STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002364	A. BUILDING: _____ B. WING _____	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA BELLA OF DANVILLE	1701 NORTH BOWMAN DANVILLE, IL 61832

(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 First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 11): 300.610a) 300.610c)2) 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. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray) These requirements are not met as evidenced by: Based on observation, interview, and record	S9999		

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S9999	Continued From page 1	S9999		

review the facility failed to follow its urinary catheter care policy for one (R1) of one resident reviewed for urinary catheters in the sample list of 21.

Findings include:

The facility's Urinary Catheter Care policy dated August 2022 documents to ensure the catheter is secured with a securement device to reduce friction and movement at the insertion site and to clean under the foreskin of uncircumcised males as part of routine perineal hygiene, and to ensure the drainage bag is kept off of the floor as part of infection control.

R1's physician order dated 12/3/24 documents to insert and maintain a size 16 French indwelling urinary catheter related to hospice care.

On 12/23/24 at 3:59 PM V27 and V28 Certified Nursing Assistants entered R1's room and V28 provided R1's urinary catheter cares. V28 did not retract R1's foreskin for cleaning during R1's urinary catheter. R1 did not have a securement device in place. After cares were completed R1's bed was lowered to the floor causing R1's urinary catheter drainage bag to come into contact with the floor. At 4:15 PM 4:15 PM V28 confirmed V28 did not retract R1's foreskin during R1's catheter cares. R1 did not have a urinary securement device and R1's urinary drainage bag was touching the floor.

On 12/24/24 at 3:33 PM V2 Director of Nursing per the facility's policy, securement devices should be used, and foreskin should be retracted for cleaning during male catheter cares. V2 stated urinary catheter drainage bags should not be touching the floor.

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S9999	Continued From page 2 (B) Statement of Licensure Violations (2 of 11): 300.615e) 300.615f) 300.615j) 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based	S9999		

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check are pending; and/or while the Identified Offender Report and Recommendation is pending.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete required background checks timely and implement safety measures while fingerprint based background check results were pending for seven (R1, R4, R16, R17, R18, R19, R20) of ten residents reviewed for background checks in the sample list of 21.

Findings include:

The facility's undated Illinois Identified Offenders Background Screening and Submission Procedure documents potential residents must be screened to determine the potential for placing others at risk of harm and a name based criminal history record using the Criminal History Information Response Process (CHIRP) must be requested within 24 hours of admission. This policy documents if the CHIRP results indicate the resident is an identified offender the facility will arrange for a fingerprint-based criminal history record inquiry within 72 hours.

1.) R1's ongoing census documents R1 admitted to the facility on 11/29/24. There was no documentation that a CHIRP was completed as of 12/26/24.

On 12/23/24 at 3:59 PM R1 resided in a semiprivate room, including R2 as a roommate.

2.) R4's ongoing census documents R4 admitted to the facility on 11/9/24. R4's CHIRP, Illinois Sex

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S9999	Continued From page 4 Offender Search and Illinois Department of Corrections (IDOC) search were uploaded into R4's electronic medical record (EMR) and completed on 11/11/24. 3.) R16's ongoing census documents R16 admitted to the facility on 12/9/24. R16's CHIRP documents completion date of 12/11/24. 4.) R17's ongoing census documents R17 admitted to the facility on 11/20/24. There was no documentation that a CHIRP was completed as of 12/24/24. R17's CHIRP documents a completion date of 12/26/24. 5.) R18's ongoing census documents R18 admitted to the facility on 12/21/24. As of 12/26/24 there is no documentation in R18's medical record that a CHIRP was completed. 6.) R19's ongoing census documents R19 admitted to the facility on 12/5/24. As of 12/26/24 there is no documentation in R19's medical record that a CHIRP was completed. 7.) R20's ongoing census documents R20 admitted to the facility on 12/17/24. R17's CHIRP documents a completion date of 12/20/24. On 12/24/24 between 9:00 AM and 9:52 AM V14 Social Services Director reviewed R1's and R16's background checks and verified accuracy and completion dates as listed above. V14 stated background checks are supposed to be done within 24 hours of admission and are completed by V13 Business Office Manager who then notifies V14 when a resident CHIRP identifies a hit. V14 confirmed there was no documentation of a completed CHIRP for R1.	S9999		

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On 12/24/24 between 2:40 PM and 2:56 PM V1 Administrator reviewed R1's and R16's background checks and verified information noted above. On 12/26/24 at 1:27 PM V1 stated V1 provided what information V1 could locate for R4's, R17's, R18's, R19's, and R20's background checks. V1 confirmed all R4's background checks were uploaded into R4's EMR. V1 stated R1, R17, and R19 do not have completed CHIRPS and were requested today. V1 stated V1 was unable to locate a completed CHIRP for R18. (C)

