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	IL6013353	A. BUILDING: _____ B. WING _____	C 05/11/2023

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S 000	Initial Comments Complaint Investigation 2393578/IL159304 2393262/IL158888 Facility Reported Incident of 03/30/23 and 04/06/23/IL158986	S 000		
S9999	Final Observations Statement of Licensure Violations: (Violation 1 of 3) 300.610a) 300.1210b)5) 300.1210c) 300.3240a) 300.3240c) 300.3240g) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 300.1210 Section 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: 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. 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term	S9999		

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S9999	Continued From page 2 Care Facility Residents Reporting Act. These requirments were not met as evidenced by: Based on interviews and record reviews, the facility failed to follow their policy and procedures for abuse prevention by not ensuring agency staff caring for a resident who is at risk for abuse was thoroughly informed about the resident's care needs prior to initiating care and by not ensuring staff provided care consistent with standards of practice to prevent pain or injury. This failure applied to one (R1) of three residents reviewed for abuse and resulted in R1 sustaining a fracture which required surgery after being provided with care from staff. Findings include: R1 is a 97-year-old female with diagnoses history of Alzheimer's Disease, Dementia w/o Behavioral Disturbance, Vitamin D Deficiency, Bilateral Primary Osteoarthritis of Knee (effective 07/23/2021), Personal History of (Healed) Pathological Fracture (effective 08/02/2021), and Personal History of (Healed) Traumatic Fracture (effective 07/22/2021). R1's Quarterly Minimum Data Set dated 02/20/23 and Significant Change Minimum Data Set dated 03/29/23 documents she has a Brief Interview for Mental Status score of 03 (severe cognitive impairment). R1's most current care plans initiated 07/23/2021 document R1 is at risk for falls related to previous fall with fracture prior to admission, dementia, poor safety awareness, legally	S9999		

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blind, R1 has a behavior of crawling out of bed and scooting on the floor with interventions including floor mats while in bed, use low bed; R1 has potential for pain related to Osteoarthritis of bilateral knees, impaired cognition, history of fracture, a-fib, Diabetes Mellitus and generalized pain with interventions including Assess pain every shift, Monitor for nonverbal indicators of pain daily with care tasks and activities, Administer pain strategies according to Medication Administration Record / Treatment Administration Record.

R1's most current care plan initiated 07/28/21 documents she is at risk for abuse related to a diagnoses of severe mental illness and/or dementia with interventions including: at onset of behavior, calmly and firmly attempt to redirect to socially acceptable behaviors, check and assure physical comfort, maintain a calm soothing approach/environment and smile/pay compliments to promote feelings of belonging and importance with resident.

R1's most current care plan initiated 11/23/22 documents R1 is receiving an antidepressant psychotropic medication, she is noted to have diagnosis of: generalized anxiety disorder and noted with behavior or mood issues of: anxiousness, depressive symptoms standing up from wheelchair and crawling out of bed, and yelling out with interventions including: avoid overstimulation or under stimulation; provide support/reassurance, engage in groups and activities participation as tolerated; document mood and behaviors as needed as they occur.

R1's progress note dated 04/29/2023 6:30 PM documents: writer called R1's room by assistive personal, upon entering room R1 observed in bed

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S9999	Continued From page 4 with head of bed elevated, yelling and screaming loudly, Upon further assessment, R1 right leg appear to be red, swollen and dislocated, R1 unable to verbalize what happened, as needed pain medication given, Physician called and orders given to transfer resident to the local hospital emergency room. [sic] R1's progress note dated 04/30/2023 03:22 AM documents: Writer called hospital and was notified that R1 was transferred to another hospital. Writer was notified that R1 has a left thigh bone broken and is still in the hospital emergency room department. R1's April 2023 Medication Administration Record does not include any abnormal observations of her skin. R1's documented pain levels are primarily at zero daily including on 04/29/23 during the morning shift prior to being discharged; pain levels documented as the following: 4/21/23 Level 1 during the evening 4/26/23 Level 4 during the day MAR does not document that any as needed pain medications were administered from 04/01/23 - 04/29/23. R1's point of care skin observation reports from 04/10/23 - 04/29/23 documents no new skin abnormalities were identified. R1's point of care reports from 04/22/23 - 04/29/23 for behavior of crawling out of bed documents she crawled out of bed once on 04/22/23 noted at 6:53 AM and no other time during those days leading up to 04/29/23. R1's point of care reports from 04/22/23 - 04/29/23 for depressive symptoms or anxiousness documents no occurrences of these	S9999		

