17 (Licensed Practical Nurse) stated she was working second shift on the third floor on 7/31/22 and stayed over a few hours to do changeover for the third floor. V17 stated V3 (Assistant Director of Nursing) gave her the nurse's keys to the second floor around 11:00 PM and then left the facility. V17 then stated that V16 (Licensed Practical Nurse) arrived to pick up the second floor's nurses keys around 11:45 PM. V17 stated she handed over the third floor's nurses keys to V16 when she left the building at 3:00 AM. V17 stated the facility has been short staffed lately, "There have been a lot of call ins." On 8/9/22 at 12:00 PM, V11 (Certified Nursing Assistant) stated she is the restorative aide, and usually does not work on the floor. V11 stated she assisted cleaning R1 up after R1 had passed away. V11 stated, "This place has been very short staffed, so I went to help clean up (R1). When I went in the room, her eyes and mouth were open, and her body was very cold. She was very, very stiff. It appeared she had been there dead for quite a while." On 8/9/22 at 12:20 PM, V12 (Certified Nursing Assistant) stated she and (V11) cleaned up R1 after she had passed away. V12 stated, "(R1) was cold and stiff. Her eyes were open and so was her mouth. The head of her bed was elevated at approximately 30 degrees and her head leaned back. She was holding onto the bed sheet." R1's medical record did not contain any documentation of a change in condition, assessment conducted or physician notification prior to R1's death on 8/1/22. On 08/04/22 at	S9999		

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12:50 PM, V1 (Assistant Administrator) confirmed nothing about R1's change in condition was charted in R1's medical record and stated, "Our charting sucks." V1 stated that R1's physician should have been notified when R1 began displaying a change in condition on the afternoon of 07/31/22. V1 stated that R1 should have been checked on at a minimum of at least every two hours. V1 stated the facility has been short staffed and it has been a challenge to fill the facility's schedule. V1 confirmed that several residents have missed showers as a result of the limited number of staff working.

On 8/11/22 at 10:35 AM, V19 (R1's Physician) stated he was never made aware of R1's change in condition on 7/31/22. V19 stated, "This is neglect. They should have called me. I cannot do anything to address the situation if I am not made aware of it. (R1) should have been checked on throughout the night. They should have checked her at a minimum every two hours."

2) R2's Minimum Data Set Assessment (dated 7/13/22) documents a Brief Interview for Mental Status score of 15, indicating that R2 is cognitively intact.

On 8/9/22 at 9:50 AM, R2 was driving his electric wheelchair on the facility's first floor. R2 was dressed and groomed and stated, "I am going to go to therapy in a few minutes." R2 stated that he has been very upset about R1's death. R2 stated that on 7/31/22 at approximately 7:30 PM, "I was in the main hall on the second floor. (R1) was in her wheelchair and was coming toward me. They (facility staff) said she was spitting on the floor. I think it is gross, but the staff say she has done this before. I have been here for over a year and never seen her do this. When she got closer to

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me, I could see blood. It was a dark red substance with little coffee ground pieces in it. It was all over her face and gown. I told the nurse she needed help and the nurse said to me, 'It is probably just chocolate pudding.' I am a grown man. I am 62 years old, and I know blood when I see it. (R1) looked bad. You could tell something was wrong with her. She was waving her arms around in the air, almost as if she was trying to say something. It was almost like she was choking, and I said that to the nurse. I don't think the nurse ever came out from behind the nurse's desk. One of the CNAs (Certified Nursing Assistants) took her to her room to clean her up and I think she put (R1) to bed afterwards. I don't think the nurse ever came out from behind the nurse's desk while all of this was going on, and I don't think they ever checked on (R1) because of the way she was found, stiff as a board. I just keep thinking about (R1), and she just had this panicked look on her face, and if you know (R1), you know that is not her normal demeanor. (R1's) was confused, so she could not tell you what was wrong, but you could tell something was wrong just by looking at her. She didn't have to die that day and shouldn't have died that way. They (facility staff) should have done something to get her some help." R2 was visibly upset and tearful throughout the interview.