Statement of Licensure Violations (3 of 11):

300.625b)
300.625c)1)2)
300.625e)
300.625g)
300.625i)
300.625j)
300.625k)

300.625 Identified Offenders

b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:

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1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender.
2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry. (Section 2-201.5(c) of the Act)

g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part.

i) For current residents who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report

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and Recommendation provided by the Department of the State Police.

j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.

k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to implement safety measures while fingerprint-based background check results are pending and failed to follow up on and obtain an Identified Offender Report and Recommendation for two (R15, R21) of ten residents reviewed for background checks in the sample list of 21.

Findings include:

The facility's undated Illinois Identified Offenders Background Screening and Submission Procedure documents the facility must notify the Identified Offenders Programs within 24 hours of a resident's fingerprint appointment and all necessary steps should be taken to ensure the safety of the residents while fingerprint or name based background checks are pending and/or while the Identified Offender Report and Recommendation is pending.

1.) R15's Minimum Data Set (MDS) dated 11/17/24 documents R15 is cognitively intact and

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R15 transfers and walks with supervision/touching assistance from staff. R15's Care Plan dated 6/12/24 documents R15 has a history of criminal behavior, has demonstrated stability during the admission screening process, and does not appear to present a risk. R15's interventions include assisting R15 with mandatory reporting if defined by the terms of R15's sentencing, R15 resides in a private room, and to monitor and record behavioral changes.

R15's Criminal History Information Response Process (CHIRP) dated 5/22/24 documents R15's criminal history includes burglary, aggravated battery and theft. R15's (Live Scan Fingerprinting Company) documents R15 was fingerprinted for a fingerprint-based background check. There is no documentation of the results of this background check or of a Criminal History Analysis and Recommendation (CHAR) report or any follow up with the Illinois State Police in R15's medical record.

On 12/24/24 between 9:00 AM and 9:24 AM V14 Social Services Director stated the facility still does not have R15's CHAR report yet and R15 was fingerprinted on 5/31/24. V14 stated R15 is considered high risk and has care planned interventions including 15 minute checks and a private room. V14 confirmed there is no documentation of any follow up with the Illinois State Police or Identified Offender Program regarding R15's CHAR or fingerprint results.

2.) R21's ongoing census documents R21 admitted to the facility on 12/3/24. R21's CHIRP dated 12/4/24 documents R21 has a criminal history that includes multiple charges of aggravated battery of a nurse, domestic battery, bodily harm, violating an order of protection, and

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theft between 1997 and 2024.

The facility's Daily Census dated 12/23/24 documents R21 resides in a semiprivate room with a roommate.

R21's MDS dated 12/10/24 documents R21 is cognitively intact and R21 transfers and walks with staff supervision/touching assistance. R21's Social Service Notes document the following: On 12/5/2024 at 8:20 AM V14 Social Services Director was informed that R21 had a "HIT" of R21's background check/CHIRP. R21 was scheduled for a fingerprint appointment. An assessment was completed and R21's care plan was updated. R21's fingerprints were completed on 12/11/24.

There is no documentation in R21's medical record of any safety interventions that were implemented while R21's fingerprint based background check results were pending.

On 12/24/24 between 9:00 AM and 9:52 AM V14 stated background checks are supposed to be done within 24 hours of admission and are completed by V13 Business Office Manager who then notifies V14 when a resident CHIRP identifies a hit. V14 stated V14 then schedules fingerprint, notifies the Illinois State Police, completes an assessment of the resident and updates the care plan. V14 stated R21's CHIRP identified hits which included burglary and R21 was recently in jail. R21 was fingerprinted on 12/11 and V14 has not received the results yet. V14 stated V14 did not identify any concerns based on V14's assessment of R21 and review of R21's behaviors. R21 is on standard supervision and behavior monitoring. V14 confirmed this is standard monitoring for all residents. R21 resides

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in a semiprivate room and is mobile, and there were no specific safety interventions implemented for R21 while R21's fingerprint results were pending.

On 12/24/24 between 2:40 PM and 2:56 PM V1 Administrator stated R21 is being moved into a private room and confirmed no specific safety interventions had been implemented while R21's fingerprint results were pending.
(C)

Statement of Licensure Violations (4 of 11):

300.650c)

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 failure was not met as evidenced by:

Based on interview and record review the facility failed to maintain copies of nurse licenses in personnel files and contact the Illinois Department of Financial and Professional Regulation (IDFPR) to verify a nurse's license. These failures have the potential to affect all 141 residents in the facility.