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S9999	Continued From page 5 behaviors. R1's progress note dated 4/29/2023 10:30 AM documents: Received resident alert and responsive, In stable condition, No signs or symptoms of distress/pain noted. [sic] R1's progress notes from 03/01/23 - 04/29/23 up until 6:30 PM do not document any behaviors of her exhibiting any concerning behaviors or yelling loudly, or showing any signs of pain or distress. R1's progress notes from 04/22/23 - 04/29/23 up until 6:30 PM did not document any falls or reports of pain, discomfort, or injury. Incident Report dated 05/03/23 documents while providing care a CNA (Certified Nursing Assistant) observed R1 to complain of pain in her right leg when being turned on her side for activities of daily living care, the CNA informed the nurse who then observed R1 in bed with her right leg in a bent position at the knee, R1 observed with no other signs of injury other than redness and swelling to the right leg, the physician was notified an ordered R1 to be sent to the hospital; V13 (Agency Certified Nursing Assistant) was interviewed and reported during the incident when he began providing incontinence care to R1 after having a very large bowel movement she began screaming out loud and he continued to clean her up, as she continued to scream he stopped providing care, he then reported it to a nurse who examined R1 and stated she believes R1 had a fracture, he reported it was the first time he ever worked at the facility, he is not sure who he talked to when he arrived to the facility and cannot recall who he spoke with when he initially arrived to the facility and was informed about his sets; V14 (Certified	S9999		

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Nursing Assistant) was interviewed and reported R1 typically cries out and screams but was not exhibiting this behavior during the afternoon when providing care for her, R1 is able to assist when she's being changed and can turn herself and lift her legs; V15 (Memory Care Director) was interviewed and reported R1 can communicate if she is in pain, has days where she does not yell or scream, can minimally provide assistance if she is being put in bed or changed; V16 (Licensed Practical Nurse) was interviewed and reported on the day of the incident she was asked to examine R1 and upon arriving to her room V13 was there and stated he didn't know why R1 was yelling out because he didn't know her behavior and was just changing her, V16 reported she observed R1's leg to be swollen and appeared to be dislocated, R1 does crawl out of bed and she has walked in and observed R1 swing her legs over the bed rails a few times; V17 (Certified Nursing Assistant) was interviewed and stated R1 is cognitively still intact and can communicate if she is in pain, he noticed she was in pain, R1 can move some in her bed, she used to put herself on the floor and crawl but it has been a couple of months since he observed her doing that; V18 (Certified Nursing Assistant) was interviewed and reported R1 can move and reposition herself, she is able to assist with her incontinence care and is not a total assist, she usually has R1 place her hand on the rail and get her to turn her body, R1 does scream out the name of V37 (Family Member) if she has needs, R1 can communicate if she is hurt or in pain or if she has other needs; V19 (Licensed Practical Nurse) was interviewed and reported she was R1's nurse when she had to be sent out to the hospital, throughout the day R1 was happy and calm, R1 was speaking Spanish and chatting when she passed her medication, she completed passing medications

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S9999	Continued From page 7 at 6:15 PM and was called back to R1's room at 6:30 PM and heard R1 yelling out loudly, she observed R1's leg and it visibly looked misplaced and the skin was red and puffy, prior to this R1 was in great spirits; Transmittal page dated 05/03/23 documents 2 pages were submitted to the State Agency including Report Page dated 05/03/23 documenting full investigation initiated, final report to follow; Final Conclusion dated 05/09/23 states local law enforcement was notified of the occurrence, the facility is unable to make a definitive determination as to how R1's injury was sustained, R1 has exhibited behavior of crawling in and out of bed in which she has a care plan for, interventions in place to prevent injury including but not limited to low bed, floor mats, and room near nurse's station were in place prior to the occurrence of the injury, as an additional precautionary measure the facility continues to ensure that staff is oriented to the care needs of the residents for which they are assigned, and to the prevention of abuse. R1's Hospital Report dated 04/29/23 - 04/30/23 documents the facility's Director of Nursing called and reported R1's Registered Nurse at the facility provided care at 6:30 PM and was observed to be comfortable and in no distress and 15 minutes later a Certified Nursing Assistant reported to R1's nurse that she was screaming, with help of interpreter R1 complained of pain in her right leg and was observed with her right thigh swollen, while receiving care from a Certified Nursing Assistant incontinence she began to scream out in pain when turned on her left side; after contacting local family support services department to report suspected elderly abuse a referral was made to the contact the state agency; R1 complained of pain to her right leg and denied falling, when R1 was asked when the	S9999		

