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S 000	Initial Comments Complaint Investigation: 2391254/IL156417 Investigation of Facility Reported Incident of January 20, 2023/IL155939	S 000		
S9999	Final Observations Statement of Licensure Violations I of III. 300.610a) 300.680a) 300.680c) 300.1010h) 300.1210b) 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 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident	S9999	Attachment A Statement of Licensure Violations	

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cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel.

c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience.

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
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

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S9999	Continued From page 2 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview and record review, the facility failed to follow their abuse policy by failing to prevent an incident of staff to resident physical abuse. This affected 1 of 3 residents (R3) reviewed for abuse. This failure resulted in R3 being aggressively pushed in back into her wheelchair. R3 was subsequently sent to the local hospital and was assessed to have sustained a strained neck muscle. B. Based on observation, interview and record review, the facility failed to follow their policy on physically restraints. This affected 1 of 3 residents (R3) reviewed for restraints. This failure resulted in R3 being physically tied to a wheelchair with plastic garbage bags, restricting R3 right to move freely. Using the reasonable person theory R3 would have been embarrassed and humiliated by be tied to a wheelchair with plastic bags. Findings Include: R3 was admitted to the facility on 8/12/22 with a diagnosis of unspecified dementia, with other	S9999		

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behavioral disturbances, generalized anxiety disorder, scoliosis, fusion of spine, spinal stenosis, osteoporosis without current pathological fracture and history of falling. R3's minimum data set dated 11/23/22 documents a brief interview for mental status score 03/15 which indicates severely impaired cognition. R3's care plan dated 8/16/22 document R3 has a diagnosis of dementia with behavioral disturbances. Interventions: allow adequate time for resident to respond; maintain a calm environment and approach to the resident; provide reassurance as needed to help the resident safe and secure. R3's screening for abuse dated 2/21/23 documents under risk measure for the likelihood of previous/recent mistreatment and potential future problems/symptoms related to mistreatment: a score of 1 which indicate low.

On 2/21/23 at 3:01pm, V18 (Certified Nurse Assistance/CNA) said, R3 was sitting behind the nursing station. R3 kept trying to stand up. V19 (Nurse) grabbed R3's wheelchair and slam it forcibly hard against the wall. R3 kept trying to stand up. V19 (Nurse) tied two clear plastic garbage bags together, wrapped the bags around R3, underneath R3's breast and tied it to the back of R3's wheelchair. R3 was tied to her wheelchair for fifteen minutes. I took the plastic bags off R3 and place them in the second draw behind the nursing station on the right side.

On 2/21/23 at 3:30pm, the surveyor requested, V26 (Nurse) to open the second draw on the right side behind the nursing station, two clear white long plastic bags similar to garbage bags were tied together in a knot.

On 2/21/23 at 3:40pm, body assessment

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S9999	Continued From page 4 completed by V20 (Nurse). R3 was observed with a liner redden area located on the upper back to the right of R3's spine. V20 said, R3 did not have that mark on her back yesterday. On 2/21/23 at 4:08pm, R5 who was assessed to be alert and oriented to person, place, and time, said V19 crossed the lines, R3 had to go to the bathroom. V19 grabbed a bag, tied it around R3 waist and tie R3 to her wheelchair. R3 started yelling, stop, stop it. R3 doesn't and won't remember the incident. On 2/21/23 at 5:30pm, the surveyor observed video recording with V1 (Administrator). V1 identified all staff and resident on the screen. The video recording of V19 and R3 was dated 2/16/23 at 4:43pm. R3 was observed in the dining room sitting at a table. R5 was sitting directly in front of R3. R3 attempted to stand up from her wheelchair multiple times. V18 ran to R3. R3 sat back down. V19 took R3 to another table, placed the back of R3's wheelchair to the wall and slid the table up R3's body. R3 was observed with no room to move between the wall and table. V19 left the dinning, returned with a long white plastic bag in hand. V19 wrapped the bag under R3's breast and tied it to the back of R3's wheelchair. On 2/22/23 at 5:19pm, V25 (R3's POA) said, I watch the video with R3 and V19. V19 was seen pushing R3 down forcibly in the wheelchair by her shoulder after R3 attempted to stand-up form the wheelchair. V19 tied a garbage bag around R3 and tied it to R3's wheelchair. R3 had attempted to stand-up from the wheelchair prior to being tied. V19 look so angry on the video. I requested for R3 to go to hospital on 2/18/22. R3 was frightened. R3 looked out of sorts and upset. I was upset about the incident.	S9999		