Findings include:

On 12/24/24 V9's (Infection Preventionist/Licensed Practical Nurse (LPN)), V34's, V35's, and V36's (LPNS) personnel files

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were reviewed. These files did not contain copies of their nurse licenses or a copy that the IDFPR website was checked to verify V9's license.

On 12/24/24 at 12:00 PM V17 Human Resources reviewed these employee files and confirmed they did not contain copies of their nurse licenses or the IDFPR check to verify V9's license. V17 stated V17 did not know that a copy of the nurse licenses must be kept in the personnel files. V17 stated V9 was hired prior to V17, but that nurse licenses are checked and verified on the IDFPR website, and a copy should be retained in the personnel file.

On 12/24/24 at 12:07 PM V2 Director of Nursing stated V9 is the facility's Infection Preventionist for both facility's buildings and confirmed V9 has access to all residents.

The staffing sheets document the following: On 12/11/24 V35 and V36 worked on the East Hall. On 12/12/24 V36 worked on the North Hall of the facility and V34 worked on the West Hall.

V9's Time Card with date range of 10/23-12/22/24 document V9 worked 16 days in the facility.

The facility's Daily Census dated 12/23/24 document 141 residents in the facility.
(C)

Statement of Licensure Violations (5 of 11):

300.670a)
300.670c)1)2)3)

300.670 Disaster Preparedness

a) For the purpose of this Section only,

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"disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility.

c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:
1) Ensure that all personnel on all shifts are trained to perform assigned tasks;
2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and
3) Evaluate the effectiveness of disaster plans and procedures.

These failures are not met as evidenced by:

Based on interview and record review the facility failed to conduct disaster drills twice per year for each shift. This failure has the potential to affect all 141 residents in the facility.

Findings include:

On 12/26/24 at 12:00 PM V11 Maintenance Supervisor stated V11 thought there were tornado warnings within the last year that would count as the facility's disaster drills. Documentation of these drills was requested at this time. At 12:15PM V11 provided the facility's Emergency Operations Plan binder which contained information for 2023 and did not contain disaster drills conducted for 2024. V11 stated V11 will need to contact former administration to locate the 2024 disaster drills. At 2:00 PM V11 stated

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V11 was only able to locate staff in-services that were conducted on disaster drills, but actual drills were not conducted as part of this training. V11 confirmed there was no documentation that disaster drills were conducted in 2024.

The facility's Daily Census dated 12/23/24 documents 141 residents in the facility.

The facility's undated Disaster Training policy documents training exercises are conducted annually to test the emergency plan and include unannounced drills, community or facility based full scale and table top exercises. This policy documents emergency training exercises, drills and simulations are conducted in accordance with all applicable local, state, and federal guidelines. This policy documents the exercises, drills and simulations are documented to include individuals that participated, identified issues, and analysis, and this documentation is maintained for at least two years.
(C)

Statement of Licensure Violations (6 of 11):

300.696a)
300.696b)
300.696d)2)3)6)
300.696f)1)2)A)B)3)A)B)4)

300.696 Infection Prevention and Control

a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility's infection preventionist who is qualified through education,

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training, experience, or certification in infection prevention and control.

b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code.

d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United Stated Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):
2) Guideline for Hand Hygiene in Health-Care Settings
3) Guidelines for Prevention of Intravascular Catheter-Related Infections
6) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

f) Infectious Disease Surveillance Testing and Outbreak Response
1) The facility shall have a testing plan and response strategy in place to address infectious disease outbreaks. Pursuant to the plan and response strategy, the facility shall test residents

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and facility staff for infectious diseases listed in Section 690.100 of the Control of Communicable Diseases Code in a manner that is consistent with current guidelines and standards of practice.
2) Each facility shall conduct testing of residents and staff for the control or detection of infectious diseases when:
A) The facility is experiencing an outbreak; or
B) Directed by the Department or the certified local health department where the chance of transmission is high, including, but not limited to, regional outbreaks, epidemics, or pandemics.
For the purposes of this Section, "outbreak" has the same meaning as defined in the Control of Communicable Diseases Code.
3) Documentation
A) For residents, document in each resident's record any time a test was completed, including the result of the test, or whether testing was refused or contraindicated.
B) For facility staff and volunteers, maintain a testing log documenting any time a test was completed, including the result of the test, or whether testing was refused or contraindicated. The testing log shall include all facility staff and volunteers.
4) Upon confirmation that a resident, staff member, volunteer, student, or student intern tests positive with an infectious disease, or displays symptoms consistent with an infectious disease, each facility shall take immediate steps to prevent the transmission by implementing practices that include but are not limited to cohorting, isolation and quarantine, environmental cleaning and disinfecting, hand hygiene, and use of appropriate personal protective equipment.