On 8/15/22 at 12:50 PM, R2 was lying in bed watching television. R2 stated that he was tired, "I haven't been sleeping very much. I just keep thinking about (R1). She shouldn't have died that way."

On 8/10/22 at 2:35 PM, V18 (former Receptionist) stated the following: "(R2) came and talked to me after (R1) had died. He was so upset and tearful. He felt like he should have done something for

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S9999	Continued From page 12 (R1). He said he wanted to call an ambulance for (R1) the night she was ill, but residents are not allowed to do this. He told me that he kept telling the nurse that (R1) needs help, and she is throwing up blood. He said the nurse looked at him and told him it was pudding. He was angry about this and told me that he is 62 years old, and he knows what blood looks like. I hugged him because he was so upset. He told me he had not been sleeping well because of what happened." On 8/9/22 at 2:00 PM, V13 (Licensed Practical Nurse) stated she learned of R1's death when she arrived at work on 8/1/22. V13 stated, "I work second shift and was told (R1) had died. She was a wanderer, and she had some behaviors. I never had seen her spit on the floor. (R2) was very upset by all of this. He told me that he felt like something was wrong and it appeared to him that (R1) was vomiting up blood. (R2) is completely with it, and I encouraged him to go to management with his concerns. He was so upset." R2's current medical record including Progress Notes, Social Service Notes and Care Plan have no mention of any type of increased monitoring or follow up offered after R2 developed emotional distress from witnessing R1 display a change in condition and learning of her death. On 8/16/22 at 10:50 AM, V1 (Assistant Administrator) stated that she is aware that R2 has been having a difficult time coping after he witnessed R1 display a change in condition on 7/31/22 and learning she later passed away. V1 confirmed that no type of increased monitoring or follow up for emotional support has been offered to R2.	S9999		

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S9999	Continued From page 13 (A) #2 Statement of Licensure Violations: 300.610a) 300.1210b)4) 300.1210c)4)A)B)C) 300.1220b)1)2) 300.1230a) 300.1230b)1)2)A)B)C) 300.1230e) 300.1230f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary	S9999		

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S9999	Continued From page 14 care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary	S9999		

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S9999	Continued From page 15 for satisfactory personal hygiene. C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 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 300.1230 Direct Care Staffing a) For purposes of the minimum staffing ratios in Section 3-202.05 of the Act and this Section, all residents shall be classified as requiring either skilled care or intermediate care. (Section 3-202.05(b-5) of the Act) b) For the purposes of this Section, the following definitions shall apply: 1) "Direct care" - the provision of nursing	S9999		

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care or personal care as defined in Section 300.330, therapies, and care provided by staff listed in subsection (i). Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the facility (e.g., housekeeping).

2) "Skilled care" - skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision. (Section 3-202.05(b-5) of the Act) Skilled nursing services are either nursing or therapy care services, furnished pursuant to physician orders, that require the skills of a licensed nurse to treat, manage, and observe a resident's condition and evaluate a resident's care. The skilled nursing services may be provided by a CNA, under the supervision of a licensed nurse to ensure the safety of the patient and to achieve the medically desired result. A resident in a skilled nursing facility is classified as receiving skilled care if:

A) The resident is receiving care covered by Medicare under any arrangement allowed by Title XVIII of the Social Security Act;

B) The resident is receiving care that would be covered by Medicare, but the resident has exhausted his or her Medicare benefits; or

C) The resident is not Medicare eligible, but is receiving care that would be covered by Medicare if the resident were eligible.

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S9999	Continued From page 17 e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. f) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs per day. 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 Regulations were not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure that sufficient staff was available to meet the needs of residents. Between 7/21/22 - 8/15/22, the facility had multiple days of not meeting their minimum staffing requirements. On 7/31/22, the facility did not meet their minimum staffing requirements, R1 was put to bed around 8:30 PM, R1 was not checked on by staff for nearly 12 hours, and R1 was subsequently found deceased in bed the following morning. R1 was found in a state of rigor mortis (stiffening of the joints and muscles of a body after death) on discovery. These failures have the potential to affect all 76 residents residing in the facility. Findings include:	S9999		

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The facility's Staffing policy (revised 10/2017) documents the following: "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment."

