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| S 000 | Initial Comments<br><br>Annual Licensure Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations 1 of 9:<br>300.1210a)<br>300.1210b)4)5)<br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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)<br><br>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 | S9999 | | |

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care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure proper wheelchair positioning to prevent a fall, failed to provide safe equipment, and failed to use a mechanical lift for transfers for one (R269) of 16 residents reviewed for accidents on the sample list of 21. These failures resulted in R269

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requiring emergency room treatment after falling from a wheelchair and hitting R269's head on the floor. R269 sustained a head injury and a hematoma to the left forehead. These failures also resulted in R269 sustaining skin tears to the left and right forearm.

Findings include:

On 2/3/25 at 11:12 PM, R269 was sitting in a reclining wheelchair by the nurse's station. R269 had a yellowish - blue bruised raised area above the left eye. This bruising extended down the left side of R269's face to underneath of R269's chin. R269 had skin protective sleeves on the left and right arm. Black and yellowish bruising was seen underneath these sleeves.

R269's Incident Report dated 1/29/25 documents that R269 was found on the floor in front of her reclining chair. A hematoma was noticed to the left temporal area and skin tear to the left knee. This incident report documents that R269 was watching television prior to the fall. This report documents R269 was sent to the emergency room for an evaluation.

R269's Emergency room visit notes dated 1/29/25 documents R269 was seen in the emergency room for a head injury due to a fall at the facility. These notes document R269 sustained a hematoma to the left forehead as a result of the fall.

On 2/05/25 at 1:38 PM, V18 (Certified Nursing Assistant/CNA) stated just prior to R269's 1/29/25 fall, R269 was seen sitting comfortably watching television in a slight reclining position in the reclining wheelchair. V18 stated that the reclining wheelchair was not all the way reclined.

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| S9999 | Continued From page 3<br><br>On 2/04/25 at 1:56 PM, V2 (Director of Nursing) stated V2 investigated the cause of the fall occurring on 1/29/25. V2 stated she interviewed the CNAs (V18 and V45) who were caring for R269 at the time of the fall. V2 stated these interviews concluded that R269's reclining wheelchair was not reclined at the time of the fall. V2 stated it should have been reclined because R269 has poor core strength and R269 has been getting therapy for this. V2 stated she determined that R269 fell forward out of the chair due to poor core strength and the chair not being reclined.<br><br>On 2/4/25 at 8:47 AM, V11 (Advanced Practice Nurse) was conducting an assessment on R269. V11 stated R269's injuries are consistent with the fall however he cannot see R269 being able to move self out of the reclining wheelchair if the chair was reclined.<br><br>On 2/04/25 at 12:25 PM, V16 (Physical Therapist) stated that R269 has poor core balance, and that therapy has been working on strengthening. V16 stated that R269's reclining wheelchair should be fully reclined to prevent R269 from falling forward out of the chair.<br><br>R269's incident report dated 1/27/25 at 11:00 AM documents, R269 was found to have a skin tear measuring 15.3 centimeters to the left arm and a three-centimeter skin tear to the right arm. This incident report documents that the staff have observed R269 putting both arms through the openings underneath the wheelchair armrests. This report documents that the metal bolts underneath the arm rests had rough edges which could have possibly caused the skin tears. | S9999 | | |

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On 2/5/25 at 10:15 AM, V45 (CNA) stated that she assisted R269 to the bathroom on 1/27/25 and noticed dry blood on R269 right and left arms. V43 stated that R269 has a daily habit of putting her arms between under the armrests. V43 stated she didn't tell anyone about R269 repeated daily stuffing arms through the wheelchair armrest and the seat of the chair. V43 stated that she always wears short sleeve shirts and tended to slide down in the wheelchair. V43 stated that upon inspection the bolts under the armrest were sharp and consistent with the skin tears.

On 2/04/25 01:56 PM, V17 (Assistant Director of Nursing) and V2 (Director of Nursing) stated that R269's wheelchair had sharp bolts underneath the arm rest on both the right and left side of the wheelchair. V2 stated V2 was working when R269 was found to have the skin tears. V2 stated it was determined that the skin tears were caused from the bolts on the wheelchair.

On 2/5/25 at 12:58 PM, V9 (Maintenance Director) stated the facility does not have a process for ensuring that wheelchairs are safe prior to use.