These failures were not met as evidenced by:

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Based upon observation, interview and record review, the facility failed to perform hand hygiene during catheter care, implement Enhanced Barrier Precautions (EBP), wear appropriate personal protective equipment (PPE) during Covid 19 outbreak for five (R1, R2, R5, R13, R14) of five residents reviewed for infection control in the sample list of 21.

Findings include:

Facility Covid policy review: Dated May 2023; Documenting and reporting Covid 19 must document symptomatic residents and staff including dates and times symptoms identified, when testing was conducted; results; actions taken based on results. Dated June 2023 Covid 19: Identification and Management of ill residents, documents the IP is responsible for establishing and overseeing screening and monitoring effects. Staff who enter room of Covid positive resident must wear an N95 mask or higher and goggles or face shields. Document titled; Using personal protective equipment Covid 19: N95 or higher, eye protection, hand hygiene before and after respirator placement and removal; gloves and isolation gown all removed in room disposed in proper receptacle. Policy includes resident and staff vaccination screenings and strongly encourage receiving vaccine if not contraindicated. Return to work test positive no symptoms 7 days after test; symptomatic 7 days after symptoms resolve.

The facility's Enhanced Barrier Precautions policy dated April 2024 documents EBP may be considered and implemented for residents with wounds and/or indwelling medical devices and gloves and gown must be worn in addition to standard precautions when providing assistance

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with dressing, bathing/showering, hygiene, incontinence cares, medical device cares, wound cares, or when changing linens.

1.) On 12/23/24 at 8:45 AM there was a sign posted on the facility's main entrance door indicating COVID-19 positive cases in the facility. V1 Administrator stated the facility was currently in its second week of its COVID-19 outbreak.

On 12/24/24 at 8:30 AM V21 and V20 CNAs were collecting meal trays from resident rooms on the West Hall while wearing surgical masks with their nose exposed. At 8:38 AM V20 was on the East Hall wearing a surgical mask with V20's nose exposed. V20 walked past R13 and R14 who were not wearing a face covering. V20 confirmed V20's mask was not covering V20's nose but should be. At 8:40 AM V21 confirmed V20's mask was not covering V20's nose and stated V20 has a hard time breathing.

On 12/24/24 at 10:45 AM V2 DON stated staff are expected to wear surgical masks during a COVID-19 outbreak, covering both the nose and mouth.

2.) On 12/23/24 at 3:59 PM there was a sign posted on R1's door that indicated EBP and to wear gown and gloves for high contact resident care. V27 and V28 CNAs entered R1's room to provide R1's urinary catheter cares. V27 and V28 did not wear gowns during R1's cares. R1 was incontinent of bowel movement and V28 cleansed R1's buttocks. V28 did not change V28's gloves and perform hand hygiene prior to apply R1's clean brief, positioning R1's blankets, and reapplying R1's oxygen nasal cannula. At 4:15 PM V27 and V28 confirmed they did not wear gowns for R1's cares and stated they were

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unaware that R1 was on EBP. V27 stated residents with urinary catheters should be on EBP and there is usually a cart containing Personal Protective Equipment outside of the room. V27 confirmed there was no cart outside of R1's doorway. V28 confirmed V28 did not change gloves between R1's incontinence care and touching R1's incontinence brief, linens, and oxygen tubing.

On 12/24/24 at 10:45 AM V2 DON confirmed EBP should be implemented for residents with catheters, feeding tubes, and chronic wounds and gowns should be worn during high contact resident care activities. At 3:33 PM V2 stated V28 should have changed gloves after R1's incontinence cares prior to touching R1's clean brief, blankets, and oxygen tubing.

3.) R5's Physician Order dated 4/8/24 documents EBP every shift and to use gowns and gloves for all direct cares.

On 12/24/24 at 9:59 AM V31 Licensed Practical Nurse flushed R5's gastrostomy tube and initiated R5's gastrostomy tube feeding via mechanical pump. V31 was not wearing a gown for R5's cares. There was a sign on R5's doorway indicating EBP and to wear gown and gloves for high contact cares. At 10:30 AM V31 confirmed V31 did not wear a gown during R5's cares and stated V31 was not aware of EBP.

On 12/24/24 at 10:19 AM V22, V32, and V33 CNAs entered R5's room and provided R5's incontinence cares and were not wearing gowns during R5's cares. This was confirmed with V32.