The Facility Assessment (dated 1/26/22) documents the following: "Staffing: Review current census daily to ensure staffing needs are adequate for patient care. Due to the unique lay out of the building additional staff are needed above what would be typical for census."

On 8/10/22 at 10:30 AM, V10 (Certified Nursing Assistant) stated she worked second shift on the second floor on 7/31/22. V10 stated, "First shift said (R1) had not eaten anything and had been drooling. We tried to get her to eat dinner. We tried applesauce, and she just wouldn't take anything. She was drooling quite a bit. It just kept coming out of her mouth. I kept grabbing towels and (R1) would spit into them. After dinner, the drool had color. It was darker. It almost looked like coffee grounds. I told the nurse we should probably get (R1) checked because there is probably something wrong since this had been going on all of my shift. The nurse never sent her out. She didn't really say anything. She just told me to put (R1) in bed. By that time, (R1) had vomited a large amount and had a brownish drool. The nurse just commented on the color and said she needs cleaned up. So I took (R1) to her room and cleaned her up and then put her in bed. I went back to the nurse and told her (R1) should probably get checked out. The nurse seemed very busy with paperwork. There is a lot of charting and paperwork on the second floor since it is the Medicare floor. The nurse should of

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at least called and had (R1) sent in to get looked at, but she stayed behind the desk and did paperwork. I never saw her go check on (R1)."

On 8/10/22 at 10:35 AM, V15 (Certified Nursing Assistant) stated she worked the second floor for night shift beginning at 10:00 PM on 7/31/22. V15 stated, "I heard (R1) passed away. I didn't even know she was on the second floor that night. She was on the third floor the last I knew. I never even saw her or went in her room that night. I worked by myself that night too. I was the only aide on the second floor."

On 8/10/22 at 2:25 PM, V16 (Licensed Practical Nurse) stated the following: "July 31st was supposed to be my night off. (V3, Assistant Director of Nursing) was the nurse working on the second floor, called and begged me to come in, and I agreed. (V3) had already left the building when I arrived and she had given the nurse's keys to (V17, Licensed Practical Nurse) who was working on the third floor. I never received any report when I arrived since (V3) was already gone. There was only one CNA (Certified Nursing Assistant) on the floor, and she left early around 5:30 AM. I had no one come to replace me when I was supposed to be off at 6:00 AM, and no CNAs had come in either. (V5, Agency Registered Nurse) showed up to relieve me at 7:30 AM, and after giving him report, I left. There were still no CNAs that had shown up when I left. Since July 31st was the last day of the month, I had to do changeover of the MARs (medication administration records). This is very time consuming. The second shift nurse on the third floor (V17) stayed over to do the third floor changeover and then she left. (V17) gave me her keys when she left and then I was responsible for covering the second floor and the third floor. I

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spent the majority of the night busy doing changeover, so I was not involved in much resident care. I can tell you that (R1) was never looked at. This is the CNA's failure. Bed checks are supposed to be done at least every two hours. A responsible aide would have caught this. The CNAs are taking advantage of the staffing shortage at the facility. They come and go when they please because they know they can get away with it. The facility has been very short staffed and a lot has been getting missed lately. I know a lot of the residents have said they have not been getting showers."

On 8/11/22 at 10:12 AM, V17 (Licensed Practical Nurse) stated she was working second shift on the third floor on 7/31/22 and stayed over a few hours to do changeover for the third floor. V17 stated V3 (Assistant Director of Nursing) gave her the nurse's keys to the second floor around 11:00 PM and then left the facility. V17 then stated that V16 (Licensed Practical Nurse) arrived to pick up the second floor's nurses keys around 11:45 PM. V17 stated she handed over the third floor's nurses keys to V16 when she left the building at 3:00 AM. V17 stated the facility has been short staffed lately, "There have been a lot of call ins."