On 2/04/25 at 12:25 PM, V16 (Physical Therapist) stated that R269 was a sit to stand lift but then had a stroke, R269 returned to the facility on 1/21/25. V16 stated R269 was made a full mechanical lift on 1/30/25. V16 stated R269's transfer status is written on a transfer directive sheet and taped to the back of the bathroom door.

R269's Transfer Directive dated 1/30/25 documents R269 is a full mechanical lift for transfers.

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| S9999 | Continued From page 5<br><br>On 2/04/25 at 10:35 AM, V14 and V15 (Certified Nursing Assistants) transferred R269 with the sit to stand lift.<br><br>On 2/04/25 at 11:07 AM, V14 and V15 transferred R269 with the sit to stand lift.<br><br>On 2/04/25 at 1:56 PM, V2 (Director of Nursing) stated V14 and V15 should have transferred R269 with the full mechanical lift.<br><br>"B"<br><br>Statement of Licensure Violations 2 of 9: 300.610a)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to date and change oxygen tubing for one of one resident (R503) reviewed for oxygen in the sample list of 13. | S9999 | | |

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Findings include:

The facility's Oxygen Therapy policy dated 1/23/02 documents change oxygen tubing and prefilled humidifiers weekly and as needed, label with a date, and record on the Treatment Administration Record.

On 2/3/25 at 2:40 PM R503 was lying in bed asleep wearing oxygen at 2 liters per minute (l/min) per nasal cannula. The prefilled humidifier bottle was 1/4 full. There was no date labeled on the tubing or the humidifier bottle.

R503's physician order dated 4/12/24 documents an order for oxygen at 2 l/min when in bed. R503's active physician orders do not include orders for routine changing of oxygen tubing and humidifier bottles.

On 2/4/25 at 11:00 AM V30 (Registered Nurse) stated residents who use oxygen should have an order to change the tubing weekly, which is changed on night shift on Sundays and documented on the Treatment Administration Record. V30 stated the humidifier bottle should be dated and changed with the oxygen tubing. V30 confirmed R503 does not have an order for routine changing of oxygen tubing and humidifier. At 2:03 PM V30 confirmed R503's oxygen tubing and humidifier bottle were not dated.

"C"

Statement of Licensure Violations 3 of 9:
300.615e)
300.615f)
300.625g)

Section 300.615 Determination of Need

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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.

Section 300.625 Identified Offenders
g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to complete background checks within 24 hours of admission for three of ten residents (R504, R10, R69) reviewed for identified offenders in the sample list of 13.

Findings include:

The facility's "Admission / Readmission To Do

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List" dated November 2024 documents the Criminal History Information Response Process (CHIRP), Illinois Department of Corrections search, and Illinois State Police Identified Sex Offender search are the three background checks that need to be completed for all admissions and this information should be saved and uploaded into each resident's electronic medical record.

1.) R69's active Census documents R69 admitted to the facility on 1/16/25. There is no documentation in R69's medical record that background checks were completed prior to 2/3/25.

On 2/3/25 at 2:47 PM V8 (Assistant Administrator) provided R69's CHIRP, Illinois Sex Offender Registry search, and Illinois Department of Corrections search dated 2/3/25.

On 2/3/25 at 4:02 PM V4 (Registered Nurse/Nurse Coordinator) confirmed V4 completed R69's background checks on 2/3/25. V4 stated V4 had to run R69's background checks today because the prior checks that were ran on 1/16/25 weren't saved/printed.

2.) R504's active Census documents R504 admitted to the facility on 12/2/24. There is no documentation in R504's medical record that background checks were completed after R504 admitted to the facility.

3.) R10's active Census documents R10 admitted to the facility on 12/17/24. There is no documentation in R10's medical record that background checks were completed after R10 admitted to the facility.

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| S9999 | Continued From page 9<br><br>On 2/3/25 at 3:34 PM V43 (Director of Resident Services) stated V43 assists with completed resident background checks. V43 was asked about R10's and R504's background checks and stated they admitted to the facility from the facility's assisted living section. V43 stated background checks are completed upon admission to the assisted living but are not done again if they transfer/admit to the facility's long term care units.<br><br>"C"<br><br>Statement of Licensure Violations 4 of 9:<br>300.650a)<br>300.650c)<br>300.661<br><br>Section 300.650 Personnel Policies<br>a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the following requirements.<br><br>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.<br><br>Section 300.661 Health Care Worker Background Check<br>A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.<br><br>This REQUIREMENT is not met as evidenced by: | S9999 | | |

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A.Based on interview and record review the facility failed to maintain copies of active nurse licenses in personnel files. This failure has the potential to affect all 45 residents in the facility.