4.) On 12/23/24 at 1:36 PM V16 Wound Nurse and V25 CNA entered R2's room to administer

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R2's right heel pressure ulcer treatment. V16 and V25 did not wear a gown during R2's wound care and there was signage on R2's room door that indicated EBP and to wear a gown during high contact care including wound care. At 4:20 PM V16 stated residents with wounds are on EBP and this is identified with posted signs. V16 confirmed gowns were not worn during R2's wound care. V16 stated V16 was "nervous and forgot."
(B)

Statement of Licensure Violations (7 of 11):

300.1060a)
300.1060b)
300.1060c)
300.1060d)
300.1060e)

300.1060 Vaccinations

a) A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated, or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of

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the admission, unless the vaccine is medically contraindicated, or the resident has refused the vaccine. (Section 2-213(a) of the Act)
b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused or medically contraindicated. (Section 2-213(a) of the Act)
c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination, or the vaccination is medically contraindicated. (Section 2-213(b) of the Act)
d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act)
e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act)

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S9999	Continued From page 21 These requirements were not met as evidenced by: Based on interview and record review the facility failed to offer influenza and pneumococcal vaccinations, maintain documentation of vaccinations, provide information on shingles, and develop and implement a process for screening for Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV) and offering the Hepatitis B vaccine for five (R1, R2, R3, R4, R5) of five residents reviewed for immunizations in the sample list of 21. Findings include: 1.) R1's ongoing census documents R1 admitted to the facility on 11/29/24 and is over age 65. R1's Care Plan revised 12/4/24 documents R1's diagnoses include Chronic Obstructive Pulmonary Disease (COPD). There is no documentation in R1's electronic medical record (EMR) of R1's influenza and pneumococcal vaccination status or that these vaccinations were offered after R1 admitted to the facility. On 12/24/24 at 12:07 PM V2 Director of Nursing (DON) stated V9 Infection Preventionist is responsible for tracking immunizations, which should be documented under the immunizations section of the resident's EMR. V2 stated if the information is not documented there then V2 does not have any additional information to provide. On 12/26/24 at 2:58 PM V2 confirmed there is no documentation of R1's influenza and pneumococcal vaccination status or that these vaccinations were offered to R1 after admission.	S9999		

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2.) R4's ongoing census documents R4 admitted to the facility on 11/9/24 and is over age 65. R2's ongoing diagnoses list includes COPD and acute respiratory failure. There is no documentation in R4's EMR of R4's influenza and pneumococcal vaccination status or that these vaccines were offered after admission.

On 12/26/24 at 2:58 PM V2 confirmed there is no documentation of R4's influenza and pneumococcal vaccination status or that these vaccines were offered to R4 after admission.

3.) There is no documentation in R1's, R2's, R3's, R4's, and R5's EMR that they were screened for Hepatitis B, Hepatitis C, HIV; that they were offered the Hepatitis B vaccine; or that information on shingles was provided.

On 12/24/24 at 10:45 AM V2 stated V2 was unsure if the facility screens for Hepatitis B, Hepatitis C, and HIV and V2 did not think information on shingles is provided to residents. V2 stated the facility offers Hepatitis B vaccination which should be documented with the immunizations. V2 stated he will find out additional information. At 12:40 PM V2 stated the Hepatitis B vaccine is offered and documented under the immunization section of the resident's EMR and we just recently implemented a screening assessment for this which is documented under the assessments section. V2 stated the facility does not have a screening process for Hepatitis C and HIV other than reviewing laboratory values, but there is no documentation of this screening process. V2 confirmed residents could be high risk or positive who have never been tested.

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On 12/26/24 at 1:27 PM V1 Administrator confirmed the facility does not have a policy for screening for Hepatitis B, Hepatitis C, or HIV. At 2:56 PM V1 stated V1 and V2 were unable to locate documentation that shingles information is provided to residents.

The facility's Influenza Vaccination policy dated March 2022 documents residents will be offered the influenza vaccine annually between October 1st and March 31st, resident refusals will be documented on a consent form in the resident's medical record, and documentation of previous vaccination should be provided to the facility.

The facility's Pneumococcal Vaccine policy dated March 2022 documents residents are assessed prior to or upon admission for eligibility of the pneumococcal vaccine series and are offered the vaccine within 30 days of admission unless the vaccine is medically contraindicated, or they were previously vaccinated. This policy documents the pneumococcal vaccines are offered in accordance with the Centers for Disease Control and Prevention recommendations. This policy documents to record vaccination administration and resident refusals in the resident's medical record.