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S9999	Continued From page 5 On 2/23/23 at 2:06pm, V29 (Medical Doctor) said, I was not informed R3 was restrained with a plastic bag and tied to the wheelchair. No human should be restrained like that. R3 had Dementia and was recovering from a hospitalization with Sepsis. Restraining R3 was not good to do and would have increased R3's agitation and made R3 upset. R3 could have hurt herself. Initial Report dated 2/17/23 documents: V18 (CNA) alleged V19 (Nurse) improperly used restrain. Local police department report dated 2/17/23 at 16:47 documents under nature of complaint: battery. Under narrative: The following is a general summary of my recollection of events and all conversations are not verbatim. In summary dispatched to facility for a complaint of elder abuse. Upon arrival, V1 (Administrator) related that on 2/16/23 V18 (CNA) came into the office and wanted to file a complaint about improper use of restraints on elderly resident. V19 (Nurse) used a piece of plastic to restrain R3's abdomen when she began attempting to stand up during mealtime. V1 further related that V19 admitted to using a piece of plastic to restrain her (R3) abdomen due to not having immediate access to proper abdomen restraint. Video footage was reviewed on 2/18/23 with observations of R3 attempting to stand up multiple times. The third time R3 attempted to stand up, V19 can be seen entering the room visibly upset. V19 returns R3 to the dining room and returns with two (2) clear plastic garbage bags tied together. V19 proceeds to tie R3 around her chest to the wheelchair with two garbage bags. V18 (CNA) contacted via phone and reported that V19 (Nurse) became increasing irritated with R3 and at one point	S9999		

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S9999	Continued From page 6 pushed R3's wheelchair causing R3 to crash into the wall. Video footage was reviewed on 2/18/23 with observations of R3 attempting to stand up multiple times. The third time R3 attempted to stand up, V19 (Nurse) can be seen entering the room visibly upset. V19 aggressively shoves R3 into the wheelchair using his right hand. V19 (Nurse) then wheels R3 into the hallway where V19 can be observed yelling in R3's face while pointing in her face with his finger. V19 makes a second lunging motion towards her, however due to the lack of camera angles, its undetermined if the lunge was an additional shove. R3's hospital record dated 2/18/23 documents: R3's family was notified yesterday that patient (R3) was forcibly pushed down, and that the patient was restrained using a plastic bag by staff member at the nursing home on Thursday. He reports R3 had been complaining of neck pain which prompted visit today. Currently R3 denies any neck pain. Although R3 was denying pain initially, later did complain of some low back pain. Was offered Tylenol but declined. Hospital diagnosis: strain of neck muscle. Under neck sprain or strain documents: A sudden force that causes turning or bending at the neck can cause sprain or strain. Skin assessment dated 2/21/23 documents: redness which measured 1.2 cm (length) X 1.2cm (width) x no depth. Facility policy regarding physical restraints undated documents: In compliance with state and federal regulations, this facility is committed to limiting and reducing the use of physical restraints. The use of physical restraints shall be limited to situations necessary to maximize the resident's physical, mental and psychosocial well-being and to treat the resident's medical	S9999		