Findings include:

The facility's employee roster documents the following: V38 (Registered Nurse) was hired on 5/14/24 and works PRN (as needed). V39 (Registered Nurse) was hired on 3/12/24 and works PRN. V40 (Licensed Practical Nurse) was hired on 9/14/21 and works PRN.

On 2/4/25 at 12:48 PM employee files for V38, V39 and V40 were reviewed with V26 (Assistant Human Resources Director). V26 stated there should be a copy of each nurse's active license in their employee file, and confirmed V38's, V39's, and V40's personnel files did not contain a copy of their active licenses.

On 2/4/25 at 1:32 PM V1 (Administrator), V8 (Assistant Administrator) and V3 Chief (Operating Officer) confirmed V38, V39, and V40 have the potential to work on all units of the facility.

The facility's Daily Census dated 2/2/25 documents 45 residents reside in the facility.

B. Based on interview and record review the facility failed to maintain documentation that background checks were completed for employees prior to hire. This failure has the potential to affect all 45 residents in the facility.

Findings include:

The facility's Selection/Hiring Process documents applications are reviewed and processed by

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Human Resources which includes license verification, Illinois Department of Public Health (IDPH) Registry, sex offender registry, and any other checks required by IDPH.

The facility's employee roster documents V32 (Housekeeper) was hired on 10/22/24, V33 (Maintenance) was hired on 12/7/24, V14 and V34 (Certified Nursing Assistants/CNAs) were hired on 10/22/24, V35 (CNA) was hired on 2/29/24, V36 (CNA) was hired on 8/26/24, and V37 (CNA) was hired on 11/21/24.

On 2/4/25 at 12:48 PM employee files for V14, V32, V33, V34, V35, V36, and V37 were reviewed with V26 (Assistant Human Resources Director) and V27 (Human Resources Assistant). V27 stated V27 is responsible for running the six required employee background checks prior to hire. V26 and V27 demonstrated the process for background checks through the facility's electronic software system. V26 and V27 confirmed there is no time stamped documentation that the listed employees' background checks included Illinois Sex Offender search, Department of Corrections (DOC) Sex Offender search, DOC Inmate search, DOC Wanted Fugitive search. V26 and V27 confirmed the facility's system only logs the date the Department of Health and Human Services Office of Inspector General search was conducted.

On 2/4/25 at 1:32 PM V1 (Administrator), V8 (Assistant Administrator) and V3 (Chief Operating Officer) confirmed the above listed employees work throughout the facility.

V37's Timecard documents on 2/1/25 V37 worked in the Greenhouse unit of the facility. V38's Timecard documents V38 worked on

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Meadowbrook (the facility's skilled unit) on 1/26/25. V40's Timecard documents V40 worked on 1/31/25 on Meadowbrook. V36's Timecard documents V31 worked in the Greenhouse on 1/31/25 and 2/1/25. V35's Timecard documents V35 worked on Meadowbrook or Greenhouse Units on 1/20/25, 1/23/25, 1/24/25, 1/29/25, 1/30/25 and 2/1/25. V35 worked on 1/30/25 from 10:55 PM until 9:45 AM. V14's Timecard documents V14 worked on Meadowbrook on 1/20/25, 1/21/25, 1/24/25, 1/26/25, 1/29/25 and 1/30/25. V34's Timecard documents V34 worked on Meadowbrook on 1/19/25, 1/21/25, 1/26/25, 1/27/25, and 1/28/25. V33's Timecard documents V33 worked on 1/19/25-1/23/25 and 1/26/25-1/30/25. V32's Timecard documents V32 worked on 1/21/25-1/24/25 and 1/27/25-2/1/25.

The facility's daily staffing schedule dated 1/31/25 documents V36 was assigned to the East Greenhouse and V35 was assigned to the East Greenhouse between 7:00 AM and 9:45 AM. The daily staffing schedule dated 2/1/25 documents V35 and V37 were assigned to the West Greenhouse and V36 was assigned to the East Greenhouse.

The facility's Daily Census dated 2/2/25 documents 45 residents reside in the facility.

