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S 000	Initial Comments Annual Licensure & Certification Survey. Complaint Investigation # 2514981/IL193655	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.615 e) 1 of 4 300.610a) 300.1010h) 300.1210b) 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 300.1010 Medical Care Policies	S9999		

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h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification

Section 300.1210 General Requirements for 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.

These regulations were not met as evidence by:
Based on observation, interview, and record review the facility failed to identify pressure injuries for a resident at risk for pressure ulcers, failed to identify pressure wounds prior to becoming advanced stages, failed to perform an initial wound assessment for a resident with a new pressure ulcer, failed to perform weekly assessments on pressure wounds, and failed to implement treatments upon identification of pressure wounds for 4 of 11 residents (R28, R3, R86, and R117) reviewed for pressure ulcers in the sample of 59. This failure resulted in R28's pressure wound not being treated for 26 days after it was identified and deteriorated to a stage

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4 and resulted in R3's pressure wounds not being identified until they progressed to stage 3 and stage 4, and this failure also resulted in R86's sacral pressure wound not being assessed between December 2024 and March 2025 at which time it had progressed to a stage 4.

Findings include:
1. R28's face sheet showed he was admitted to the facility 9/21/22 with diagnoses to include anemia, hypertension, atrial fibrillation, primary osteoarthritis of left knee, primary osteoarthritis of left hip, and pressure ulcer of right ankle. R28's care plan initiated 10/3/22 showed, "Risk for impaired skin integrity due to incontinence and decreased functional mobility... Approaches: ... Daily skin inspection; report any changes in skin or signs of possible skin breakdown or redness... Nutritional support based on assessment and MD (physician) orders..." R28's care plan initiated 5/21/25 showed, "Pressure Ulcers/Skin Prevention... [R28] has a stage 4 pressure wound to sacrum. Factor complicating wound healing include impaired mobility and occasional incontinence..."

R28's Dietary Note entered 3/27/25 by V4 (Registered Dietitian) showed, "Patient with pressure wound to coccyx... To promote skin health, additionally this writer recommends Active Liquid Protein 60ml/daily. This will provide 200 calories and 30 grams of protein..." R28's medical record showed no evidence of R28 receiving the Active Liquid Protein supplement.

R28's Wound Assessment Report dated 2/15/25 showed, "Date wound identified: 2/15/25... Wound Location: sacrum; tunneling wound... Present Upon Admission: No... Measurements: Length 0.5 cm, Width 0.6 cm, Depth 1.0 cm...

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Physician Notified: Yes.... Treatments: Pending treatment orders..." This assessment showed no classification of R28's sacral wound. R28's medical record showed no evidence of wound assessments completed for his sacral wound between 2/15/25 and 3/13/25.

R28's February 2025 eTAR (electronic Treatment Administration Record) showed no treatments for R28's wound. R28's March eTAR showed an order initiated on 3/13/25 for "Hydrocolloid Dressing to Coccyx... for Open wound..." (26 days after the wound was identified).

R28's Skin Evaluation Form for his coccyx wound dated 3/13/25 showed, "... Origin Date: 3/13/25... Treatment: Hydrocolloid patch to coccyx... Tunneling wound to coccyx... Length 2.0 cm, Width 0.1 cm Depth 1.0 cm... Smooth undermining Sinus Tract: 1 cm... Resident noted to have reopened wound to his coccyx.... Area cleaned and covered with a hydrocolloid dressing until wound physician can assess."

R28's Wound Physician Initial Wound Evaluation dated 3/25/25 showed, "... Stage 4 Pressure Wound, Sacrum, Full Thickness... Duration: greater than 60 days... Wound size 2.0 x 0.4 x 0.9... "

On 6/05/25 at 12:13 PM, V6 (Wound Care Nurse) said R28's coccyx wound was changed to a sacral wound after it was reassessed. V6 said the floor nurses do the initial wound assessments when the wound is identified on a skin evaluation form. V6 said the wound started out as MASD (moisture associated skin damage) and was real wet and nasty. V6 said the wound opened up then into pressure. V6 said she has a skin assessment for R28 dated 2/26/25 showing no

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existing skin issues. V6 then said she found a wound evaluation in the electronic record showing a wound assessment from 2/15/25 confirming the wound was present. V6 confirmed the assessment dated 2/15/25 was a wound assessment. V6 said no further assessments were documented until 3/13/25. V6 said she follows pressure wounds, vascular wounds, diabetic wounds, and arterial wounds but anything surgical, skin tears, MASD the floor nurses follow weekly.