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S9999	Continued From page 7 symptoms. It shall be the policy of this facility that physical restraints shall not be applied for the purposes of punitive actions against a resident or for staff convenience. Physical restraint means any manual method or physical or mechanical device, equipment or material that meets all the following criteria: is attached or adjacent to the resident's body; cannot be removed easily by the resident (resident is able to remove the device the same manner it was applied to by the facility staff); restricts resident freedom of movement or normal access to his/her body. Convenience means actions taken by the facility to control resident behavior or maintain a resident, is not in the resident's best interest, with less effort or expense than would otherwise be required by the facility. Facility abuse final report dated 2/23/23 documents under investigation documents: On Saturday police officer returned to view footage. Officers watched the alleged interaction where the restraint was being applied by the nurse. The officer asked to see additional footage from earlier during the day before restraint was applied. At that time, V1 saw on the tape that V19 (Nurse) appeared to use force to her (R3) right shoulder to get R3 to sit back on her wheelchair after she (R3) was repeatedly trying to stand. The investigation also revealed that V19 did not follow the restraint policy and applied a plastic bag. During the course of the investigation, it was also discovered that V19 used force to encourage R3, who was a fall risk to remain in her wheelchair. While the facility believes that V19 actions were intended to protect the resident (R3) from a fall, the application of force violates facility policy and standards. V19 will be terminated. Abuse policy revised 10/2022 documents: The	S9999		

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S9999	Continued From page 8 facility affirms the right of our residents to be free from abuse. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental mean. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical Abuse is the infliction of injury on a resident that occurs other than by accident means and that requires medical attention. Physical abuse includes hitting. Slapping, pinching, kicking, and controlling behavior through corporal punishment. "A" Statement of Licensure Violations II of III. 300.610a) 300.1210b)3) 300.1210d)2)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	S9999		

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S9999	Continued From page 9 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. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor and recollect a contaminated	S9999		

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urine culture sample for a resident with an indwelling catheter and a history of urinary tract infections. This affected 1 of 3 (R1) residents reviewed for physician orders. This failure resulted in R1 who was observed with purulent urine, abnormal urinalysis, and low urine output, being hospitalized for complicated catheter associated urinary tract infection with sepsis present on admission and pseudomonal bacteremia secondary to urinary tract infection.

Findings include:

R1 admitted to the facility on 2/5/22 with a diagnosis of urinary tract infection, multiple scleroses, sepsis, and neuromuscular dysfunction of the bladder.

R1's minimum data set dated 1/2/23 documents a brief interview for mental status score of 13/15 which indicates cognitively intact.

R1's laboratory report dated 1/26/23 documents under urine culture: mixed flora more than 100,000 count. Multiple bacterial morphotypes present, possible contamination. Suggest a recollection if clinically indicated. Urinalysis dated 1/25/23 documents under bacteria many and leukocytes large.

R1's nurse practitioner progress notes dated 1/24/23 documents: Patient reports having (indwelling catheter) changed over the weekend due to being dislodged. Nursing notes indicate (indwelling catheter) was changed last night due to leaking. (Indwelling catheter) to gravity, urine purulent, yellow in tubing. Do not change (indwelling catheter) for leaking. Ok to flush if possibly clogged. (Indwelling catheter) only to be changed only monthly or if dislodged. Urinary

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tract infection-purulent output in (indwelling catheter). Checking urinalysis with culture and sensitivity.

R1's nurse practitioner progress notes dated 1/26/23 documents: Patient states that she had (indwelling catheter) changed last night due to leaking. Urine specimen was sent to the lab. Under genitourinary documents: positive leaking. Under assessment and plan: leaking (indwelling catheter) monitor urinary output, urinalysis 1/25 positive for large leukocytes and many bacteria; urine culture showed mixed flora- contamination-will recollect; no leukocytosis, no fever; will educate nursing staff to not exchange (indwelling catheter) every time is leaking; may flush (indwelling catheter) if concerned for clogging.