On 8/9/22 at 12:00 PM, V11 (Certified Nursing Assistant) stated she is the restorative aide, and usually does not work on the floor. V11 stated she assisted cleaning R1 up after R1 had passed away. V11 stated, "This place has been very short staffed, so I went to help clean up (R1). When I went in the room, her eyes and mouth were open, and her body was very cold. She was very, very stiff. It appeared she had been there dead for quite a while."

On 8/15/22 at 12:40 PM, R3 stated the facility has

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been extremely short staffed. R3 stated, "There was a time when I missed a shower for three weeks, and another time for two weeks. That is gross. I've been getting myself up. I do it on my own because there is no one to help me."

The facility's Shower Schedule (undated) documents R3 is scheduled to receive a shower on Mondays and Fridays during second shift.

R3's Shower Sheets (dated 6/1/22 - 8/10/22) document R3 received a shower on 6/13/22, and then not again until 14 days later on 6/27/22.

On 8/15/22 at 12:50 PM, R2 stated, "They are always running short. I pretty much do for myself because you have to wait so long to get help around here."

On 8/15/22 at 3:20 PM, R8 stated things are, "Terrible. This place is so short staffed right now. I have missed a few showers. This makes you feel so dirty. There is not enough help, and I see others that need help not get it, especially the ones who cannot speak for themselves."

The facility's Shower Schedule (undated) documents R8 is scheduled to receive a shower on Mondays, Wednesdays and Fridays during first shift.

R8's Shower Sheets (dated 6/1/22 - 8/10/22) document the following: R8 received a shower on 6/18/22, and not again until 9 days later on 6/27/22; R8 received a shower on 7/6/22, and not again until 10 days later on 7/16/22.

On 8/10/22 at 9:15 AM, R12 was propelling his wheelchair toward the exit to the smoking area on the first floor. R12's hair was unkempt and

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S9999	Continued From page 22 appeared greasy. R12 stated, "I was supposed to get a shower yesterday, and did not. They are so short staffed. It is impossible to get the help you need around here." On 8/10/22 at 1:08 PM, R9 was sitting in a wheelchair watching television. A mechanical lift sling was in place underneath her. R9 stated, "This place is pretty short staffed and at times it is hard to find help when you need it. I have missed a shower a time or two. I am a (mechanical) lift and two people are needed to use the lift to get me out of bed. I have to stay in bed sometimes because if there is only one aide on the floor, there isn't enough help to get me up." The facility's Shower Schedule (undated) documents R9 is scheduled to receive a shower on Sundays and Wednesdays during second shift. R9's Shower Sheets (dated 6/1/22 - 8/10/22) document the following: R9 was not offered or received a shower on 7/6/22, 7/17/22, 7/20/22, and 8/10/22. On 8/10/22 at 1:10 PM, R10 was sitting in her wheelchair watching television. R10 stated, "It is so short staffed around here. At times, I have to wait over 30 minutes for someone to answer my call light when I need help. The wait times seem to be longer recently." The facility's Shower Schedule (undated) documents R10 is scheduled to receive a shower on Sundays and Wednesdays during first shift. R10's (local hospice) Visit History Summary documents the following: R10 received a shower from the local hospice staff on 6/1/22, 6/8/22	S9999		

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(Shower offered but R10 declined), 6/15/22, 6/22/22, 6/29/22, 7/6/22, 7/13/22, 7/21/22, 7/28/22, 8/4/22, and 8/11/22. On 8/16/22 at 10:50 AM, V1 (Assistant Administrator) stated that she could not provide any Shower Sheets indicating the facility has offered or given R10 a shower. V1 stated, "(R10) is hospice, and hospice is doing her showers."

R6's Face sheet documents R6 with a diagnosis of Multiple Sclerosis/MS.