"C"

Statement of Licensure Violations 5 of 9:
300.682a)1)2)3)4)
300.682b)
300.682c)
300.682h)
300.682i)

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Section 300.682 Nonemergency Use of Physical Restraints
a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:
1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective;
2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being;
3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and
4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act)

b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

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c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used.

h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible
progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well being.

i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to obtain a physician order, obtain consent, and assess for the use of restraints for two of two residents (R502, R503) reviewed for restraints in the sample list of 13.

Findings include:

The facility's Emergency Use of Physical Restraints policy dated 7/18/13 documents the following: A physical restraint may be used briefly for emergency care if other less restrictive

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interventions were ineffective. Obtain a physician order for use. Assess for the effectiveness of the restraint and any negative resident impact while the restraint is used. Document in the resident's medical record the behavior that prompted the use of the resident, the date and time it was applied and released, the physician's order, the effectiveness and any negative impact, and the date of the scheduled care plan conference,

1.) On 2/4/25 at 10:12 AM R502 was lying in bed. One side of the bed was against the wall. On the opposite side of the bed was a foam bolster positioned underneath of a top sheet which was tied to the bedframe in a knot at each corner of the bed. The bolster was approximately six inches tall and was the length from R502's shoulders to knees.

On 2/4/25 at 10:15 AM V29 (Certified Nursing Assistant/CNA) entered R502's room and stated the bolster is used to keep R502 from rolling out of bed. V29 confirmed the tied sheet was holding the bolster in place. V29 stated R502 is not able to remove the bolster herself. V29 asked R502 to remove the bolster and R502 did not attempt to remove the bolster.

R502's Nursing Note dated 1/9/25 at 10:46 PM documents R502 has moderate cognitive impairment and is alert and oriented to person only.

R502's Care Plan with revised date of 2/05/2021 documents R502 is at risk for falls and includes an intervention dated 11/26/22 for R502's bed to be against the wall, roll control bolster placed on bed, and fall mat while in bed. This care plan does not identify this bolster as a restraint.

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R502's medical record does not document an assessment, physician's order, or consent for the use of the bolster restraint.

2.) On 2/4/25 at 2:07 PM R503 was lying in bed on a raised edge mattress and one side of the bed was against the wall. V28 CNA placed a foam bolster underneath a fitted sheet along the raised edge of the mattress on the side of the bed opposite the wall. This bolster was approximately six inches tall and was the length from R503's shoulders to knees. V28 placed R503's hand on the bolster and asked R503 to remove the device. R503 was unable to remove the device.

On 2/3/25 at 10:54 V44 (CNA) stated the bolster is used to keep R503 from falling out of bed and R503 is unable to remove it himself.

R503's Nursing Note dated 1/29/25 at 10:30 AM documents R503 has short term memory loss and is oriented to person only.

R503's Care Plan dated 11/27/23 documents R503 has gait/balance problems and includes an intervention dated 4/2/24 for roll control bolster instructions placed in room for a fall on 3/31/24. This Care Plan does not identify this bolster as a restraint.

R503's medical record does not document an assessment, physician's order, or consent for the use of the bolster restraint.

On 2/4/25 at 3:01 PM V1 (Administrator) stated there weren't any restraints currently being used (where R502/R503 reside). V1 stated we weren't considering the bolsters as a restraint since the device was implemented as a fall intervention. V1 confirmed there were no documented

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assessments, orders, or consent for the use of bolster restraints for R502 and R503.

"B"

Statement of Licensure Violations 6 of 9:
300.686b)
300.686d)1)2)3)4)5)6)
300.686i)

Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications
b) State laws, regulations, and policies related to psychotropic medication are intended to ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. (Section 2-106.1(b) of the Act)

d) A resident shall not be given unnecessary drugs. An unnecessary drug is any drug used:
1) In an excessive dose, including in duplicative therapy;
2) For excessive duration;
3) Without adequate monitoring;
4) Without adequate indications for its use;
5) In the presence of adverse consequences that indicate the medications should be reduced or discontinued (Section 2-106.1(a) of the Act); or
6) Any combination of the circumstances stated in subsections (d)(1) through (5).

i) All facilities shall implement written policies and procedures for compliance with Section 2-106.1 of the Act and this Section. A facility's failure to make available to the Department the documentation required under this subsection is

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sufficient to demonstrate its intent to not comply with Section 2-106.1 of the Act and this Section and shall be grounds for review by the Department. (Section 2-106.1(b-15) of the Act)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to document behaviors and implement nonpharmacological interventions prior to administering antianxiety medication for two of two residents (R502, R503) reviewed for psychotropic medications in the sample list of 13.