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pain started she reported she was in her bed when a female moved her abruptly to turn her, R1 reported that she does not walk and uses a wheelchair to ambulate; per emergency medical services they were called to R1's facility because she had a fracture deformity to her right thigh bone, according to facility staff she was found that way, R1 although demented states a girl at nursing home did this to her and appears to be in excruciating pain; R1 arrived to the hospital emergency room with midshaft thigh fracture that needs stabilization regardless of her palliative/hospice status, as she is in excruciating pain; V38 (Orthopedic Physician) also shares V39 (Emergency Room Physician) concern that R1's injury is a nonaccidental trauma therefore nursing notified the Department of Aging.

On 05/09/23 at 10:35 AM V1 (Administrator) stated V13 (Agency Certified Nursing Assistant) is suspended pending investigation for R1's injury. V1 stated the facility is still investigating R1's incident involving injury on 04/29/23.

On 05/09/23 from 12:25 PM - 12:30 PM V17 (Certified Nursing Assistant) stated he has worked for the facility more than thirteen years. V17 stated he knows R1 well and she screams like a loud bird whenever she wants to go back to bed or to the bathroom. V17 stated R1 may do this maybe a couple of times a day and some days won't scream at all. V17 stated R1 may make this sound while calling out to one of her family members and sometimes she'll call out V37's (Family Member) name repeatedly really loud which may have been one of her family members who used to take care of her. V17 stated he's never observed R1 to be in pain. V17 stated R1 doesn't normally make those loud sounds while receiving care.

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S9999	Continued From page 9 On 05/09/23 at 1:45 PM V15 (Memory Care Director) stated she has worked for the facility for approximately 13 years. V15 stated R1 yells out a lot for V37 (Family Member) and yells out "ah ah" loudly. V15 stated R1 makes that noise sometimes when she wants to go back to bed and at other times for no particular reason. V15 stated some days R1 won't yell out and other days she will yell out off an on throughout a few times a day. V15 stated she has never observed R1 to be in pain and when she does yell out they ask how she's doing and if she's in pain and she never says she's in pain but just may say she just wants to go to bed. V15 stated she has heard that R1 crawls around on the floor but cannot recall any reports of her doing so in April but would have to check her documentation. V15 stated it is documented when R1 is yelling out or crawling around on the floor under the point of care task observations and would be care planned. V15 stated to her knowledge R1 did not have any broken bones or injuries prior to going to the hospital. On 05/09/23 from 2:34 PM - 2:40 PM V19 (Licensed Practical Nurse) stated R1 was the last person she had seen 04/29/23 for medication pass and 15 minutes later when she came back in R1's room R1 was screaming loudly. V19 stated when she pulled the covers back from R1 she observed her right leg and could see the bone through the skin was bent and turned and wasn't normally aligned. V19 stated she could see R1's bone protruding right underneath the skin but it did not breach the skin. V19 stated R1's skin on over the injury was warm and red and she was screaming out in pain really really loud. V19 stated R1 was not yelling out as part of her normal behavior and was instead	S9999		

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continuously screaming nonstop in a loud and agonizing way. V19 stated she didn't see when the V13 (Agency Certified Nursing Assistant) went in R1's room to provide incontinence care but he was in her room when she arrived. V19 stated R1 only speaks Spanish and there was another male Spanish speaking CNA (Certified Nursing Assistant) present and he stated R1 could not communicate what happened to her.