R6's Minimum Data Set/MDS Assessment, dated 6/6/22, documents R6 requires physical help of one person assist for bathing and extensive assistance of one-person physical assist for personal hygiene.

R6's current Care Plan documents R6 has an ADL (Activities of Daily Living) self-care deficit related to R6's MS. R6's documented goal states, "I will be clean, dressed and up daily."

The facility's shower schedule documents R6 is to receive showers every Tuesday and Friday on first shift.

R6's shower sheets, for the months of June 2022-August 2022 do not document R6 receiving showers on the following dates: 6/17/22, 6/21/22, 6/24/22, 7/1/22, 7/5/22, 7/8/22, 7/12/22, 7/15/22, 7/19/22, 7/26/22, 7/29/22, 8/2/22, or 8/11/22.

On 8/15/22 at 11:28 A.M., V25 (R6's Power of Attorney) stated, "(R6) is dependent on all cares due to her MS/Multiple Sclerosis. The facility is understaffed. (R6) has not been getting bathed, has not been getting out of bed and has not been getting wound care. She is supposed to be showered two times a week and she has not

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been getting her showers. Last month when I came to visit, she reeked of urine and her (incontinence brief) was soaked. (R6's) nails were so long and caked with dirt and filth. They don't have the staff to bathe or get these residents up. (R6) had dried feces caked in her pubic hair and vagina, it was so gross. I come here every single day now just to make sure (R6) is getting the care she needs. I have had to give her the last few baths and clean and trim her nails because no one else here is doing it. Her nails were disgusting. If I don't do it, it doesn't get done. I have even helped clean the floors of the hallways because I know (the facility staff) don't have the help they need."

On 8/16/22 at 10:50 A.M., V1 (Assistant Administrator) verified resident shower sheets should be filled out when showers are received, and that staff should be marking on the sheets if nail care was provided to the residents. V1 stated R6 should be receiving nail care during her showers.

On 8/16/22 at 4:02 P.M., V1 verified no further shower sheets/documentation could be provided to note that R6 was being showered per R6's shower schedule.

On 8/10/22 at 1:15 PM, R11 stated, "They just don't have enough help. This place needs more CNAs (Certified Nursing Assistants)."

On 8/10/22 at 1:17 PM, R13 stated, "It is very short staffed here. They are short both CNAs and nurses. I have to wait such a long time for my call light to get answered. Sometimes it is at least 30 to 45 minutes. There is a lot of staff leaving, and this is very concerning."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008866	A. BUILDING: _____ B. WING _____	C 08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NSG & REHAB CTR	767 30TH STREET ROCK ISLAND, IL 61201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25 On 08/10/22 at 1:30 PM, R7 stated, "It is pretty short staffed. I think third shift has been the worst. They get me up with a (mechanical) lift, and I have had to stay in bed a few times because they didn't have enough staff to get me up. It takes two people to use the lift and sometimes only one CNA is scheduled. I don't like being forced to stay in bed. I like being up and busy during the day." On 8/10/22 at 1:10 PM, V22 (Certified Nursing Assistant) stated, "This place is so short staffed. It is not fair to the residents. The CNA shifts aren't getting filled. It is hard to be the only one on the entire floor working by yourself. The fourth floor has 7 (mechanical) lift residents. I will not put my license on the line and attempt to get them up by myself. So, if there isn't a good nurse working that is willing to help with the (mechanical) lift residents, they have to stay in bed some days." Resident Council Minutes (dated June 2022) document the following concerns: "Staff are burnt out; There needs to be 2-3 CNAs per floor, not just one; Call lights are not being answered in a timely manner; Upset that their cares are not being met because of no staff on the floors; Residents are concerned with staff have to work multiple floors during their shift; Residents think that the CNAs who have been working here a while need a raise so they won't quit." Resident Council Minutes (dated July 2022) document the following concerns: "Scheduling is messed up; When it is close to the end of their shift, some aides refuse to give cares; Suggested that there needs to be specific aides just for showers; Call lights are not being answered in a timely manner."	S9999		