Findings include:

The facility's Psychotropic Medication policy dated 3/28/18 documents psychotropic medications will not be administered unless behavioral programming, environmental changes and non-pharmacological interventions were implemented and failed. This policy documents to identify and document targeted behaviors as well as individualized non-pharmacological interventions implemented.

1.) R502's December 2024 and January 2025 Medication Administration Records (MARs) document to monitor R502 twice daily for targeted behaviors of anxiety/restlessness for Ativan, record "yes" if behaviors are displayed and "no" if no behaviors observed. These MARs document to give Ativan (antianxiety medication) 0.5 milligrams (mg) one tablet by mouth every two hours as needed (PRN) for anxiety/restlessness, and this medication was given on 12/15/24 at 11:39 PM, 12/24/24 at 3:04 AM and 1/2/24 at 1:11 AM. There are no documented behaviors and implemented nonpharmacological interventions in R502's nursing notes or MARs for the listed

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dates/times of Ativan administration.

2.) R503's January 2025 MAR documents to monitor R503 twice daily for targeted behaviors of anxiety, restlessness and hospice comfort, and to record "yes" if behaviors are displayed or "no" if no behaviors are observed. This MAR documents to give Ativan 0.5 mg one tablet by mouth every two hours PRN for anxiety or restlessness, and this medication was given on 1/3/25 at 2:40 AM and 1/19/25 at 2:59 AM. There are no documented behaviors and implemented nonpharmacological interventions in R503's nursing notes or MARs for the listed dates/times of Ativan administration.

R503's Nursing Note dated 11/27/2024 at 5:51 AM documents R503 had increased restlessness and attempts to place legs over the side of the bed and PRN Ativan was administered for restlessness. There is no documentation what failed nonpharmacological interventions were attempted prior to administering Ativan.

On 2/3/25 at 2:46 PM V31 Registered Nurse stated the nurses document in a nursing note the behavior that prompted PRN Ativan to be given and what interventions were used prior to giving the medication, which should be a last resort. V31 stated targeted behavior monitoring is noted on the MAR, but PRN medications should have a progress note. V31 reviewed R502's nursing note dated 12/15/24 and confirmed the note does not document the behavior and nonpharmacological interventions attempted.

On 2/4/25 at 3:01 PM V1 (Administrator) stated the nurses should document behaviors and nonpharmacological interventions in a nursing note or on the MAR. V1 confirmed there was no

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| S9999 | Continued From page 20<br>documentation of R502's and R503's behaviors and nonpharmacological interventions attempted prior to Ativan administration for the dates listed above.<br><br>"B"<br><br>Statement of Licensure Violations 7of 9:<br>300.696a)<br>300.696b)<br>300.696d)1)2)14)<br>300.696g)<br><br>Section 300.696 Infection Prevention and Control<br>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, training, experience, or certification in infection prevention and control.<br><br>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. | S9999 | | |

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d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States 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):

1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections

2) Guideline for Hand Hygiene in Health-Care Settings

14) Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs)

g) Certified facilities shall comply with 42 CFR 483.80(h).

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent cross contamination during wound care, incontinence care, and catheter care for one of two (R502) residents reviewed for infection control in the sample list of 13.

Findings include:

The facility's Catheter Care policy dated 1/22/18 documents the catheter bag should not be placed on the floor.

The facility's Perineal Care policy dated 4/2/18 documents to remove gloves and perform hand hygiene after washing and drying the resident's rectal area prior to repositioning covers.

On 2/4/25 at 10:12 AM R502 was lying in a bed

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that was positioned low to the floor. R502's urinary catheter collection bag was hanging on the bed frame and touching the floor.

On 2/4/25 at 10:15 AM V29 (Certified Nursing Assistant/CNA) entered R502's room and confirmed R502's urinary collection bag was touching the floor. V29 stated the CNAs are trained that the collection bag should be kept off the floor. R502 was incontinent of bowel movement and V29 did not change gloves and perform hand hygiene after providing R502's incontinence cares, prior to touching and applying a clean brief and R502's blankets. While wearing the same gloves, V29 then assisted with turning R502 in bed and holding R502's leg during wound care. At 10:41 AM V30 (Registered Nurse) cleansed R502's right leg wound and applied gloves that were taken from V30's shirt pocket. V30 applied a petroleum dressing directly to the wound bed and covered with an adhesive dressing while wearing the same gloves that were removed from V30's pocket.

