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S 000	Initial Comments Facility Reported Incident of January 1, 2025 IL185395	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.680 c) 300.682 a)1) 300.682 a)2) 300.682 a)3) 300.682 a)4) 300.682 b) 300.1210 b) 300.3240 a) 300.3240 b) 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 300.680 Restraints c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience.	S9999		

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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.

Section 300.1210 General Requirements for

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Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

These requirements are not met as evidenced by:

Based on interview, record review and observation, the facility failed to ensure residents were free from unnecessary physical restraints(s), failed to identify the specific medical symptoms warranting the use of physical restraints, failed to obtain physician orders with medical justification for the placement of a physical restraint(s), failed to obtain resident or responsible party consent for the use of a physical restraint, and failed to immediately report inappropriate use of a physical restraint to the facility's Abuse Coordinator for two of 12 residents reviewed for restraint usage in the sample of 12. These failures resulted in R1 and R2 being physically restrained to their wheelchair

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with a gait belt placed around their torso and fastened behind their back with the inability to rise from their chair and suffering psychosocial harm of humiliation and embarrassment that any reasonable person would experience being improperly restrained.

Findings include:

The facility's final Report to Illinois Department of Public Health, dated 01/10/25 identified R1 and R2 as the subjects of the incident. This report documents the following: "On 01/06/25 CNA (verified as V4) reported that (R2) was improperly restrained on evening shift but was unsure when it happened." This report further documented, "Interviews with staff revealed that on the evening of 01/01/25, Resident (R2), BIMS/Brief Interview for Mental Status 0 (zero/severely cognitively impaired), was improperly restrained in her wheelchair. The report stated, "Staff interviews reveal they observed the resident at the nurse's station improperly restrained. Staff said they observed a second resident, (R1), BIMS 01 (severely cognitively impaired), improperly restrained to his wheelchair at the nurse's station. Neither resident was able to provide any comment upon interview."

The facility's Restraint Program Policy and Procedure, dated 11/10/2015, documents the following: "Policy: It is the policy of this facility to provide appropriate care for residents in relation to restraint utilization. 3. If a restraint is necessary, physician and POA (Power of Attorney) are notified, and a Restraint Consent is completed. Specific risk factors are marked as appropriate for the individual resident."

The facility's Nonemergency Use of Physical

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Restraints policy dated 3/1/11 documents the following:
"I. Physical restraints shall be used when required to treat the resident's medical symptom or as a therapeutic intervention, as ordered by a physician, and based on: A. the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; B. the assessment of a specific condition or medical treatment that requires the use of a physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable, mental, physical, mental, or psychosocial wellbeing.
II. A physical restraint will be used only with the informed consent of the resident, the resident's guardian, or other authorized representative This informed consent will include 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.
VII. Physical restraints will not be used on a resident for the purpose of discipline or convenience."

The facility's Emergency Use of Physical Restraints policy dated 7/1/02 documents: "B. If a resident needs emergency care and other less restrictive interventions have proved ineffective, a physical restraint will be used briefly to permit treatment to proceed. The attending physician will be contacted immediately for orders. If the attending physician is not available, the facility's advisory physician or Medical Director will be contacted." 11. The emergency use of a physical restraint will be documented in the resident's record and include: 1. The behavior incident that prompted the use of the physical restraint; 2. The

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date and times the physical restraint was applied and released; 3. The name and title of the person responsible for the application and supervision of the physical restraint; 4. The action by the resident's physician upon notification of the physical restraint use; 5. The new or revised orders issued by the physician; 6. The effectiveness of the physical restrain in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident; and 7. The date of the scheduled care planning conference or the reason the resident's emergency need for physical restraints. III. The facility's emergency use of the physical restraints will comply with our policy for non-emergency use of physical restraints section III, IV, V, and IX."

The facility's Abuse Prohibition policy dated 3/15/18 documents the following: "Reporting - Allegations Of Abuse And Neglect: 1. A facility employee or agent or covered individual who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility administrator. All residents have the right to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of property, exploitation. This includes but is not limited to freedom from...physical or chemical restraints not required to treat the resident's symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative."

