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	IL6008510	A. BUILDING: ______ B. WING ______	C 02/03/2023

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S 000	Initial Comments Complaint Investigations: 2360575/IL155597 & 2360869/IL155953	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)3 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

These Requirements were not met as evidenced by:

The failures at this level require more than one deficiency statement.

A.) Based on record review and interview the facility failed to supervise a resident with suicidal ideation, failed to implement the facility suicide watch policy and failed to initiate care plan interventions after R1 verbalized intentions of killing R1's self. Theses failures resulted in R1 continuing to experience thoughts of self harm and then attempting to strangle R1's self with call light and bed control cords. These failures affect one (R1) of five residents reviewed for accidents in a sample list of 31 residents.

Findings include:

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a. R1's Nurse Progress Note dated 1/3/23 at 11:34 PM documents "Found (R1) in his bed with two call lights and bed control cords wrapped around (R1's) neck. R1's Nurse Progress Note dated 1/4/23 at 7:00 AM documents R1 was sent to the emergency room for psychiatric evaluation.

R1's undated Face Sheet documents R1 admitted to facility on 10/6/22 with medical diagnoses of Surgical Aftercare following Surgery on the Nervous System, Spinal Stenosis, Muscle Weakness, Muscle Wasting and Atrophy, Malignant Neoplasm of the Prostate, Rheumatoid Arthritis, Major Depressive Disorder and Anxiety.

R1's Minimum Data Set (MDS) dated 1/13/23 documents R1 as cognitively intact. This same MDS documents R1 as requiring extensive assistance of one person for bed mobility, transfers, dressing, and toileting, supervision with eating, and limited assistance of one person for personal hygiene.

R1's current Care Plan does not document a focus area, goal nor interventions for risk of abuse. R1's Care Plan documents a focus area of 'Risk for harm to self or others' dated 10/7/23. R1's Care Plan does not document any added interventions from 10/7/22-1/4/23.

R1's Nurse Progress Note dated 12/20/22 at 10:55 AM documents "(R1) was making suicidal comments, was crying. (R1) wanted to hurt himself with the call button cord. (V18) Licensed Practical Nurse (LPN) went to (R1's) room to check on (R1). (R1) stated 'December was supposed to be my month of healing, my sister canceled my trip to Michigan, the beginning of the year was filled with sadness, loneliness'. (R1)

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S9999	Continued From page 3 stated 'I am working in therapy, and nothing is working'. (V18) asked (R1) if wanted to hurt himself. (R1) responded 'I feel hopelessness. There is nothing for me here.' " R1's Nurse Progress Note dated 12/27/22 at 9:20 PM documents "(R1) was really tearful and sad all day. During medication pass (R1) refused medications. (R1) stated 'I do not want my medication, food or water. I am just going to let mother nature take its course with this body'. Encouraged to think positive. (R1) refused and stated, 'just wants to die and wanted to be left alone.' " R1's Nurse Progress Note dated 12/30/22 at 8:52 AM documents "(V31) (R1's family) called in relation to new referral to see in-house psychiatrist. Questions and concerns addressed." R1's Nurse Progress Note dated 1/2/23 at 7:15 AM documents "(R1) lying in bed crying. Stating that "this is no quality of life". (R1) stated that he was tired of just taking drugs and not feeling normal. Non-pharmacological interventions: distraction and conversation. Summary: (R1) was wanting to not take medication anymore due to feeling out of sorts." R1's Nurse Progress Note dated 1/3/23 at 11:34 PM documents "Found (R1) in his bed with two call lights and bed control cords wrapped around (R1's) neck. (R1) stated this is where all of his problems started, that this is where they will all end. (R1) unhappy about his medical diagnoses, the amount of medication he is taking, not being able to go to his own home, being denied going to his sister's for Christmas. Non-pharmacological interventions: Conversation and distraction. Summary: (R1) made aware of why cords were	S9999		

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removed at this time. (R1) does not wish to be sent out to the hospital but also does not have any hope of living at this time."

R1's Nurse Progress Note dated 1/4/23 at 7:00 AM documents "Spoke with (V1) Administrator and (V1) stated to call the doctor about (R1's) current mood state. Once off the phone with (V1), called the on-call Physician. On call Physician called back and stated (R1) needed to be sent to emergency room for psychiatric evaluation. Family was notified and is ok with sending (R1) out."

R1's Nurse Progress Note dated 1/11/23 at 12:33 PM documents "(R1) told staff that he did not see any point in living anymore. (R1) states he would like to stop eating and just close his eyes and go to sleep and not wake up. (R1) has one on one in room at this time."