(B)

Statement of Licensure Violations (8 of 11):

300.1210a)
300.1210b)
300.1210d)3)5)6)

300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A

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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)

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:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
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 are not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement pressure relieving interventions and treatments, assess pressure ulcers, implement gastric tube interventions and orders, and implement smoking supervision for five (R2, R5, R6, R10, R11, R12) residents. R2 and R6 are two of two residents reviewed for pressure ulcers. R5 is one of one resident reviewed for gastrostomy tubes, and R10, R11, R12 are three of three residents reviewed for smoking in a sample list of 21.

Findings include:

1. On 12/23/24 at 3:45 PM, V16 Wound Nurse stated the wound doctor comes every Tuesday. V16 stated R6's wound was closed last Friday but this morning was open so it must have opened over the weekend. V16 stated she put a new treatment order in this morning for the change in

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wound conditions. V16 denied knowledge of pressure ulcer at time of admission. V16 stated skin checks were in place but stated she is unclear why R6's wound was not being treated prior to 12/17/24. V16 and V14 provided perineal care and wound care for R6. Wound noted to coccyx area. No dressing in place currently. Area pink in middle and white around edges. Scant clear drainage noted from middle of wound. Wound measures approximately 3cm (centimeters) x 2cm x 0.01cm. V16 did not date dressing prior to assisting R6 back into incontinence brief.

R6's hospital records dated 12/10/24 document pressure ulcer to sacrum on 12/10/24 measuring 2.0 centimeters (cm) x 2.0 cm X 0.01 cm.

R6's wound notes dated 12/17/24 document stage 2 pressure ulcer to sacral area measuring 3.3 x 3.7 x 0.01 cm. with no treatment documented prior to 12/17/24 wound doctor visit. R6's treatment records dated month of December document no treatments prior to 12/17/24.

R6's physician order sheet dated 12/24/24 documents no orders for wound treatments prior to 12/17/24. R6's list of assessments dated 12/24/24 does not document any skin assessments prior to 12/23/24.

R6's care plan dated with admission date of 12/10/24 documents at risk for skin impairment on 12/10/24 and pressure wound on 12/16/24 with intervention of specialty mattress. No specialty mattress in place currently.

The facility's Pressure Injury Risk Assessment policy dated March 2020 documents to document findings of the resident's skin assessment on the

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approved skin assessment tool, initiate a form related to the type of skin alteration if noted and notify the physician of new skin alterations. This policy documents the residents centered care plan will include interventions based on the resident's risk factors and assessment.

The facility's Prevention of Pressure Injuries dated April 2020 documents to inspect skin on a daily basis while assisting with personal cares to inspect pressure points and identify any signs of developing pressure ulcers. This policy documents preventative skin care includes using a barrier product for moisture protection and using protective dressings.

2.) On 12/23/24 at 3:30 PM three residents (R10, R11, R12) were helped out of the north wing door (COVID unit) to smoke. One resident was in wheelchair and one used walker and one walking. The staff who assisted the residents out the door did not stay with residents outside. At 3:35 PM residents were still outside without staff present. There were no staff present outside or inside that were directly supervising the residents while smoking.

On 12/23/24 at 3:45 PM V1 Administrator stated per policy all smokers are 100% supervised. R10, R11, and R12 smoking assessments all document they require supervision during smoking.

The facility's Smoking Safety policy dated August 2024 documents a smoking assessment will be completed to determine the level of assistance and supervision needed during smoking which will be care planned and followed.

3.) R2's Minimum Data Set (MDS) dated 10/23/24

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	IL6002364	A. BUILDING: _____ B. WING _____	12/26/2024

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documents R2 has severe cognitive impairment and is dependent on staff for dressing. R2's current care plan documents R2's diagnoses include Alzheimer's Disease, Type Two Diabetes Mellitus, Cerebral Infarction, and left above knee amputation.

R2's Wound Evaluation & Management Summary dated 12/17/24, recorded by V30 Wound Physician, documents R2's stage four pressure ulcer of the right heel with duration of over 234 days measured 1 centimeter (cm) by 0.7 cm by 0.3 cm and had undermining of 0.5 cm at 9 o'clock. This note documents a treatment order to apply collagen powder, apply calcium alginate, apply skin protectant to peri wound, and cover with a bordered foam dressing daily; and includes a recommendation to wear a heel protector when in bed. This order and recommendation are also listed on R2's current December 2024 Treatment Administration Record.

On 12/23/24 at 9:13 AM and 9:34 AM R2 was lying in bed and was not wearing a pressure relieving boot on R2's right foot. At V19 Certified Nursing Assistant (CNA) was feeding R2 lunch. R2 was lying in bed and was not wearing a pressure relieving boot. At 1:05 PM V19 confirmed V19 was R2's assigned CAN. R2 was not wearing a pressure relieving boot and located R2's boot on a night stand across the room. V19 stated V19 was not aware that R2 had a right heel wound.