R1's February 2023 medication administration record for (indwelling catheter) output every shift document on 2/4/23 700-300pm shift 350ml, 300-1100pm shift 100 ml,11-7am shift medium. On 2/5/23 700-300pm shift 200ml, 300- 1100pm shift 60 ml,11-7am shift medium. No documentation for 2/6/23 am shift.

R1's progress note dated 2/6/23 at 6:52AM documents: This morning states her abdomen has colic and cramps. Abdomen somewhat distended with some tympany noted. States the last bowel movement when given a shower a few days ago. Positioned to the left side of her body and will request assistance to place her on the commode for relief.

R1's progress notes dated 2/6/23 at 3:47PM documents: Writer found the patient with altered mental status, tachycardia, and fever. Referred to nurse practitioner with order to send resident to local hospital for evaluation. Picked up at

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S9999	Continued From page 12 1:48PM. R1's hospital record dated 2/6/23 documents under discharge diagnosis: complicated catheter associated urinary tract infection with severe sepsis present on admission (POA), acute metabolic encephalopathy, pseudomonal bacteremia secondary to urinary tract infection. R1's hospital record dated 2/6/23 documents: bed side ultrasound utilized, does have a distended bladder with indwelling foley catheter, concern for urinary retention, possibly clogged foley catheter. Under hospital course side ultrasound, patient does have a significant urine in her bladder. On 2/21/23 at 11:28AM, V2(Assistant Director of Nurses/ADON) said nurse practitioners will verbally inform nurse on duty of any new orders and nurse would be responsible for carrying out the order. V2 said she is not sure what happened and possibly a miscommunication for why R1's urine culture was not recollected. V2 said nurses are responsible for documenting amount of urine at the end of the shift. Urine output 200 ml or less she would expect nurses to check the foley, check for abdominal distention and notify doctor of changes. On 2/22/23 at 10:00AM, V13(Physician) said for R1's urine culture with mixed flora, they would not start treatment but would have re-culture the urine to rule out infection. V13 said he would expect the physician's orders to be followed. V13 said he was not sure and would not be able to determine if the facility's failure of not rechecking R1 urine led to her hospitalization for urinary tract infection and sepsis. V13 said urine output less than 150 ml during an 8-hour shift would be abnormal and would expect to be notified.	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 Facility policy titled Physicians orders revised 5/17 documents: the nursing staff member or the one assigned to the resident is responsible to transcribe the order. Transcribing the order includes completing laboratory requests. For facilities on electronic health records. Orders must be promptly entered into the computer. Facility policy titled catheter insertion and maintenance revised 10/22 documents: to maintain constant urinary drainage based on physician order. Maintain a closed urinary system to prevent introduction of bacteria into urinary tract. Measure drainage at the end of each eight-hour shift, if ordered, unless more frequent measurement has been ordered. "A" Statement of Licensure Violations III of III. 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 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	S9999		

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	IL6006837	A. BUILDING: _____ B. WING _____	C 02/28/2023

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S9999	Continued From page 14 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their fall policy and plan of care by not using a mechanical lift for transfers. This	S9999		

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affected 1 of 3 (R2) residents reviewed for safe transfers. This failure resulted in R2 sustaining a fall with a large hematoma, swollen left knee and an oblique fracture of the proximal tibia that required hospitalization and surgical interventions.

Findings Include:

R2 was diagnosis with hemiplegia and hemiparesis following cerebral infraction affecting left non-dominate side and history of falling. Brief interview for mental status dated 1/12/23 documents a score of nine which indicates moderately impaired. Section F (functional status) dated 1/12/23 documents: R2 is total dependent with two plus physical assist with transfers. R2 has impairment on one side to the upper extremity (shoulder, elbow, wrist, hand) and impairment on both sides to the lower extremities (hip, knee, ankle, foot). Care plan dated 1/2/23 documents R2 had inability to transfer self and is at risk for ADL decline related to muscle weakness. R2 requires two staff assist with use of mechanical lift for transfers.