R1's Nurse Progress Note dated 1/11/23 at 5:43 PM documents "(R1) stated he'd rather die than take those things (medications) that allow us to control him. Summary: (R1) continues to verbalize suicidal thoughts and thoughts of death."

R1's Nurse Progress Note dated 1/16/23 at 9:35 AM documents "Sent a referral packet to Psychiatric Service on 1/11/23. (R1) was approved and is on the list for counseling services."

R1's Electronic Medical Record (EMR) does not document R1 was placed on suicide watch per facility policy and does not document notification to V40 Physician of R1's statements on 12/27/22 and 1/2/23.

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On 1/27/23 at 11:45 AM V28 Certified Nurse Aide (CNA) stated "I am (R1's) CNA today. (R1) is not on any kind of 15-minute checks or continuous observations. Nobody has been watching (R1). I have seen (R1) a couple of times this morning. (R1) has either been in his room or roaming around facility in wheelchair. I think (R1) is in the dining room now. I will have to check."

On 1/26/23 at 1:35 PM R1 stated "I have had Depression for many years. I have taken medicine for it for many years. I have gotten to the point lately where I just do not want to live anymore. The medicine does not seem to help. I thought December would be better, but I feel worse now than ever. They (staff) told me now I have Parkinson's Disease. Sometimes I just feel like there is no hope."

On 1/26/23 at 12:25 PM V2 Director of Nurses (DON) stated "(V20) Licensed Practical Nurse (LPN) should have sent (R1) out to the emergency room as soon as she was aware (R1) attempted suicide. Instead of calling the doctor and Power of Attorney (POA), (V20) called (V21) Dementia Coordinator who was the nurse manager on call that night. (V21) instructed (V20) to monitor (R1). I would have sent (R1) directly to the emergency room for evaluation."

On 1/27/23 at 1:00 PM V22 Registered Nurse (RN)/Assistant Director of Nurses (ADON) stated "I came into work on 1/4/23 and saw the cords sitting on the nurses desk so I asked (V20) what was going on. (V20) told me that (R1) had tried to commit suicide earlier in her shift and she was told by (V21) to remove the cords from (R1's) room so she did. When (V20) told me that I immediately told (V21) to call (R1's) physician, Power of Attorney (POA) and facility

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Administrator. I told (V21) 'I need you to call right now' and (V21) started making phone calls. We (staff) sent (R1) out to the emergency room for evaluation."

On 1/26/23 at 1:30 PM V21 Dementia Coordinator/Nurse Manager stated "I was on call the night (R1) attempted suicide. (V20) LPN called me and told me the staff had found (R1) laying in (R1's) bed with all the cords wrapped around (R1's) neck. (V20) told me (R1) was ok so I told (V20) to keep a close eye on (R1) by increasing visual checks. I did not tell (V20) to place (R1) on continuous monitoring or send to the emergency room. I did not notify (V1) Administrator, (V2) Director of Nurses or anyone else. I just told (V20) to make sure nothing was in reach. I should have had (V20) send (R1) out immediately and make all the notifications. (V2) DON brought all the managers together in the conference room on 1/4/23 and inserviced us on what to do when a resident attempts suicide and the suicide watch protocol."

On 1/26/23 at 1:45 PM V24 Social Service Assistant (SSA) stated R1 was referred for therapy for Depression after the 1/3/23 attempted suicide. V24 stated "We (facility) do have (V25) Licensed Clinical Social Worker come out to facility. (V25) has been coming to facility for over a year to visit with residents. After (R1) attempted suicide we (staff) started doing one to one visits with (R1). (R1) was first seen by (V25) on 1/13/23. (R1) did not see any other therapists or psychiatrists prior to (R1) attempting suicide. We (staff) knew (R1) was depressed because he would cry, refuse medications and make statements about how lonely and sad he was. We (staff) should have gotten (R1) help sooner."

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S9999	Continued From page 7 On 1/27/23 at 2:45 PM V2 Director of Nurses (DON) stated "(R1) does have a history of Depression. (R1) has made comments indicating or stating (R1) wants to kill himself. We (staff) did not respond as we should have. We (staff) should have not given (R1) his call light after he said he wanted to use it to harm himself. We (staff) should have tracked and monitored (R1's) behaviors. We (staff) should have updated (R1's) Care Plan on 12/20/22 after (R1) made the comment that he wanted to use the call light to kill himself. We (staff) should have gotten (R1) a referral for psychiatric services sooner than we did. We (staff) should have placed (R1) on suicide watch after each statement of (R1) wanting to harm himself. The suicide watch policy was completely disregarded. We (facility) have failed (R1) in many ways. We are in the process of fixing those problems but they should have never happened in the first place." The facility policy titled 'Suicidal/Violent Residents' revised 11/01/05 documents "Policy: This facility offers initial management stabilization and transfers when needed, to residents with psychiatric emergencies. A psychiatric emergency is an urgent, serious disturbance of behavior, affect, or thought that makes the resident unable to cope with life and/or personal relationships. Psychiatric emergencies may include, but are not limited to overactive, violent or suicidal residents. Verbalization of "wishes to die", "I wish I was dead", and other remarks or actions leading staff to believe the resident is suicidal will automatically trigger a suicide watch. This will require Physician and Power of Attorney (POA) notification and a every 30-minute charting sequence to be initiated. This will be reevaluated every 12 hours until Physician discontinues such a requirement. Procedure: 6. Facility supervisor	S9999		

