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S 000	Initial Comments Annual Licensure and Certification Survey Investigation of Facility Reported Incident of 10/3/24/IL179567	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4) 300.650c) Section 300.650 Personnel Policies c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file. This regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure employee personnel files contained a copy of the nurse's license. This failure has the potential to affect all 85 residents residing in the facility. Findings include: V5 Registered Nurse (RN) and V31 Licensed Practical Nurse's (LPN) personnel files did not contain a copy of their nursing license. The facility's Employee list with hire dates provided on 10/21/24 by V1 Administrator documents V5's hire date was 8/1/24 and V31's hire date was 12/13/23.	S9999		

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On 10/21/24 at 3:14 PM, V15 Office Manager confirmed the facility did not have a copy of V5's or V31's nursing license on file. V15 stated that she was told she did not need to have the license on file.

The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 10/20/24 documents 85 residents reside in the facility.

(C)

Statement of Licensure Violations (2 of 4)

300.661

Section 300.661 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.

This regulations were not met as evidenced by:

Based on interview and record review the facility failed to complete the required internet Healthcare Worker Background checks on an employee prior to that employee working. This failure has the potential to affect all 85 residents residing in the facility.

Findings include:

The facility's Resident Care Policy and Procedure Regarding Abuse and Neglect, Involuntary Seclusion, Exploitation, Misappropriation of Resident Property, Injuries of Unknown Origin, and Social Media policy with a revised date of

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3/15/18 documents, "Screening of potential employees will be conducted and hiring will be dependent upon the screening result. Screening shall include: (a) A Uniform Criminal Information Act (UCLA) non-fingerprint conviction information check for every potential employee through the IDPH (Illinois Department of Public Health) web portal. If there is nothing to keep you from hiring the individual (disqualifying convictions) and if the individual has not previously had a FEE_APP (Fee application inquiry) or CAAPP (Criminal Activity on Applicant) background check then you must initiate a new fingerprint background check. (b) Fingerprinting of all personnel per the State background-check implementation schedule. (c) Reference checks/checks with appropriate licensing boards and/or registries when applicable."

The facility's Employee list with hire dates provided on 10/21/24 by V1 Administrator documents V32 Certified Nursing Assistant (CNA) was hired on 9/9/24.

V32's employee file did not contain internet website checks for the Department of Corrections Sex Offender Search Engine or the Department of Corrections Wanted Fugitive Search Engine, Department of Corrections Inmate Search Engine, Illinois Sex Offender Search Engine.

On 10/21/24 at 3:14 PM, V15 Office Manager stated she printed the registry check for V32 on 7/25/24 but the previous Administrator supposedly took care of the rest. V15 stated that she cannot say for sure what websites were checked for V32 prior to her being hired. V15 confirmed the above websites were not checked and confirmed that V32 worked in the facility on 9/15/24.

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The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 10/20/24 documents 85 residents reside in the facility.

(C)

Statement of Licensure Violations (3 of 4)

300.610a)
300.1210a)
300.1210d)2)
300.3220f)

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

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

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

This regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide targeted interventions to prevent skin breakdown, failed to assess, evaluate and document resident skin on a regular basis, and failed to obtain appropriate treatment orders for pressure ulcers for two (R20, R58) of five residents reviewed for pressure ulcers from a total sample list of 44 residents. These failures resulted in one resident (R20)

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developing a new, unstagable, deep tissue injury and a second resident (R58) developing seven, new stage two pressure wounds.

Findings include:

The facility Wound and Ulcer Policy and Procedure dated 3/28/24 documents that it is the policy of this facility to provide nursing standard for assessment, prevention, treatment and protocols to manage resident at any level of risk for skin breakdown and for wound management. A skin assessment will be documented daily for resident assessed to be at moderate or high risk for the development of pressure ulcers. When a resident is found to have a wound, the wound will be documented in the medical record, a treatment protocol will be initiated, the physician and family will be notified and orders implemented.

1.) The facility provided ulcer on-going summary report documents that R20 has an in-house acquired stage two wound on her sacrum and a bruise on her left wrist. R20's Minimum Data Set dated 9/3/24 documents that R20 is cognitively intact.

R20's facility skin assessment dated 10/9/24 documents R20 is as at moderate risk for skin breakdown. R20's October 2024 medical record does not document daily skin checks.

On 10/20/24 at 10:57AM, R20 was laying in bed with her heels resting directly onto the mattress. No specialty mattress was observed. R20 stated, "I have a wound on my backside and my foot hurts, pointing to her left foot. R20 was wearing non-slip footwear and said that she had no dressings on her feet.

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On 10/21/24 at 3:35PM, R20 was laying in bed with her heels pushing into the mattress. No specialty mattress was observed. R20 stated, "My left foot hurts and it has for at least a week. I've told them that it hurts."