On 05/10/23 at 12:31 PM V38 (Orthopedic Physician) stated he never examined R1 when she arrived to the hospital emergency room but reviewed her x-rays and recommended transfer to another hospital for surgery. V38 stated the emergency room physician reported that the department of aging was contacted because it didn't make since that the type of fracture R1 sustained happened to a non-ambulatory resident and R1 reported a girl did this to her so he agreed that the department of aging should be notified based on this information. V38 stated the thigh bone fracture R1 sustained usually occurs from a fall that possibly no one witnessed and it is unlikely that it would occur from a patient just laying in bed.

On 05/10/23 at 12:41 PM V37 (Family Member) stated R1 reported to her that when she was being changed someone twisted her leg. V37 stated R1 is blind so she could not inform who exactly hurt her. V37 stated R1 is completely blind and can maybe see shapes but cannot clearly see figures. V37 would always complain about the nursing home reporting that they would always mistreat her. V37 stated R1 has not provided specific details as to how they mistreat her but states "they don't treat me right" and "I don't want to be here anymore." V37 stated when R1 was in the emergency room that the physician

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stated it wasn't an accident. V37 stated R1 is mentally capable of communicating her needs and experiences.

On 05/10/23 at 3:09 PM V1 (Administrator) and V11 (Registered Nurse/Restorative Nurse) stated they had not received any reports that R1 had fallen, or been injured, or had been crawling around on the floor prior to her injury on 04/29/23. V11 stated she spoke with V16 (Licensed Practical Nurse) about R1's incident on 04/29/23 and she reported R1 was up in the geriatric chair most of the day for her meals and there was no complaints and she was her usual self. V1 stated V3 (Assistant Director of Nursing) attempted to speak with family after R1 was admitted to the hospital but was unsuccessful. V1 stated they were unable to conclude what happened to R1. V1 stated R1's injury was believed to be an injury of unknown origin at the time which should be reported to the state agency immediately as well as allegations of abuse. V1 stated when she heard that something happened with R1 she immediately suspended V13 (Agency Certified Nursing Assistant) because she knew something had happened with the resident he was working with. V1 stated this would fall into the category of an abuse investigation. V1 stated residents who are at risk for abuse are monitored for signs of abuse by observing a change in mood, change in behavior, verbalized allegations of abuse, observing how staff interact with residents. V1 stated residents are monitored for bruises of unknown origin, scratches, or any injuries that were not normally on their body. V1 stated certified nursing assistants normally report any changes during morning standup meetings. V1 stated the certified nursing assistants notify her immediately of any abnormal physical changes, and they also notify nurses. V1 stated residents

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S9999	Continued From page 12 are monitored daily for any physical signs of abuse. V1 and V11 stated prior to R1's injury there had been no abnormal physical observations for her nor any abnormal complaints of pain. V11 stated R1's bed was in low position during the time of her injury and she also has floor mats on both sides of the bed. On 05/11/23 from 9:07 AM - 10:02 AM V1 (Administrator) stated it is of the utmost importance that agency staff are informed about the residents they are being cared for. V1 stated V8 (CNA/Scheduler/Unit Manager) is responsible for orienting agency staff or new Certified Nursing Assistants (CNA) about their assigned residents during the morning shift until 3PM and V40 (Administrative Night Manager) is responsible for this orientation during the evening shift and follows up new and agency staff orientation after 3 PM. V1 stated she added V40's position to ensure that orientation and resident education was being implemented during the evening/night shifts. V1 stated stand up meetings including the nurses and CNA's were also added during the evening shift to discuss any pertinent information concerning residents. V1 stated during both times the facility spoke with V13 (Agency Certified Nursing Assistant) told us he couldn't remember who spoke with him about his assigned residents. V1 stated V13 was irritated about his suspension and financial situation and that did come across when interviewing him about the incident with R1. V1 stated V13 stated he can't tell you what lady spoke to him about the residents. V1 stated V13 reported someone told him about his assigned residents, but he couldn't confirm who. V1 stated she's not sure if she asked V13 what information he received about R1 because she was mainly concerned about ensuring he was informed about all of the residents he was assigned to. Esther	S9999		