R1's medical record documents R1 is 83 years old and was admitted to the facility on 12/18/2024 with diagnoses including: Unspecified Dementia with Agitation; Alzheimer's Dementia; Impulsiveness and Generalized Muscle. Weakness.

R1's current Care Plan documents R1 has

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significant cognitive impairment, is dependent on staff for ADLs/Activities of Daily Living, transferring and ambulation. R1's MDS/Minimum Data Set dated 12/31/24, documents R1's BIMS/Brief Interview for Mental Status score was 01 of 15, indicating R1 is severely cognitively impaired; R1 uses a wheelchair, requires assistance with ambulation and ADLs.

R2's medical record documents R2 is 80 years old and was admitted to the facility on 12/4/2023 with diagnoses including: Dementia with other Behavioral Disturbance; Disorientation; Cognitive Communication Deficit; Weakness; Recurring Falls; Anxiety Disorder and Insomnia.
R2's current Care Plan documents R2 is dependent upon staff for cares, including transferring, ambulation, and ADL's/Activities of Daily Living. R2's Care Plan documents R2 has significant cognitive impairment and is a fall risk. R2's Quarterly MDS Cognition Assessment documents R2 has severe cognitive impairment with a BIMS score of 0 (zero) of 15.

There was no documentation, no physicians order, and no medical symptom listed justifying the use of this inappropriate restraint in R1's nor R2's medical records.

The facility's January 2025 Nursing schedule documents V3 LPN/Licensed Practical Nurse worked the evening shift on 01/01/25 and 01/03/25.

On 02/11/25 at 2:10pm, V6 CNA stated that on 01/06/25 she and another CNA were getting R2 ready to get out of bed, when she noted a gait belt fastened around R2's wheelchair. When V6 mentioned the gait belt, the other CNA told her that on 01/01/25, V3 LPN/Licensed Practical

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Nurse had used gait belts "to keep (R2) in her wheelchair." V6 stated R2 was continent of bowel and bladder and able to let the staff know if she needed to use the bathroom and was able to ambulate with CNA assistance to the bathroom in her room, and a fall risk due to weakness.

On 2/11/25 at 2:45pm V3 LPN/Licensed Practical Nurse stated that on 01/01/25 at approximately 6:00pm, she fastened a gait belt around R1 and R2 while they were sitting in their wheelchairs near the Nurses Station. V3 stated she fastened the gait belts behind the back of the chairs, out of the residents' reach, in order to prevent R1 and R2 from rising from their wheelchairs. V3 confirmed she was aware her actions constituted inappropriate use of physical restraints at the time. V3 stated R2 uses a cushioned lap restraint and removes it frequently and tries to stand up from her wheelchair. V3 stated it was a very busy and hectic time, after dinner, and no staff were available to keep watch on R1 and R2, as CNAs were transferring and toileting the residents and putting some residents to bed for the evening. V3 stated she felt R1 and R2 required 1:1 attention to prevent a fall when trying to stand up from their wheelchairs and there was not enough staff on duty to provide it.

On 02/11/25 at 9:00am V6 CNA stated she was on duty on 01/01/25 on 2nd shift and, at approximately 6:00pm, V3 LPN was working and R1 was anxious and repeatedly asking for his wife at the Nurses Desk. V6 stated she saw V3 place a gait belt "across (R1's) chest, under his arms and fastened it in the back of his wheelchair. R1 would have been unable to release the gait belt" V6 stated R1 has dementia and severe hearing deficit and does not always process what you're saying and does not follow

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commands. V6 stated R1 is ambulatory with assistance and is "very unsteady." V6 stated she did not report the incident to the Abuse Coordinator/Administrator because she felt V3 LPN was not approachable as she seems "rude".

On 02/11/25 at 2:00pm V4 CNA/Certified Nursing Assistant stated that on 01/06/25, a CNA (unable to identify) she was working with told V4 that V3, LPN restrained R2 in her wheelchair with a gait belt "to keep her in her wheelchair." V4 stated she immediately reported the incident to a supervising nurse and V1 Administrator/Abuse Coordinator.