On 12/23/24 at 1:36 PM V16 Wound Nurse and V25 CNA entered R2's room to administer R2's pressure ulcer treatment. V16 stated R2 uses a pressure relieving boot and is compliant with wearing it but sometimes R2 kicks off the boot and staff have to reapply it. V16 removed the

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dressing and there was a pink/red circular wound to R2's outer right heel. V16 cleansed the wound, applied collagen powder, applied calcium alginate, and covered with a bordered foam dressing. V16 did not apply a skin protectant to the peri wound as ordered. At 1:56 PM V19 confirmed V19 did not apply the skin protectant during R2's wound treatment and stated it was being used primarily for adhering the dressing.

On 12/24/24 at 10:45 AM V2 Director of Nursing (DON) confirmed nurses should follow the entire treatment order for wound care.

4.) R5's current Care Plan documents R5 has a gastrostomy tube (g-tube), the head of bed should be elevated, and to check tube placement and gastric residual volume per facility protocol and record.

R5's December 2024 Medication Administration Record (MAR) documents the following: Check gastric residual prior to feeding and medication administration. If greater than 100 milliliters (ml), hold feeding and recheck in one hour, if not resolved then notify the physician. Elevate head of bed at least 30 degrees during feeding or medication administration and for 30 minutes after feeding. Administer Jevity 1.2 (feeding) at 65 ml/hour for 22 hours per day, off from 8:00 AM until 10:00 AM.

There is no documentation in R5's medical record that R5's gastric residual volume amounts are recorded for each check as ordered. R5's Nursing Note dated 12/16/24 at 2:49 AM documents water was gushing from R5's g-tube after flushing and R5's feeding was held. This note does not document how long R5's feeding was held for, gastric residual volumes, or that the

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physician was notified. R5's Nursing Notes dated 11/3/24 at 11:08 PM and 11/4/2024 at 2:18 AM document R5's feeding was turned off due to fullness of stomach contents and overflow. These notes do not document gastric residual volumes, how long the feeding was held for, and if the physician was notified.

On 12/24/24 at 9:53 AM R5 was lying in bed with feeding and tubing connected to R5's g-tube and the feeding pump was turned off. At 9:59 AM R5 was lying in bed with feeding still connected and feeding pump off. V31 Licensed Practical Nurse stated R5's feeding was stopped at 8:00 AM by another nurse and confirmed the feeding has remained off with the tubing still connected. V31 disconnected the feeding tubing, used a syringe to plunge 130 ml of water into R5's g-tube, and did not check placement of R5's gastrostomy tube via air rush or gastric residual volume. R5 coughed and a small amount of water came out of R5's gastrostomy tube as V31 connected and initiated R5's tube feeding. V31 was asked about checking tube placement and stated tube placement is checked prior to initiating feedings. V31 used air rush technique earlier prior to this observation. V31 then demonstrated this technique with 20 ml of air via syringe but did not check gastric residual volume. V31 stated V31 was unsure about gastric residual volume checks and was unsure if there were ordered parameters for holding R5's feedings. V31 confirmed V31 does not check gastric residual volume prior to administering R5's feedings and medications. R5's orders were reviewed with V31 and verified orders to check gastric residual volume and parameters to hold feedings and notify the physician.

On 12/24/24 at 10:19 AM V22, V32, and V33

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CNAs entered R5's room. V31 turned off R5's feeding and left the room. V22 lowered the head of R5's bed less than 30 degrees, almost flat, and the bed remained in this position while V32 provided R5's incontinence cares. V32 stated the nurse must turn off R5's feeding before any cares are provided. V32 confirmed the head of R5's bed was not elevated during R5's observed care and should be. At 10:30 AM V31 stated the head of R5's bed should not be flat during cares due to risk for aspiration.

On 12/24/24 at 12:06 PM V2 DON stated V2 would refer to the facility's enteral feeding policy for g-tube care. V2 confirmed the feeding tubing should be disconnected and the g-tube flushed with water when feedings are stopped. V2 reviewed R5's MAR and nursing notes and confirmed gastric residual volume is not recorded for each ordered check or when R5's feeding was held. V2 stated the nurses should document follow up with the physician in the nursing notes.