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stated she can't explain why V13 reported to V16 (Licensed Practical Nurse) that he wasn't aware of R1's behaviors and maybe he wasn't aware of R1's behavior of screaming out. V1 stated she's not sure what information V13 may not have received about R1, however she just knows that he confirmed that he was oriented to his assigned residents. V1 stated if there is any important information left out of anything in life it can increase risks. V1 stated she cannot speak for sure about what information V13 received about R1 because she was not there when he was oriented however the facility's standard process of orientation includes providing all pertinent information about the residents being assigned to new and agency staff. V1 stated she doesn't believe R1 had a behavior of screaming during care prior to her incident but if it was a new behavior then V13 would not have been informed of this. V1 stated if R1 did exhibit screaming as a behavior during care it would make sense that V13 would stop and go find someone else to find out why she is screaming during care. V1 stated she is wondering if R1 was exhibiting a new behavior of screaming during care which V13 would not have been informed about. V1 stated hopefully V13 did discontinue providing care when he observed her screaming although in his statements, he did say he continued to provide care to R1 and when she continued screaming that's when he went to go and get someone. V41 (Licensed Practical Nurse/Minimum Data Set Coordinator) stated if a staff is providing incontinence care and a resident screams the staff should stop and assess the resident for anything that may be causing the resident any pain or causing them to scream. V41 stated if staff don't assess the cause of the residents yelling they may not be able to determine what may be harming the resident or may not notice

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something is causing the resident pain. V41 stated if a residents screams during care because they are injured if staff do not stop to assess what is going on first this could possibly further the injury or cause the resident more pain. V1 stated she did hear that the scream R1 exhibited when she was receiving care from V13 was different than her normal behavior of screaming and yelling.

The facility's Abuse Policy reviewed 05/10/23 states:
"This facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse of its residents and has attempted to establish a resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse of our residents.
"This facility is committed to protecting our residents from abuse by anyone."
"Abuse means any physical injury inflicted upon a resident other than by accidental means in a facility. Abuse is willful infliction of injury resulting in physical harm, pain, or mental anguish. Willful means the individual acted deliberately, not that the individual must have intended the injury or harm. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish."
"Serious Bodily Injury is any injury involving extreme physical pain; involving protracted loss or impairment of the function of a bodily member; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation."

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S9999	Continued From page 15 (Violation 2 of 3) 300.610a) 300.1210b)3) 300.1210c 300.1210d)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 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	S9999		

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S9999	Continued From page 16 measures shall include, at a minimum, the following procedures: 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. 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: 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. 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)	S9999		

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S9999	Continued From page 17 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to monitor and treat urinary tract infections for one resident (R3) who was displaying signs and symptoms of UTI for over one month. This failure affected one of one (R3) resident reviewed for nursing care and resulted in R3 being hospitalized with a diagnosis of sepsis. Findings include: R3 is a 62 year old female who originally admitted to the facility on 2/20/07 and currently resides in the facility. R3 has multiple diagnoses including but not limited to the following: multiple sclerosis, hemiplegia, neuromuscular dysfunction of the bladder, depression, mild protein calorie malnutrition, dysphagia, hydronephrosis, and calculus of kidney. Per facility progress note dated 4/17/23, R3 was sent to the emergency room due to altered mental status. Facility progress note states in part but not limited to the following: At 9:50 AM, R3 was observed alert, nonverbal, only making mumbling and moaning noises when spoken to. Pupils are nonreactive, no direct eye contact, mouth is open, minimal drooling, no asymmetrical facial features, and bilateral arms are flaccid. Nephrostomy tube is draining tea colored, urine is cloudy and odorous. 911 called. A later progress note dated 4/17/23 states in part but not limited to the following: R3 will be admitted to the intensive care unit with diagnosis	S9999		

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S9999	Continued From page 18 of sepsis. Per hospital records and discharge summary dated 4/24/23 states in part but not limited to the following: R3 presented to the emergency department for complaints of altered mental status. R3 was hypotension refractory to fluids, a positive urinalysis, hypernatremia, and leukocytosis. She was admitted to the ICU for septic shock and pressor support. Discharge diagnoses show but are not limited to the following: urinary tract infection associated with nephrostomy catheter, hypernatremia, and septic shock. Facility progress notes dated 3/8/23-3/12/23 states in part but not limited to the following: notified by hospital that patient urine is cloudy, needs a urinalysis with culture and sensitivity. Result of urinalysis relayed, no new order. Per V12 (Physician), he will consult physician at hospital and return call regarding follow-up. Per urinalysis results dated 3/9/23 show R3 had abnormalities including cloudy urine, large leukocytes, protein: 100, large blood, white blood cells: 5-10, and red blood cells: 5-10. On 5/8/23 at 11:20AM, V26 (family member) was interviewed about R3's hospitalization on 4/17/23. V26 said the hospital told us that R3 was severely dehydrated and her kidneys were not functioning properly. They told us that she had an untreated UTI for a long time which caused her to go septic. On 5/9/23 at 11:05AM, V12 (Physician) was interviewed regarding R3's treatment and care. V12 said R3 has kidney issues and develops kidney stones very rapidly. The tubing gets crusted with calcium from the stones. R3 went to	S9999		