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in charge will notify (V2) Director of Nurses (DON)/(V1) Administrator. They will instruct the nurse to notify psychiatric hospital to prepare the resident for immediate psychiatric consultation and hospitalization."

B. Based on record review, observation and interview the facility failed to ensure a resident was properly positioned in a wheelchair and failed to correctly implement a fall intervention for one of five residents (R10) reviewed for accidents on the sample list of 31.

Findings include:

b.) R10's Face Sheet dated on admission 2/18/2020 documents the following diagnoses: Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, and Osteoporosis Without Current Pathological Fracture.

R10's Minimum Data Set (MDS)dated 11/3/22 documents R10 is severely cognitively impaired, totally dependant on two staff for transfers and requires extensive assistance with mobility on unit.

R10's "Fall" incident report investigation, dated 1/4/23 documents the following: "Witness statement of what happened written by (V53 Certified Nurses Aide) entered by (V22, Assistant Director of Nursing/ADON) on 1/6/23. While attempting to reposition resident (R10), resident leaned back sliding forward in (the) chair, and staff member lowered resident to the floor." The same report documents: Conclusion, IDT (Interdisciplinary Team) met and reviewed, resident (R10) observed on the floor "ROOT CAUSE' slid to the edge of the chair while CNA (V53) was pushing her (R10) back to her room,

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CNA lowered her (R10) to the ground. 'INTERVENTION' (non-skid material) in wheelchair." The same report documents: "Root Cause, Due to resident action or internal factor."

On 2/2/23 at 4:10 pm V53, stated "I (V53) was the CNA that assisted (R10) the day (1/4/23) she (R10) fell out of the wheel chair." V53 stated the following: "It basically happened after lunch. I wasn't the CNA that fed (R10), or cared for (R10), I (V53) was just helping out. I (V53) saw her (R10) awake, out in the lounge on West hall. I (V53) could see she had slid down in her wheelchair, some. Her (R10's) shoulders were low and up against the wheel chair back. Her (R10) butt must have been closer to the front edge of the seat, than I thought. (R10) was covered in a blanket. Basically, I (V53) could not see how far she (R10) was scooted forward. Basically, I (V53) should have checked (to see how far forward R10 had scooted in the wheel chair). Basically, I started to push (R10's) wheelchair down to her room. (R10) had scooted more, so I hurried to get her back in her (R10's) room. I (V53) was only about one room from hers. I pushed (R10's) wheelchair really fast into her room. I needed to catch her before she fell out (of the wheelchair). I grabbed the back of her waistband and (R10's) shoulder started to lean back farther. By then I was basically at the side of her (R10's) wheelchair. I pushed the wheelchair backwards, out of the way. Basically, (R10) slid the rest of the way to the floor, basically down my leg. (R10) did not have a wheelchair chair cushion in her wheelchair that I saw. It (wheelchair cushion) may have slide out of the wheelchair with her (R10). (R10) does not stand. Her (R10's) cushion may have been under her on the floor, I don't know for sure. I just know it was not in her chair. I went to get (V22, ADON). She

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(V22, ADON) basically, came and took care of her (R10)."

On 2/2/23 at 2:40 pm R10 was laying in a low bed with scoop mattress. R10 was pleasantly confused. R10's wheelchair had a 12 inch by 12 inch piece of non-skid material on top of the wheel chair slick, polyester covered cushion. The wheel chair, cushion sat directly on the vinyl wheel chair seat. The wheelchair cushion slid easily front to back and did not have non-skid material. V16, CNA confirmed the non-skid material on the top of the wheel chair cushion and stated "I don't know why that (non-skid) is on top instead of under the cushion. It does not stop the cushion from slipping right off the wheel chair."

On 2/2/23 at 2:47 pm V22, Assistant Director of Nursing (ADON) assessed R10's wheelchair and stated "I don't know a lot about this. I can see this cushion slides all over the place. That doesn't work. The (non-skid material) should be under the cushion I'd say. Or maybe both on top and below the cushion, because R10 does scoot down in her wheel chair."

(B)