| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6001275 | A. BUILDING: _____ B. WING _____ | C 05/08/2025 |

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| S 000 | Initial Comments<br><br>Complaint Investigation 2553857/IL191462 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.3210a)2)<br><br>Section 300.610 Resident Care Policies<br><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>Section 300.1210 General Requirements for Nursing and Personal Care<br><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 | S9999 | | |

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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.

Section 300.3210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility.

2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure residents were

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assisted with activities of daily living (ADL's) and call lights were answered in a timely manner promoting dignity for 3 of 5 (R3, R4, R5, R10 and R13) residents reviewed for dignity in the sample of 26. This failure resulted in R13 asking for assistance to toilet for at least 35 minutes while in the dining room and common area and subsequently having an episode of incontinence. R13 was visibly upset and crying out for help during this 35-minute time frame. This would cause any reasonable person to feel embarrassed and humiliated.

Findings include:

1. R13's Resident Face Sheet with a print date of 5/6/25 documents R13 was admitted to the facility on 9/7/2024 with diagnoses that include unspecified dementia, moderate, with anxiety. R13's MDS (Minimum Data Set) dated 2/5/25 documents a BIMS (Brief Interview for Mental Status) score of 01, indicating R13 has a severe cognitive deficit. This same MDS documents R13 is frequently incontinent of urine and bowel and requires substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toilet transfer.

On 5/6/25 from 12:25 PM until 12:58 PM this surveyor conducted continuous observation of the common area/dining room. At 12:25 PM, when this surveyor entered this area, R13 was sitting in the dining room in her wheelchair talking with V25 (Patient Aid/PA). R13 asked V25 to take her to the bathroom. V25 responded to R13 that she couldn't but "they" (Certified Nursing Assistants/CNA's) would take her as soon as they could. V25 told R13, "They can't stop feeding residents to take you." R13 continued to ask V25 who then told R13, "They can't take you right

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now. They will take you as soon as they can." At 12:27 PM, R13 stopped an unknown staff member who entered the unit and asked them where she was supposed to go. R13 told this staff member she was about to "pee my pants." This unknown staff member told R13 they would get to her as soon as they could. At 12:29 PM, R13 self-propelled her wheelchair out of the dining room and through the common area surrounding the nurse's station. R13 was crying out, "I got to go to the bathroom. Why can't I go to the bathroom. Someone help me." R13 was visibly upset. V21 (Dietary Manager) entered the unit and R13 said "Help me someone, help me." V21 told R13 she would get someone to help her. Throughout this observation, V22 and V23 (Certified Nursing Assistants/CNA's) were feeding residents in the dining room. At 12:31 PM, R13 yelled, "Help, I am going to pee in the floor." R13 continued to yell for help. At 12:35 PM, R13 stated, "It is an awful place when you can't get waited on in the nursing home." At 12:44 PM, R13 asked for help again with no response from staff. At 12:48 PM, R13 cried out, "Help, help, help." At 12:49 PM, R13 told V21 (Dietary Manager) "Help me, help me. I just peed myself." V21 moved R13's wheelchair next to a chair in the common area and sat down next to R13 and began to talk with her. R13 was visibly upset throughout this observation.

On 5/6/25 at 12:59 PM, V22 (CNA) stated R13 yells out for help even if the staff have just taken her to the bathroom. V22 stated she had been told R13 was asking to toilet, and she would take her after she charted lunch.

On 5/6/25 at 1:02 PM, V23 (CNA) stated they had three CNA's when they came to work this morning but one got sick and had to leave early.

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V23 stated they currently have two CNA's and one PA working. When asked if that was enough staff to meet the residents needs timely, V23 stated, "No." V23 stated, "We had people hollering to go to the bathroom while we were feeding, and we aren't allowed to stop feeding to take them to the bathroom." V23 stated they had taken R13 to toilet right before lunch (around 11:00 AM). V23 stated R13 hollers out a lot but she can tell when she urinates.

On 5/6/25 at 1:13 PM, this surveyor reviewed the observation with V24 (LPN/Licensed Practical Nurse) and V24 stated R13 yelled out for help frequently and was previously on a bladder training program. V24 stated staff need to stop what they are doing and help. When asked if they were allowed to stop feeding residents to provide needed care to other residents, V24 stated she only worked on Tuesdays, so she wasn't sure if something had changed but they used to stop and help residents.

On 5/6/25 at 1:31 PM, V25 (PA) stated she is not allowed to provide direct resident care, she is only there for extra eyes and support. V25 stated R13 constantly asks to go the bathroom, even after they have just taken her.

On 5/6/25 at 1:37 PM, V26 (CNA) stated she clocked in for her shift at 1:00 PM and took R13 to the bathroom. V26 stated R13 had feces in her incontinence brief, and it was "soaked" with urine. V26 stated she also had to change R13's pants because they were wet.

On 5/6/24 at 2:58 PM, V2 (Director of Nurses/DON) stated V22 (CNA) should have taken R13 to the bathroom instead of charting lunch. V2 stated they don't stop feeding because

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the meal will get cold, but someone should have taken over with feeding residents so the CNA's could have provided care.

The facility Quality of Life Dignity policy dated 2/2012 documents, "Policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Procedure: ...11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by:...b. Promptly responding to the resident's request for toileting assistance..."

2. On 5/6/25 at 9:37AM, R3, who was alert and oriented to person, place, and time, stated she has lived here a few years at least. R3 stated that the call light wait times are too long. R3 stated, "Sometimes I even take myself to the bathroom because they don't answer it soon enough, and I don't want to have an accident. They (the staff) get mad at me, but I don't want to have an accident."

3. On 5/5/25 at 11:41AM, R10, who was alert and oriented to person, place and time, stated, "Sometimes during lunch hour my call light can be on for an hour or longer."

4. On 5/6/25 at 9:20 AM, R5, who was alert and oriented to person, place, and time, stated that call light wait times have improved in the past two months but are still too long. She said there are residents who require two CNA's (Certified Nurse's Aides) to assist them, and that takes away from staff that can answer call lights. She says they only have two CNA's on her hall, and they need three.

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5. On 5/6/25 at 9:26 AM, R4, who was alert and oriented to person, place, and time, stated that call light wait times are too long. R4 stated that on average it takes fifteen minutes to get them answered, sometimes longer. R4 stated that call light wait times are worse on evening shift when they have less staff.

6. Resident council meeting minutes dated 1/30/25 documents call light wait times as a concern for the residents.

On 5/7/2025 at 11:52 AM, V1 (Administrator) stated that he would consider a reasonable amount of time to wait for a call light to be answered as ten to fifteen minutes at most. When asked if he thought that it was appropriate for a resident to take herself to the toilet without assistance, knowing that she needs assistance, but unable to wait for staff to answer her call light because of fear she may have an episode of incontinence, V1 stated no, that was not acceptable practice for assisting residents with toileting needs.

Facility's call light policy dated July 2014 in step 8 under heading "General guidelines" documents, "Answer the resident's call as soon as possible."

(B)