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the hospital on 4/17/23 where she was treated for a UTI infection which had led to sepsis. She does not get UTI's often but she is at high risk for developing UTI's due to calcium deposits and the nephrostomy tube. I reviewed the urinalysis that was obtained on 3/9/23 and consulted with the radiologist at the hospital. Our plan was to not order anything but to monitor R3 for signs of symptoms such as altered mental status or possibly do a blood test.

It is to be noted that no blood test was ordered/obtained and no documentation of monitoring for signs and symptoms were received.

At 1:05PM, V32 (Medical Director) was interviewed regarding infection management within the facility. V32 said I would expect the staff to be taking vitals every shift, monitoring mentation status, looking for a fever, making sure the resident is not experiencing tachycardia to make sure the resident is not experiencing a UTI. However, if a urinalysis comes back positive, I would recommend putting the resident on an antibiotic right away. These residents are geriatric and have comorbidities. If we do not start antibiotics, there is a possibility the resident could end of up in the hospital with sepsis.

R3's care plan with initiation date of 1/20/12 states in part but not limited to the following: Focus: R3 requires use of nephrostomy related to frequent renal calculi. Goal: Nephrostomy tube site will be free from signs of infection till next review. Interventions: Empty drainage bag every shift and as needed; notify MD for any change of condition of the resident.

Focus: R3 is noted to have potential for

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dehydration due to lack of awareness to drink fluids and inability to reach for liquids. Goal: R3 will not exhibit signs of dehydration. Interventions: Encourage fluids unless contraindicated. Monitor for signs and symptoms of dehydration such as: change in mental status, fever, infection, electrolyte imbalance, and concentrated urine.

Requested policy for preventing urinary tract infections, however did not receive any sort of policy.

(A)

(Violation 3 of 3)

300.610a)
300.1210a)
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 ResidentCare 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

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a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to have effective fall interventions in place and failed to provide adequate supervision to keep residents assessed to be at risk for falls, free from injury related to falls. These failures

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applied to two (R4 and R5) of four residents reviewed for accidents and supervision and resulted in R4 having a fall and sustaining a right hip fracture and resulted in R5 having a fall that required treatment with three sutures for a laceration to his lip.

Findings include:

1. R4 is a 78 year old male who originally admitted to the facility on 2/23/23 and later expired in the facility under hospice care on 4/13/23. R4 has multiple diagnoses including but not limited to the following: CHF, palliative care, CAD, CKD IV, pulmonary edema, dementia, type II DM, depression, hyperlipidemia, GERD, and history of falling.

Facility incident report dated 4/1/23 states in part but not limited to the following: Activity staff notified nurse on duty that the resident was on the floor. R4 was observed sitting on the floor with his reclining chair directly behind him. R4 was sitting on his buttocks, back is upward, and knees are flexed. His left arm is extended with his palm on the floor and his right arm is in his lap. The reclining chair was unlocked. R4 is alert and oriented to his name only and was unable to give any explanation of what happened.

On 5/9/23 at 10:26AM, V11 (Restorative Nurse/Fall Coordinator) was interviewed regarding R4's fall on 4/1/23. V11 said R4's family member came into the facility and took him back to his room. At some point after this she had left the facility and did not let the staff know she was leaving. No one saw her leave. A staff member saw R4 on the ground in his room. His room was set back in the hallway and not located in a high traffic or visible area. R4 is verbal but not

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understandable. He was not able to let us know what happened. The intervention we put in place was to educate the family to let us know when they are leaving. R4 needs increased supervision since he would constantly attempt to get up on his own. He should be in a common area and never left unsupervised in his room alone. On 4/3/23, the family member let us know he was having pain to his pelvis area. An x-ray was ordered which showed he had a fracture to his right hip. However, the family member told us that he had previously fractured his hip in this same area prior to him admitting to the facility. The family opted to not do surgery when this happened. V11 said the CNA is responsible to provide supervision and care for the resident whether the family is visiting or not.

