STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005037	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING BRUWAERT HOUSE	6101 COUNTY LINE ROAD BURR RIDGE, IL 60521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incidents: FRI of 04.29.24/IL173554 FRI of 06.04.24/IL174314	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3240 a) 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	S9999		

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S9999	Continued From page 1	S9999		

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. (Section 2-107 of the Act)

These requirements were NOT met as evidenced by:

Based on interview and record reviews, the facility failed to follow its abuse policy and procedures and keep residents safe from abuse and neglect.

Findings include:

1. On 7/15/24 at 12:30 PM, V3, Licensed Practical Nurse/LPN stated R1's family wants R1 to receive morphine medication prior to staff providing any care for R1. V3 stated he was respectful of R1, as he always is, whether family are present at R1's bedside or watching the surveillance footage in R1's room. V3 stated V3 explained to R1 what he was doing. V3 stated V3 was following R1's care plan for pain medication administration.

On 7/15/24 at 3:30 PM, V1, CEO (Chief Executive Officer) stated V3, LPN, completed nursing program during the COVID-19 pandemic, and does not believe V3 received much clinical training. V1 stated V3 is task oriented. V1 stated V1 reviewed the surveillance camera footage from 4/29/24 at 4:30 PM with R1's POA (Power of Attorney) on 5/2/24. V1 stated on this six minute video footage, V3 was observed administering

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medication to R1 after R1 is heard saying 'no'. V1 stated R1 was asleep and V3 woke R1 up to take the medication. V1 stated V3 repeatedly informs R1 that R1 has to take the medication for pain, and R1's family wants him to take it. V3 was observed pressing R1's jaw to administer the medication, even though R1 was unarousable. V1 stated during the video, V3 appeared to be mocking R1. V1 stated when V3 was questioned, V3 responded he thought he was having a playful interaction with R1 by mouthing back what R1 was saying. V1 stated V3 informed V1 he did not believe he was behaving in an inappropriate manner. V1 stated R1's care plan notes that R1's family does not want R1 to be in pain. R1's family wants R1 to receive pain medication if he is alert; they do not want R1 to be woken up to receive this medication.

R1's controlled substance form, dated 4/29/24, notes morphine sulfate 20mg (milligrams)/ml (milliliter), administer 0.25ml every one hour as needed for pain. On,4/29 at 4:30 PM, V3, LPN, administered 0.25ml morphine to R1.

This facility's abuse investigation, dated 4/30/24, was initiated immediately upon V1, CEO, being notified by R1's POA that surveillance video footage noted V3 forcefully administering morphine sulfate to R1 when R1 was verbally saying he did not want to take the morphine.

2. On 7/13/24 at 12:15 PM, V5, RN (Registered Nurse), stated V4, CNA (Certified Nurse Aide), thought the hospice nurse was going to feed R1 his lunch meal on 6/4/24. V5 stated after lunch, V4 removed R1's tray, but did not check to see if R1 ate any of his meal. V5 stated V5 was confident R1 would be fed his lunch because

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there are special instructions regarding R1's care noted on the daily assignment sheets. V5 stated it was a misperception by V4 that the hospice nurse would feed R1.

On 7/13/24 at 12:50 PM, V6, CNA, stated V6 worked day shift on R1's nursing unit on 6/4/24. V6 stated V6 was not assigned to provide care for R1 that day. V6 stated V4, CNA, was assigned to provide care for R1 that day. V6 stated the nurse from the outside hospice agency was present in the facility at lunchtime to see R1. V6 stated she asked V4 if the hospice nurse was going to feed R1 lunch. V6 stated V4 was going to check with the hospice nurse. V6 stated R1 is the only resident that does not eat in dining room; R1 eats meals in R1's room. V6 stated she got busy assisting the residents in the dining room with lunch. V6 stated R1's lunch tray remained on the counter in the dining room throughout lunch and was not passed to R1 by V4. V6 stated she did not notice R1's tray never left the counter; V6 assumed V4 was going to feed R1. V6 stated it is communicated after meal if any of the residents did not eat well, refused meal, or did not like food served.

V4, CNA, was unavailable for interview during this survey.

There is no documentation found in R1's amount eaten task of medical record, dated 6/4/24, noting R1 received lunch meal.

On 7/13/24 at 2:00 PM, V1, CEO (Chief Executive Officer), stated R1's POA (Power of Attorney) video records R1's room to monitor R1's care. V1 stated R1's POA reviews the days camera footage in the evenings. V1 stated R1's POA alerted V1 that after reviewing the footage,

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S9999	Continued From page 4 R1 did not receive lunch on 6/4/24. The facility's investigation into R1 not being fed lunch meal on 6/4/24 was initiated immediately upon being notified by R1's POA. The facility noted they have to ensure that our residents receive the nutrition for their particular needs, including making sure that they actually eat the food provided because not providing adequate food is indeed considered a form of neglect. Neglect can take many forms, and failing to meet the resident's basic needs, including proper nutrition is one of them. The facility's abuse policy and procedure, undated, notes all residents will be free from any form of abuse or neglect. This facility will make every effort to promote the safety and wellbeing of the residents through ongoing abuse prevention efforts. Staff will receive education annually and as needed on resident rights, as well as how to prevent, recognize, react to and report abuse. (B)	S9999		