On 10/21/24 at 3:38PM, V19 Certified Nursing Assistant (CNA) removed R20's left non-slip sock and exposed a quarter sized, black, deep tissue injury, unstagable. When V9 Licensed Practical Nurse (LPN) entered the room she stated that R20 only had a wound on her sacrum. V19 CNA showed V9 LPN, R20's left heel. R20 then stated that her left foot had been hurting for at least a week. V19 LPN said that she was unaware that R20 had a heel wound and had no idea how long it had been there. V19 confirmed that there was no treatment order for R20's heel wound because no one knew about it.

On 10/21/24 at 3:55PM, V2 Director of Nursing stated that she was unaware of R20's wound on her left heel and that the staff should report any skin issues to the nurses who should then assess the issue, obtain orders from the physician, and that all residents with a stage two or greater should be on a specialized mattress.

On 10/22/24 at 9:20AM, V6 Wound Nurse said that the CNA's are supposed to fill out shower sheets every time that they give a shower and mark on the sheet if there are any changes to the skin. The nurses are then supposed to let the Infection Preventionist, the Physician and the Family know when there is a skin change and get orders for a treatment. "None of these things happened. I usually do a skin sweep, but that didn't happen either. Based on its size and color I would guess it has been present for 3-4 weeks. I

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suggested when she broke her arm (July 2024) that she needed a (specialty) mattress, but it was not ordered. This unstageable wound will likely open and could cause an infection or other issues."

2.) The facility provided wound summary report dated 10/18/24 documents that R58 has wounds on her right upper inner thigh, left buttock and right buttock. All were documented as developed in house on 8/6/24.

R58's Minimum Data Set dated 9/27/24 documents R58 as cognitively intact.

R58's facility skin assessment dated 10/1/24 documents R58 is a high risk for skin breakdown. R58's medical record does not contain daily wound assessments.

R58's physician orders dated 8/31/24 document to cleanse the right buttock with soap and water, pat dry apply calcium alginate to wound bed and cover with silicone border dressing daily and as needed and to cleanse the left buttocks with soap and water, pat dry apply calcium alginate to wound bed and cover with silicone border dressing daily and as needed.

On 10/21/24 at 11:46AM, V6 Wound Nurse removed R58's brief and no dressings were on R58's seven open areas on her buttocks and inner thighs. V6 stated that there are new wounds on R58's buttocks and thighs and that when a new wound is found, an assessment should be completed, the wound nurse and physician notified, treatments orders obtained and notifications made and that none of these things were done. R58 was sitting in a wet brief and stated that she was last changed at 8:00AM that

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morning.

On 10/21/24 at 3:55PM, V2 Director of Nursing stated that she was unaware of R58's new wounds on her buttocks and thighs and that the staff should report any skin issues to the nurses who should then assess the issue, obtain orders from the physician, and that all residents with a stage two or greater should be on a specialized mattress.

On 10/23/24 at 11:45AM, V6 Wound Nurse stated that R58 should have had a dressing on her wounds or a refusal if the resident would not allow the dressings to be completed, neither of which was done.

On 10/23/24 at 11:20AM, V30 Nurse Practitioner stated that failing to do skin checks, failing to implement interventions such as alternating air mattresses or repositioning a resident every two hours, and failing to find and address wounds sooner could certainly cause harm to the resident and in the case of R20, did cause the wound to become an unstagable, deep tissue wound.

(B)

Statement of Licensure Violatios (4 of 4)

300.610a)
300.1210a)
300.1610a)1)2)

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

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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

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)

Section 300.1610 Medication Policies and Procedures

a) Development of Medication Policies

1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These

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policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

2) Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly.

This regulations were not met as evidenced by:

Based on interview and record review the facility failed to monitor a resident (R22), with Dysphagia (difficulty swallowing), after administering oral medication. This failure affects one resident (R22) of 7 residents reviewed for medication administration in the sample list of 44. R22 experienced a choking episode when staff had left R22's room after oral medication administration. Upon staff hearing R22's coughing, staff returned to R22's room and performed the Heimlich Maneuver to expel the tablet from R22.

Findings include:

A) R22's Facility Census documents R22 was admitted to the facility on 7/1/24 and has the following medical diagnoses; Muscle Wasting and Atrophy, Muscle Weakness, Anxiety Disorders, Dysphagia Oropharyngeal Phase and Forms of Stomatitis.

R22's Minimum Data Set (MDS) dated 10/7/24 documents R22's Brief Interview for Mental Status (BIMS) score 13, cognitively intact.

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R22's Physicians Order Sheet dated 10/3/24 documents Simethicone Tablet Chewable 80 milligrams, Give 1 tablet by mouth every 8 hours as needed for lower GI gas and bloating.

R22's Care plan documents R22 has impaired Nutrition; Interventions-Assist with meals (Feed/Set-up) as needed, Encourage R22 to eat slowly, using pursed lip breathing between bites, Ensure R22 is in proper position for eating.