On 2/4/25 at 11:07 AM V29 used a mechanical lift to transfer R502 from the bed to the wheelchair. R502's urinary collection bag was lying directly on the floor as V29 raised R502 above the bed. V29 then picked up the bag and attached it to the mechanical lift sling as V29 transferred R502 into the wheelchair.

On 2/4/25 at 11:36 AM V30 confirmed V30's gloves were taken out of V30's pocket during R502's wound care and pockets would not be considered clean.

On 2/4/25 at 11:47 AM V29 confirmed V29 did not change gloves and perform hand hygiene after providing R502's incontinence care and prior to

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applying a clean brief, blankets, and assisting with wound care. V29 stated V29 thought it was acceptable to wear the same pair of gloves from start to finish during incontinence care.

On 2/4/25 at 2:51 PM V2 (Director of Nursing) confirmed gloves removed from an employee's pocket would not be considered clean. V2 stated the gloves should have been taken directly out of the box at the time they are used. V2 confirmed catheter bags should not be touching the floor.

"B"

Statement of Licensure Violations 8 of 9:
300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)3)4)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
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and

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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.

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:

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

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CLARK-LINDSEY VILLAGE | 101 WEST WINDSOR ROAD URBANA, IL 61801 |

| (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 |
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resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete weekly wound assessments and follow manufacturer's instructions for an air mattress for one of two (R502) residents reviewed for wounds in the sample list of 13.

Findings include:

R502's Care Plan revised on 1/14/25 documents R502 has a stage two pressure ulcer of the coccyx, and interventions include the use of an air mattress.

R502's January and February 2025 Treatment Administration Records document the following: Apply a foam bandage to bilateral gluteal sore every three days. Clean right lower leg wound and apply a nonstick dressing daily until healed from 1/5/25 until 1/29/25. Cleanse the right lower leg wound, dry the wound, apply a petroleum gauze and cover with an adhesive bordered dressing every three days and as needed beginning on 2/1/25. Wound tracking and monitoring every Tuesday and update wound picture.

R502's Skin/Wound Note dated 1/4/2025 at 9:39 AM documents R502 had an open area on

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| S9999 | Continued From page 26<br><br>R502's right lower leg that appeared to be a broken blister with brown colored liquid and measured 4 centimeters (cm) by 3.5 cm. R502's medical record does not contain assessments of this wound after 1/4/25 until 1/21/25. R502's Wound Evaluation dated 1/21/25 documents this wound measured 8.13 cm long by 1.88 cm wide. R502's medical record does not document this wound was assessed after 1/21/25.<br><br>On 2/4/25 at 10:12 AM R502 was lying in bed on an air mattress. The air mattress was covered with a sheet that was tied to the bed frame with a knot for all four corners of the bed. At 10:15 AM V29 Certified Nursing Assistant entered R502's room and confirmed the sheet was tied to the bed frame on all four corners of the bed. V29 stated that sheet should not be tied like that and fitted sheets aren't supposed to be used on an air mattress. V29 confirmed the applied pressure from the sheet can affect the functioning of the air mattress.<br><br>On 2/4/25 at 10:41 AM V30 (Registered Nurse) administered R502's wound care. R502's buttock skin was pink but intact. V30 cleansed the area and applied a new protective dressing. R502's right shin had a red, open, oblong wound. V30 cleansed the area and applied the dressing as ordered. V30 stated the buttock dressing is preventative as V30 has a pressure ulcer that comes and goes. At 11:36 AM V30 stated V30 believes R502's right shin wound is vascular due to diagnosis of Peripheral Vascular Disease and since it started as a blister. V30 stated V30 assists in completing the wound assessments and weekly assessments and measurements are only done for pressure ulcers and not R502's shin wound. | S9999 | | |