On 02/11/25 at 1:30pm V7 LPN stated she was on duty with V3 LPN on the evening shift of 1/1/25. V7 stated at approximately 6:00pm, she saw R1 was restrained in his wheelchair with a gait belt. V7 stated she was aware V3 had placed a gait belt around R1 and fastened it behind the back of his wheelchair. V7 stated R1 would not have been able to remove the gait belt and would not have been able to rise from the wheelchair. V7 verified she did not report the incident to anyone. V7 stated she knew this was improper restraining of a resident at the time of the incident and, even though she knew that the policy was to report incidents immediately to the Administrator/Abuse Coordinator, she did not report it.

On 2/11/25 at 10:45am V2 DON/Director of Nursing stated V3 LPN inappropriately restrained R1 and R2 in their wheelchairs using gait belts fastened around them and clasped behind the back of their wheelchairs, out of reach of the residents. V2 confirmed V3 should not have restrained R1 and R2 in that manner and the action constituted inappropriate use of restraints.

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On 2/11/25 at 11:15am V2 DON stated there were interventions in place for R1 and R2, including redirection, implementing an activity with an Activity staff member with "one on one" assistance; television viewing and taking R1 and R2 for a walk around the facility with CNA assistance.

On 2/11/25 at 2:30pm, V2 DON verified the physical restraining of R1 and R2 by V3 LPN should have been immediately reported to the Abuse Coordinator/Administrator and was not reported to her until 01/06/25.

On 2/13/15 at approximately 10:00am, V2 stated the fall preventions interventions in place for R2 were providing a low bed, and a mattress next to her bed when she is sleeping; a pressure bed alarm, a cushioned lap restraint when R2 is up in her wheelchair. Redirection interventions included taking a walk with CNA assistance, distraction with activities and television viewing.

On 2/11/25 at 1:15pm, V1 Administrator stated she was notified of this incident on 01/06/25, after the incident occurred on 01/01/25, and began the investigation of the incident immediately, calling the evening shift staff for questioning. V1 stated she first called V3 LPN/Licensed Practical Nurse for information, who had worked the evening shift on 01/01/25 and was usually considered the charge nurse for the shift. V1 stated V3 readily admitted that she had placed gait belts around R1 and R2 in their wheelchairs and fastened them out of their reach, behind the backs of the wheelchairs in order to prevent them from standing. V1 verified V3 stated she was aware the incident constituted inappropriate physical restraints when she did it. V1 stated she suspended V3 immediately, pending the outcome

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of the facility's investigation.

On 2/18/25 at 3:55pm, V1 stated she did not bring this incident to the attention of the IDT/Interdisciplinary Team or QA/Quality Assurance members. V1 stated the next QA meeting will be in April 2025.

On 2/11/25 at 9:20am R1 was seated in his wheelchair at a table near the Nurses Station, working with building block materials with an activities aid. R1 was calm with no behaviors exhibited. No restraints were noted. R1 did not respond to this surveyor's greeting or question.
On 2/11/25 at 11:20am, R1 was calm and quiet, self-propelling his wheelchair down the hallway toward his room. R1 did not respond to surveyor's greeting or question. No restraints noted.
On 2/11/25 at 3:00pm R1 was in bed with his eyes closed. There were no restraints noted.
On 2/13/25 at 9:45am, R1 was sitting in a wheelchair near the Nurses Station. R1 was alert, calm and quiet. R1 did not respond to this surveyor's greeting or question.

On 2/11/25 at 9:20am R2 was sitting in a high-backed wheelchair with a lap cushion in place.
On 2/11/25 at 10:05am, R2 was seated in a high-backed wheelchair near the Nurses Station. A lap cushion was in place, and R2 was counting out loud with her eyes closed. R2 did not respond to this surveyor's greetings or questions.
On 2/11/25 at 3:05pm, R2 was lying in bed with her eyes closed. The pressure alarm on R2's bed was turned on.

(B)