On 6/05/25 at 2:31 PM, V2 DON (Director of Nursing) said when the nurses think they see a pressure injury they are supposed to let the Wound Champion (V6) know. V6 would then go evaluate, put treatment orders in place and put him on the list to see V7. V2 said treatments should be initiated as soon as possible for the quickest possible healing for the resident. V2 said assessment of wounds is important to see if the wound has made progress, if the treatment is working, or if something needs to be changed. The nurses are supposed to be doing a skin assessment weekly and documenting the changes.

On 6/05/25 at 8:50 AM, V7 (Wound Physician) said he has been seeing R28 for about a month now. V7 said he believes R28's wound was a stage 4 when he started following him. V7 said they should be discovering wounds when they are a stage 1 or 2.V7 said high protein supplements for wound healing and offloading are the two most important measures for pressure ulcer prevention and healing.

2. R3's face sheet showed she was admitted to the facility 10/10/24 with diagnoses to include muscle weakness, moderate protein calorie

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malnutrition, anemia, hypothyroidism, major depressive disorder, delusional disorder, anxiety disorder, and rheumatoid arthritis. R3's facility assessment dated 5/29/25 showed she has severe cognitive deficit and is dependent upon staff for all cares.

R3's care plan initiated 5/23/25 showed, "Pressure Ulcers/Skin Prevention... [R3] will maintain skin integrity without new skin related injuries over the next review period... Observe skin for redness and breakdown during routine care... Follow community skin care protocol...

[R3] has impaired skin integrity, has a stage 4 pressure ulcer on sacrum, stage 3 pressure ulcer on left heel, stage 4 pressure ulcer on right heel, stage 4 pressure ulcer to right, upper, lateral shin..."provide supplements to promote healing as ordered by physician... "

R3's medical record showed she was present in the facility from 10/10/24 through 2/23/25.

R3's Wound Assessment Report dated 12/19/24 showed, "... Date wound identified 12/19/24... Wound Location: Right Heel; Left outer heel... Assessment Occasion: New Wound... Stage: Unstageable due to slough/eschar... Measurements Length 2.4 cm x Width 3.0 cm... Pain with wound/treatment: Yes... Pain Intensity: Moaning, grimacing... Wound Bed: Eschar 100%.

R3's medical record showed she was present in the facility from 4/2/25 through 4/19/25.

R3's Skin Evaluation Form dated 4/17/25 showed, "... Origin Date: 4/17/25... Category: Full Thickness Wound... Type: Pressure Injury... Description: Stage 3 Pressure Injury of Right

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Upper Lateral Shin... Cause: Pressure... Size: Length 1.5 cm x Width 0.3 cm x Depth 0.3 cm..."

R3's Wound Physician Evaluation dated 4/17/25 showed, "... Stage 3 Pressure Wound of the Right, Upper, Lateral Shin, Full Thickness... 1.5 cm x 0.3 cm x 0.3 cm... Duration: greater than 2 days..."

On 6/05/25 at 12:26 PM, V6 (Wound Care Nurse) said a skin check is done on admission and they put all the same wounds in all over again. V6 said R3 had an immobilizer in place at one time to her right leg from some fractures. V6 said she is not sure where the pressure wound came from to R3's shin. V6 said it could have been the immobilizer but she couldn't say for sure. V6 said the wound was facility acquired on 4/17/25. V6 said she expects new areas to be brought to her through the wound module in addition to notification to the unit manager or herself.

On 6/5/25 at 8:50 AM, V7 (Wound Physician) said R3's wound on her right shin was caused by her being in a cast or immobilizer after a fracture. V7 said when they took the immobilizer off there was that wound. V7 said if there was an immobilizer in place covering the leg he would not be looking under that during his rounds.