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| S9999 | Continued From page 27<br><br>On 2/4/25 at 1:32 PM V1 (Administrator) stated V1 was notified that R502's sheet was tied to the bedframe and confirmed R502's sheet should not be tied to the bedframe and fitted sheets should not be used on air mattresses as this can restrict the air flow or function of the mattress. V1 stated the facility has posted signs about not using fitted sheets on air mattresses. At 3:01 PM V1 stated non-pressure related wounds should have documented weekly wound assessments.<br><br>The facility's Skin Impairment Prevention and Wound Management policy dated 12/12/24 documents wounds will be assessed and documented weekly in the assessments section of the resident's electronic medical record.<br><br>The undated Operation Manual for R502's air mattress, provided by the facility, documents to cover the mattress with a cotton sheet, make sure air hoses are not kinked or tucked underneath the mattress, and to ensure valves are properly attached. This manual documents to check for suitable pressure by placing one hand between the air mattress and the bed frame or foam base to feel the patient's buttock. There should be space felt in between and the acceptable range is approximately one to one and a half inches.<br><br>"B"<br><br>Statement of Licensure Violations 9 of 9: 300.3210o)<br><br>Section 300.3210 General<br>o) The facility shall also immediately notify the resident's family, guardian, representative, | S9999 | | |

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conservator, and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify, report, and investigate an injury of unknown origin for one of one resident (R502) reviewed for injury of unknown origin in the sample list of 13.

Findings include:

The facility's Abuse Prevention and Prohibition policy dated 1/30/23 documents residents have the right to be free from abuse and incidents or suspected abuse must be immediately reported to the immediate supervisor and administrator, and to other officials in accordance with state law. Incidents will be investigated immediately by the Director of Nursing (DON), or designee as appointed by the Administrator, and any findings of abuse will be reported to the (state surveying agency). This policy documents incident investigations may include completing an incident report for injuries and interviewing the person reporting abuse, the resident, witnesses, and staff who had contact with the resident during the time period for the alleged incident. This policy documents the nursing staff is responsible for reporting suspicious bruising and the DON is responsible for determining the source of the abnormality. This policy does not mention criteria for determining injuries of unknown origin or reporting injuries of unknown origin to (state surveying agency).

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On 2/4/25 at 10:15 AM V29 (Certified Nursing Assistant/CNA) provided R6's urinary catheter care while R502 was lying in bed. R6 had a large, purple/blue bruise along the length of R502's right upper arm. V29 was unsure what caused the bruise and stated the bruise was not there when V29 last cared for R502 two days ago. R502 was unable to say what caused the bruise or if the area was painful. At 10:41 AM V30 (Registered Nurse/RN) entered R502's room to administer wound care. V29 reported R502's bruise to V30. V30 was unaware of the bruise and stated V30 would need to "look into it".

R502's active care plan documents R502 has a diagnosis of Dementia. R502's Nursing Note dated 1/9/25 at 10:46 PM documents R502 has moderate cognitive impairment and is alert/oriented to person only. R502's active physician orders do not document R502 receives blood thinning medications. There is no documentation in R502's medical record that R502 had any incidents, accidents, or injuries within the last two weeks.

R502's Injury of Unknown Cause report dated 2/4/25 at 10:30 AM documents notified by CNA (V6) of new bruise to right upper arm that was not there two days prior. R502 was unable to verbalize what happened. The bruise measured 16 centimeters (cm) long by 5.5 cm wide and was dark purple in color. V2 (DON), R502's physician, and R502's family were notified. There is no documentation that this injury was reported to the state surveying agency or that an investigation was initiated to determine the cause of the injury.

On 2/4/25 at 11:36 AM V30 (RN) stated R502's bruise would be considered an injury of unknown

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origin due the large size and unknown cause. V30 stated V30 interviews the staff who discovers the injury to determine cause, but V29 (CNA) was unsure what caused R502's bruise.

On 2/5/25 at 10:30 AM V2 (DON) stated V2 was notified yesterday of R502's bruise, V2 was unsure of the cause and has not done any follow up regarding the bruise. V2 stated V2 notified V1 who was responsible for the follow up.

On 2/5/25 at 10:37 AM V1 (Administrator) stated R502's bruise was reported to V1 yesterday and V1 was unsure of the cause. V1 stated V2 is going to be following up on the bruise. V1 confirmed an investigation had not been initiated yet. V1 stated we investigate to determine the cause of the injury which then determines if it is an injury of unknown origin. V1 stated R502's bruise was not reported to the state surveying agency since the facility had not yet investigated the cause of the bruise. V1 stated the facility does not have a policy on injuries of unknown origin other than the facility's abuse policy. At 3:35 PM V1 reviewed the facility's abuse policy and confirmed it does not address injuries of unknown origin.

"B"