The facility's Enteral Nutrition policy dated November 2018 documents the provider will consider the need for supplemental orders, including confirming tube placement, head of bed elevation, and checking for gastric residual volume. This policy documents staff are trained on how to recognize and report complications including aspiration and clogging of the tube, and the risk of aspiration may be affected by improper positioning of the resident during feedings and failure to confirm tube placement prior to feedings.
(B)

Statement of Licensure Violations (9 of 11):

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S9999	Continued From page 32 300.2420b)2) 300.2420 Equipment and Supplies b) Privacy Screens and Curtains 2) Each multiple-bed resident room must be designed or equipped to assure full visual privacy for each resident. Full visual privacy means that residents have a means of completely withdrawing from view while occupying their beds (e.g., curtains, movable screens). This requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure full visual privacy for two (R1, R2) of three residents reviewed for environment in the sample list of 21. Findings include: The facility's Dignity policy reviewed September 2024 documents, "Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures". On 12/23/24 at 3:59 PM V27 and V28 Certified Nursing Assistants provided R1's urinary catheter care. During R1's cares V29 Registered Nurse attempted to pull the privacy curtain between R1's and R2's bed. The curtain would not close all the way leaving a gap and R1 exposed and in view of R2 during R1's urinary catheter care. V27 and V28 stated they had attempted to close the curtain as well, but it wouldn't close all the way. R1's Minimum Data Set (MDS) dated 12/6/24 documents R1 has severe cognitive impairment. R2's MDS dated 10/23/24 documents R2 has	S9999		

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S9999	Continued From page 33 severe cognitive impairment. On 12/24/24 at 3:33 PM V2 Director of Nursing stated V2 expects privacy curtains to be pulled during cares. V2 confirmed the curtains should provide full visual privacy. (C) Statement of Licensure Violations (10 of 11): 300.3210a) 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United Stated solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act) This requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident (R3) was treated with dignity and respect. R3 is one of one resident reviewed for resident rights in the sample list of 21. Findings include: On 12/23/24 at 10:02 AM R3, Resident Council President, stated there have been many complaints brought up in council meetings about V9 Infection Preventionist/Licensed Practical Nurse and management. R3 stated, staff tell us V9 was spoken to about V9's behavior. R3 stated V9 referred to us residents as "wild animals" saying "(V9) is so sick of these residents." R3	S9999		

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stated V9 continues to make comments. R3 stated on an unidentified date in September 2024, V9 walked past R3, gave R3 a "dirty look", and said "grown man acting like a four year old" referring to R3.

R3's Minimum Data Set dated 9/25/24 documents R3 as cognitively intact.

The facility's Resident Council Issues Response Form dated 9/25/24 documents residents voiced concerns that V9 takes too long and is "rude and hateful" every day. The documented response for this concern is: V9 is now the Infection Preventionist and will no longer be working as a floor nurse. The form is signed by V3 Assistant Director of Nursing.

On 12/23/24 at 11:42 AM V8 Activity Director stated V8 coordinates and attends the resident council meetings. V8 stated V9 has been brought up in the meetings, that the residents don't like V9's attitude and V9 has made "snide comments" and has a "big head". V8 was unable to recall which residents complained about V9.

On 12/23/24 at 1:01 PM V26 Registered Nurse stated V26 has been told that V9 can't work the South Hall (R3's hall) due to so many residents complaining about V9. V26 described V9 as being "short" at times with the residents.

On 12/23/24 at 1:54 AM V25 Certified Nursing Assistant stated at times V9 can be "short" with the residents.

On 12/23/24 at 2:24 PM V3 Assistant Director of Nursing stated there were prior complaints of V9's bedside manner such as rushing and lack of patience. V3 stated staff were in-serviced on

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S9999	Continued From page 35 customer service after the September 2024 Resident Council Meeting, and V9 was given one to one counseling, but V3 has no documentation of that. On 12/23/24 at 2:40 PM V1 Administrator stated "rude and hateful" is unacceptable behavior in this facility. The facility's Dignity policy dated September 2024 documents, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem." "Residents are treated with dignity and respect at all times." "Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs." (B) Statement of Licensure Violations (11 of 11): 300.3260f) 300.3260 Resident's Funds f) The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the Departments of Public Health and Insurance that all residents' personal funds deposited with the facility are secure against loss, theft, and insolvency. (Section 2-201(5) of the Act). This requirement is not met as evidenced by: Based on interview and record review, the facility failed to secure a surety bond to cover the	S9999		

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S9999	Continued From page 36 amount deposited in the resident trust fund. This failure has the potential to affect all 146 residents in the facility. Findings include: Resident trust fund balance report dated 12/23/24 documents a total balance of $111,115.85. Facility surety bond dated 8/1/2024 documents coverage up to $50,000 total. 12/24/24 2:15 PM V1 Administrator confirmed the resident trust fund is offered to all residents in the facility and the current total of funds deposited exceeds the surety bond of $50,000 with the balance of trust at over $110,000. The Daily Census dated 12/23/24 documents 141 residents in the facility. (C)	S9999		