The facility's policy and procedure with revision date of 07/2024 showed, "Pressure Injury Assessment/Treatment... Purpose: The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention of acquiring additional pressure injuries... General Guidelines... Skin risk and general skin assessment is to be completed upon admission

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and then weekly times 4 weeks. Basic skin assessment is to be completed on residents weekly and as needed..."
3. R86's electronic face sheet printed on 6/5/25 showed R86 has diagnoses including but not limited to congestive heart failure, severe protein-calorie malnutrition, pressure ulcer of sacral region, stage 4, and pressure ulcer of left lower back, stage 2.

R86's facility assessment dated 3/27/25 showed R86 has no cognitive impairment and has a stage 2 and stage 3 wound and is at risk for pressure ulcers.

R86's wound assessment dated 12/27/24 showed, "Coccyx: irritation/excoriation 1x1x0.5cm(centimeters). Area assessed and is getting better ..."

R86's wound physician assessment dated 3/18/25 showed, "Stage 4 pressure wound of the sacrum, full thickness. Present greater than 30 days, 2.9x1.1x0.7cm, 2.9cm undermining, light serous exudate, 10% slough 70% granulation. Surgical excisional debridement procedure performed during this visit to remove necrotic tissue and establish margins of viable tissue ..."

No wound assessments were present from 12/27/24-3/18/25 for R86's sacral wound.

R86's care plan dated 3/19/25 (after initial wound physician visit) showed, "(R86) has a stage 4 pressure injury to his sacrum related to noncompliance with repositioning in bed and refusing care. He is also incontinent of bowel. Due to his pressure injury, he is at risk for further deterioration, infection, fluid loss, and pain ...float heels in bed, reposition side to side every 1-2

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hours ..." (No pressure ulcer care plan was present for R86 prior to this date)

A review of R86's treatment records dated January 2025-February 2025 showed R86's sacral wound treatment was not performed 8 days during the month of January and 4 days during the month of February.

R86's skin assessment dated 5/24/25 showed no new areas of skin concern besides his sacral wound.

On 6/4/25 at 8:39AM, R86 stated, "I've been sitting like this since 4:30AM and my feet and butt are killing me. (foot of bed elevated and feet turned outward with ankles lying flat and rubbing on bed). I have sores on my butt, I came with one of them, one I think I got here; I'm waiting for them to change my dressings. (R86's right ankle was red and appeared to have a sore on it) They give me a bed bath every few days and wash my whole body because I don't to take a shower. I supposed if there were any sores on my ankles they would have seen them. I can't have my feet elevated because it hurts too much, I've tried everything, and I can't stand it. I wish I had some foam or something on my ankles. the nurse was supposed to put my dressings on my ankle at 4am and she brought the dressings and then left and hasn't been back."

On 6/4/25 at 9:24AM, V3 (Registered Nurse) stated, "(R86) doesn't have any orders for bandages to his ankles, he has nothing on them so there isn't a reason for a bandage." At 1:10PM (V3) stated, "I did look at his ankles and he does have an open area on his right ankle now. That should have been noted during his bed bath or skin checks, but it wasn't. I put some padded

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dressings on to keep them covered until the wound nurse & doctor see him tomorrow."

On 6/5/25 at 8:49AM, V7 (wound physician) stated, "Facility acquired wounds should not be identified as stage 3 or 4, they should be identified at stage 1 or 2. (R86) has a new wound to his right ankle that is a stage 2. This should have been identified by staff during cares and his heels should have been elevated. It was resolved for a few weeks and now it is back. I am assuming because his heels are not being elevated. There are different strategies the facility could be using for pressure reduction. Some patients don't like the boots, so you need to be mindful of that, just using a heel protector is not enough, he has a special pillow, and I don't know why they aren't using it, the heels up device is the best for him but he is noncompliant with certain things. He must have something instead of the feet resting on the mattress, plain and simple. I didn't know he was refusing the heels up device otherwise I would have tried something different for him. He is a high risk for skin breakdown due to his noncompliance and lower weight because he doesn't have a lot of fat on him. They should be keeping a very close eye on him. You should not have identified his new wound, that should have been identified by the staff."