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S9999	Continued From page 26 A Grievance/Complaint form (dated 6/27/22) documents the following: "Resident called (V23, Social Service Director) upstairs to inform her that there is only one aide at this time on the floor." On 8/16/22 at 10:20 AM, V1 (Assistant Administrator) stated the following: "At a minimum, on first and second shifts, the second floor needs one nurse and one CNA (Certified Nursing Assistant) staffed; the third and fourth floors should have one nurse and two CNAs staffed. On third shift, each floor should have one nurse and one CNA at a minimum. We do like to have two CNAs if possible on third shift but can get by with one." On 8/16/22, V1 (Assistant Administrator) provided the facility's daily staffing sheets (dated 7/21/22 - 8/15/22) which document what staff members were working, and the location that they worked. V1 also provided the corresponding timesheets indicating when the employee clocked in and out for their shift. These sheets document the following: On 7/22/22, a nurse worked three hours of third shift on the third floor, leaving no nurse working for 5 hours of third shift; On 7/23/22, only one CNA was scheduled for second shift on the second and third floor; On 7/24/22 on third shift, a CNA worked for 15 minutes, leaving the fourth floor without a CNA for over 7.5 hours; On 7/25/22, 7/27/22, and 7/29/22, only one CNA was scheduled to work second shift on the second floor; On 7/29/22, the fourth floor only had one nurse working for the first hour, and then no nurse coverage for the remainder of the shift; On 7/30/22, the second floor and the fourth floor only had one CNA scheduled; On 7/31/22, the CNA working third shift on the second floor worked 6.5 hours, and there was no CNA scheduled for the	S9999		

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S9999	Continued From page 27	S9999		

last 1.5 hours of the shift; On 7/31/22, the facility's third floor had a nurse work for 4.75 hours, leaving the remaining 3.25 hours with no nurse working; On 8/2/22 and 8/3/22, no nurse was scheduled to work third shift on the second floor; On 8/4/22, only one CNA was scheduled to work second shift on the second floor; On 8/4/22, a nurse worked 2 hours of third shift on the third floor, leaving the third floor without a nurse for 6 hours, and a CNA worked 6.75 hours, leaving the floor without any direct care staff for 1.25 hours; On 8/6/22, only one CNA was scheduled to work second shift on the third and fourth floor; On 8/7/22, only one CNA was scheduled to work first shift on the second floor, and one CNA worked 6 hours of third shift on the fourth floor, leaving the fourth floor with no CNA coverage for 2 hours; On 8/8/22, only one CNA was scheduled to work second shift on all three floors, and one CNA worked 6 hours on third shift on the third floor, leaving the third floor without a CNA for 2 hours; On 8/9/22, no nurse was scheduled to work first shift on the fourth floor; On 8/10/22, no nurse was scheduled to work third shift on the third floor; On 8/12/22, no CNA was scheduled to work third shift on the third floor; On 8/13/22, only one CNA was scheduled to work second shift on the second floor; and on 8/15/22, a CNA worked 4.5 hours of third shift on the second floor, leaving no CNA for 2.5 hours.

On 8/16/22 at 10:40 AM, V1 (Assistant Administrator) confirmed that the facility has been short staffed and confirmed that at times, the facility goes without Nursing and CNA coverage on the resident floors. V1 stated that she had received multiple concerns from the residents regarding the facility's staffing and direct care not being completed. V1 confirmed that several residents have missed showers due to limited

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S9999	Continued From page 28 staff. V1 stated, "I do not do anything with the CNA schedule. (V21, Administrator/Owner) has not allowed me to touch it. I haven't dealt with the nurse's schedule for at least 6 months. (V2, Director of Nursing) schedules the nurses." V1 stated that management can cover when there is a hole, and stated, "They (management staff) can cover an open shift, but it doesn't make sense for management to come in on night shift and just sit there when the residents are sleeping, and then we do not have them in the building for their management duties the following day." The Resident Roster (dated 8/4/22) documents 76 residents resided in the facility at the time of survey. (A)	S9999		