R22's Health Status note dated 10/3/24 at 9:05 am documents administered as needed gas relief as ordered, educated R22 on chewing tablet very well, walked into hall by residents room, V8 Certified Nursing Assistant (CNA) walked past and saw R22 coughing, walked out room, V7 Licensed Practical Nurse heard R22 gasp and grab R22 throat, V7 yelled out for help, V8 and V11 Certified Nursing Assistant helped this V7 remove R22 from bed, R22 lips blue, still grabbing at R22's throat, one maneuver of Heimlich completed, R22 was able to clear R22's airway successfully. Vital within normal limits, Medical Doctor aware Power of Attorney aware. Respiratory assessments ordered twice a day for 72 hours changed by mouth gas x to Mylanta liquid to prevent further choking hazards.

Facilities Medication Administration Policy dated 1/11/10 documents: Objective; To provide accuracy during medication pass to assure quality care for residents. Policy: It is the policy of this facility to accurately administer medication following physician's orders. Procedure: 9. Administer meds with adequate fluids. Dilute medications, if needed, in juice or water according to pharmacy guidelines and the resident's restrictions. 13. Make sure the resident

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takes the medication. Generally-Do not leave meds at bedside.

On 10/21/24 at 11:38am V8 Certified Nursing Assistant said, on 10/3/24 at 9:00am V8 and V11 Certified Nursing Assistant were pushing residents back to South Hall from breakfast. V8 said, V7 Agency Licensed Practical Nurse (LPN) was outside of R22's room by the medication cart. V8 said, walking back from South Hall, V8 heard R22 coughing. V8 said, V8 observed V7 go into R22's room and then heard V7 call out for help. V8 said, V8 and V11 entered R22's room and R22 was holding R22's throat. V8 said, V3 and V11 assisted R22 to the edge of the bed, and V8 got R22 out of bed and administered the Heimlich maneuver and R22 spit something out of R22's mouth and stopped choking. V8 said, V8 did not see what R22 spit out, only that R22 informed them that "it's out". V8 said, V11 informed V8 that it was a pill that R22 spit out.

On 10/21/24 at 1:18pm R22 said, a couple of weeks ago while R22 was in bed just after breakfast, R22 had a stomach ache a V7 Agency Licensed Practical Nurse gave me medication. R22 stated that "after V7 gave R22 the medication, V7 left the room and R22 began to choke on the medication, and staff came back in and help R22 spit it out".

On 10/21/24 at 1:38pm V11 Certified Nursing Assistant (CNA) said, on 10/3/24 R22 was in V11's group. V11 said, after breakfast V11 assisted R22 back to bed and was in a sitting up position. V8 said, at 9:00am V11 and V8 Certified Nursing Assistant were pushing residents back to the South Hall. V11 said, V11 observed V7 Licensed Practical Nurse outside R22's room. V11 said, after bringing the residents back to

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South Hall and walking back to the dining room, V11 heard V7 call out for help from R22's room. V11 said, V11 and V8 went into the room and observed R22 holding R22's throat. V11 said, V11, V3 and V8 got R22 up to the edge of the bed, and V8 administered the Heimlich Maneuver and R22 spit out a pill, and R22 stated, "it came out'.

On 10/22/24 at 9:34am V2 Director of Nursing said, V2 conducted the investigation regarding R22's choking incident. V2 said, on 10/3/24 V7 Agency Licensed Practical Nurse (LPN) administered R22 a chewable tablet per physicians orders. V2 said, V7 left the room prior to R22 thoroughly chewing and swallowing the tablet and began to choke. V2 said, V7 and V8 heard R22 coughing, and then V7 heard R22 "gasping for air". V2 said, V7 entered the room and observed R22 grabbing R22's throat and V7 called out for help. V2 said, V7, V8 and V11 Certified Nursing Assistant got R22 to the edge of the bed and V8 administered the Heimlich maneuver and R22 was able to clear the medication. V2 said, V7 should have never exited the room until R22 chewed and swallowed the medication to ensure there were no issues with R22 swallowing the medication.

On 10/23/24 at 8:39am V7 Agency Licensed Practical Nurse said, on 10/3/24 at 9:00am V7 administered R22's medication and R22 informed V7 that R22's stomach was upset. V7 said, V7 went and got R22 Simethicone for R22's upset stomach and put it in R22's mouth and told R22 to chew it. V7 said, V7 turned and walked out of the room and V8 Certified Nursing Assistant was walking by and R22 began to cough, V7 turned around and went back into R22's room and R22 was gasping for air and holding R22's throat. V7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002141	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY HEALTH	2304 C R 3000 N GIFFORD, IL 61847

(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 14 said, R22's lips were blue, and V7 yelled for help, and V8 and V11 Certified Nursing Assistant came into R22's room. V7 said, V8 and V11 assisted in getting R22 up and V8 administered one stomach thrust and R22 spit the pill/medication out and was able to breath. V7 acknowledge that V7 should have stood at bedside and ensured that R22 had chewed and swallowed the medication, before turning and leaving the room. (A)	S9999		