2. R5 is an 81 year old male who originally admitted to the facility on 1/4/2023 and currently resides in the facility. R5 has multiple diagnoses including but not limited to the following: hypotension, syncope, dementia, legal blindness, SOB, HTN, insomnia, and hallucinations.

Facility incident report dated 3/30/23 states in part but not limited to the following: Heard yelling from down the hall and when entered R5's room, he was observed to be on his hands and knees at the end of his roommate's bed. Fall mat was pushed against the wall and resident had pulled roommates television down and turned over oxygen concentrator in the room. Blood was noted on the floor and R5's body. Observed blood coming from R5's lower lip from a laceration. R5 states 'I fell and a board hit me.' Laceration noted to lower lip, abrasion noted to left side of chin and to great toe. R5 was sent to emergency room.

Emergency room report dated 3/31/23 stated in

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part but not limited to the following: patient arrived to emergency department complaints of unwitnessed, mechanical fall at nursing home. Patient fell and hit his face on the ground. Patient has cut on his lip and complains of body aches. MD at bedside stitching patients lip.

On 5/10/23 at 2:00PM, V34 (licensed practical nurse) was interviewed regarding R5's fall on 3/30/23. V34 said I was the nurse assigned to V34 when he fell on 3/30/23. V34 said R5 is blind and needs increased supervision because he will try and get up unassisted. On this day, I heard yelling and went to his room. I observed him on his hands and knees on the ground. There was blood on him and on the floor. He speaks Spanish and I was unable to understand what had happened. From my understanding, he had attempted to get out of bed on his own and fell, pulling down his roommates television and oxygen concentrator. I received orders to send him out to the hospital and he came back with sutures. I would say he is a high fall risk since he does attempt to walk without any assistance.

Facility progress note dated 2/28/23 states in part but not limited to the following: R5 on floor on his floor mat and heard calling out for help. R5 stated he was looking for us. Resident denies any pain or discomfort. No signs of injury. Will cont. to monitor.

On 5/10/23 at 12:05PM, V33 (CNA) was interviewed regarding R5's fall on 2/28/23. V33 said I was R5's CNA when he fell on 2/28/23. I was doing rounds and walked past R5's room. I observed R5 on the ground on his fall mat. Another staff member, not sure who, helped assist me get him up into his wheelchair and brought him to the nursing station. Prior to this,

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S9999	Continued From page 25 R5 had not exhibited any sort of behaviors such as trying to get up unassisted or crawling on the floor or out of his bed. At 1:30PM, V11 was interviewed regarding R5's fall on 2/28/23. V11 said I was never notified of this incident. If I had been notified, I would have completed a fall incident report. We did not investigate it as a fall. At 3:51PM, V1 (administrator) was interviewed regarding facility understanding of falls. V1 said this would be considered a fall since it is a change of plane. Asked V1 if a resident was found on the floor, with no documentation of any behaviors, and they are unable to let you know what happened, would this be considered a fall? V1 answered yes. It is to be noted that no incident report or interventions were put in place after R5 fell on 2/28/23. Facility care plan for R5 dated 1/4/23 states in part but not limited to the following: R5 is at risk for falls r/t poor safety awareness, recent fall with injury, dementia, left extremity weakness, unsteady gait/impaired balance, use of walker and wheelchair, hypotension, hypertension, various medications, incontinence, decline in ADLs, and blindness. Goal: Will show no change to fall risk score through next review. Interventions: Encourage resident to keep room free of obstacles. Fall risk assessment quarterly and as needed. Provide an environment clear of clutter. Facility policy titled Management of Falls dated 8/2020 states in part but not limited to the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 26 following: Policy: the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize risks for fall incidents and/or injuries to the resident. Procedure: 1. Complete a fall risk assessment upon admission, readmission, significant change, post-fall, quarterly, and annually. 3. Develop a plan of care to include goals and interventions which address resident's risk factors. 6. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. (B)	S9999		