On 6/5/25 at 2:47PM, V6 (wound champion) stated, "I checked in our old charting system and there are not any assessments for (R86's) wound from 12/27/24-3/18/25. It is the responsibility of the floor nurse's to ensure these wound assessments and treatments are being done."
4. R117's face sheet documents she was admitted to the facility on 4/29/25 with multiple diagnoses including the presence of a stage 3 pressure ulcer to the left buttock, a stage 4

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pressure ulcer to the left lower back, stage 3 pressure ulcer to the sacral region, and stage 3 pressure ulcers to the right upper back and left lower back.

On 6/4/25 at 10:25 AM, R117 was lying in her bed with an air mattress, and she was positioned onto her right side with pillows.

The skin evaluation forms were requested and reviewed and show the first pressure ulcer assessments were completed on 5/8/25.

On 6/5/25 at 9:24 AM, V10 RN, said when a resident is admitted with pressure injuries it is the responsibility of the admitting nurse to perform wound assessments and document them in the wound sheets. She said this should be done on the day of admission. After the initial assessment the resident is placed on wound rounds and will be seen by the wound physician and V6. She said the initial assessment should include the measurements of each wound, and the wound bed description. (B)

2 of 4
300.610a)
300.1010h)
300.1210b)

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

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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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification

Section 300.1210 General Requirements for 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.

These regulations were not met as evidence by:
Based on observation, interview, and record review the facility failed to ensure accurate weights were obtained, failed to ensure significant weight loss was identified and reported to the dietitian, and failed to implement dietitian

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recommendations for 4 of 6 residents (R28, R3, R55, R41) reviewed for nutrition in the sample of 59. This failure resulted in R28 experiencing significant weight loss without the Registered Dietitian being notified.

Findings include:

1. R28's face sheet showed he was admitted to the facility 9/21/22 with diagnoses to include anemia, hypertension, atrial fibrillation, primary osteoarthritis of left knee, primary osteoarthritis of left hip, and pressure ulcer of right ankle. R28's care plan initiated 10/3/22 showed, "Risk for impaired skin integrity due to incontinence and decreased functional mobility... Approaches: ... Nutritional support based on assessment and MD (physician) orders..." R28's care plan initiated 9/28/22 showed, "[R28] has increased potential for weight changes related to diuretic use... Goal and Target... Intakes to meet needs, Weight remain without significant changes... Medications per MD order... weigh resident per facility protocol. Record results and report any significant change to physician and dietitian..."

R28's weights were documented as follows: 5/22/25 - 226.4 lbs; 5/23/25 - 227.6 lbs; 5/24/25 - 226.7 lbs; 5/28/25 - 214.0 lbs; 5/29/25 - 214.0. These weight changes represented a significant 5.6 % weight loss from 5/22/25 through 5/28/25.

R28's Nutrition Note entered 3/27/25 by V4 showed, "Patient with pressure wound to coccyx... additionally, this writer recommends Active Liquid Protein 60 ml/daily. This will provide 200 kcal and 30 grams protein."

On 6/05/25 at 9:56 AM, V4 RD (Registered

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Dietitian) said, "They didn't notify me of that change, he is a monthly weight, so we obtain his weight the first shower of the month. I question the weights. It was as of yesterday that I was notified of his weight being 216. When I visibly look at him his chest and abdomen area does seem smaller. I think the readmission weight may have been incorrect because he was in the hospital... He comes out to the dining room to eat and when he first came back, he wasn't wanting to eat. He used to eat 100% of his meals and he is telling me he isn't wanting to eat as much now. When they enter a weight, if it is significantly off I think it sends them a notification but I think there may be an issue with how it calculates the changes as 30 day, 60 day, 90 day changes. The nurses monitor the weights and let me know if there are changes. My hope would be after they enter the weight, it would be good practice to then look at their weight history to see if they have had a significant weight change..."

On 6/05/25 02:29 PM V2 DON (Director of Nursing) said the RD's dietary recommendations would be handed off to the unit manager or the nurse on the floor. The recommendations would be communicated to the Nurse Practitioner and they would give it as order.