On 2/17/23 at 12:01pm, R2 who was assessed to be alert to person, place and time said, I was being assisted from my wheelchair to the bed by V8 (Certified Nurse Assistant/CNA) and V10 (CNA). V8 and V10 were on each side of me, both V8 and V10 were holding me under my arm, no gait belt or mechanical device was used. V8 and V10 lifted me up from my wheelchair, I lost my balance and fell. I fell on the floor, on my buttock with my leg bent under my body.

On 2/17/23 at 4:08pm, V8 said V10 help me put R2 in bed. V10 lifted R2 from the wheelchair by placing his arms under R2 arms like a forklift.

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V10 picked R2 up without using a gate belt or mechanical lift. V10 sat R2 up on the bed, R2's legs did not come with R2's body. I grabbed R2's leg and swung them with R2's body. We did not use the mechanical lift due to R2 not having the sling pad under her buttock while sitting in her wheelchair. It would have been impossible to get a pad under R2 while in the sitting position in her wheelchair. We did not use a gait belt either. Anytime, I need to transfer R2 from the wheelchair, I always get help from a male staff member to assist with lifting R2. I have not had any training on transfers or fall prevention.

On 2/21/23 at 1:57pm, V15 (Occupation Therapist) said, R2 can't transfer from the wheelchair to the bed without a mechanic lift. A two person assist without a gait belt due to R2's limited mobility and strength would be unsafe.

On 2/21/23 at 12:08pm, V27 (Nurse Practitioner) said, an oblique fracture tibia is caused by a direct landing with the knee in a flex position on a hard surface. R2 is dead weight. R2 can't stop or support herself with any momentum. R2 is not a candidate for a two-person transfer. R2 does not have strength. R2 is alert and orient times three (person, place, and time).
New Employee (V8) Orientation Check List no date documents: V8's Initial for fall prevention and no trainer initial was documented.

Fall risk assessment dated 1/12/23 documents: R2 is a high fall.

R2's fall incident dated 1/21/22 documents: Type: fall Location: resident room, Activity: Transfer: Cognition prior to and after occurrence: Oriented X3. Injuries: Left lower leg skin discoloration: Notes: CNA informed writer that this resident (R2)

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S9999	Continued From page 17 leg does not look too good. R2's left lower extremity was noted to have increased edema and discoloration. R2 stated, I slipped off my wheelchair yesterday. Transfer form dated 1/21/23- R2 was transferred to the hospital due to left knee swelling and bruising. Hospital papers dated 1/21/23 documents: R2 presented to the emergency room from the nursing home for evaluation of the left knee hematoma that was painful to touch. R2 said, she had a fall yesterday. R2 had left weakness and flaccid, bilateral leg weakness, left knee with large hematoma, and was swollen. Bruising and erythema (redden) present. Knee X-ray dated documents: oblique fracture of the proximal tibia (The proximal tibia is the upper part of the shinbone that connects to the knee joint) extending from the medical margin superior. Preoperative diagnosis documents: Left displaced medial tibial plateau fracture, left displace tibial tubercle fracture with patellar tendon avulsion (tendon rupture) and left lower extremity hematoma with skin threatening. Procedure performed was an open reduction and internal fixation left tibial plateau, open reduction and internal fixation left tibial tubercle and incision and drainage of deep hematoma left tibia. Fall policy dated 10/2022 documents: It is the policy of the facility to have a fall reduction program that promotes the safe of resident in the facility. The program's intent is to assist clinical staff in determining the needs of each resident through the use of standard assessment, the identification of each resident's individual risks, and the implementation of appropriate	S9999		

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S9999	Continued From page 18 interventions, supervision and/or assistive device deemed appropriate. Example of standard fall/safety precautions that may be applicable. #1. Staff will be oriented and trained in the fall reduction program. #12. Transfer conveyance shall be used to transfer resident in accordance with the plan of care. "A"	S9999		