2. R3's facesheet showed she was admitted to the facility 10/10/24 with diagnoses to include muscle weakness, moderate protein calorie malnutrition, anemia, hypothyroidism, major depressive disorder, delusional disorder, anxiety disorder, and rheumatoid arthritis. R3's facility assessment dated 5/29/25 showed she has severe cognitive deficit and is dependent upon staff for all cares.

R3's care plan initiated 5/23/25 showed,

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"Nutritional Status; [R3] has increased nutrient needs related to need for healing as evidenced by history of stage 4 pressure wound to sacrum. Also as increased potential for pressure wounds related to limited mobility. [R3] will have nutritional needs met and will not have an unplanned significant weight change over the next review period..."

R3's Nutrition Risk Assessment dated 5/26/25 showed, "... Current weight: 120 pounds... Nutrition: Increased nutrient needs related to need for healing as evidenced by presence of multiple pressure wounds... Interventions: Diet as ordered... Continued 1:1 assistance at meals. Goals: ... weight remain stable." R3's medical record shows the last weight obtained for R3 was 120 pounds on 5/10/25. R3's medical record showed she was discharged to the acute care hospital 5/20/25 and returned as a readmission to the facility 5/23/25. R3's record contained no weights between her return to the facility 5/23/25 and 6/5/25.

On 6/05/25 at 10:32 AM, V4 RD (Registered Dietitian) said R3 came back from the hospital 5/23/25 and no weights have been done since her readmission. V4 said R3's record showed a significant weight loss prior to her hospitalization but she feels that the weight that had been entered on 4/2/25 was not accurate. V4 said if a reweigh was done and a weight confirmed her record would show "confirmed" next to it. V4 said R3's 127 lb weight was not confirmed but R3 usually stays around 120 lbs. V4 said upon admission or readmission the facility policy is to get a weight every day for 3 days, then once weekly for 4 weeks, and if stable they would start doing monthly weights to monitor. V4 said she would have expected them to get readmission

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weights. V4 reviewed R3's record and said weekly weights were scheduled on the eMAR (electronic Medication Administration Record) but none of them were signed off. V4 said it is important to get readmission weights so she can assess R3 for significant loss. V4 said if she doesn't have those weights she has nothing to compare them to.

On 6/05/25 at 2:21 PM, V2 DON (Director of Nursing) said weights are done with the first shower of the month so they are all in the system by the 7th. V2 said the CNAs are getting the weights and entering them in the system and if they don't enter them sometimes the nurses do. V2 said if there was a significant change the system should flag it and it asks them if they really want to enter it. V2 said she does not know how the Registered Dietitian gets notified of significant weight changes. V2 said V4 (Registered Dietitian) should be looking at the weights at least every month. V2 said if there is anyone that has significant weight loss V4 would be documenting it and talking about it in their meetings. V2 said V4 should be able to print out all the residents weights every month. If there is a reweigh needed V4 will ask us for that. V2 said V4 is the expert with weight loss, she is the one who can give us the input on recommendations. V2 said it is V4's expertise the facility relies on for recommendations for getting supplements in place if needed.

The facility's policy and procedure with approval date 06/2025 showed, "Weight Monitoring... It is the policy of [the facility] that appropriate nutritional care shall be provided to residents who have a significant weight change. A significant weight change is identified as a weight loss or gain of 5.5% in 30 days, 7.5% in 60 days, or 10%

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in 180 days. .. Each resident should be weighed daily for the first three days of admission, weekly for the first four weeks, and monthly thereafter... Residents with a weight change of 5 lbs or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record... The RD should make recommendations for nutritional interventions based on the information obtained from the weekly Resident At Risk Review huddle meetings. RD recommendations should be reviewed and initiated by nursing associates... A nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD has requested a nutritional intervention..."
4. R55's Face Sheet showed she was admitted to the facility on 12/11/24 with diagnoses to include Alzheimer's (dementia), a Stage 4 pressure ulcer, and a hip fracture.

R55's active order set showed an order for monthly weights, which was ordered on admission.

R55's electronic health record (EHR) showed she weighed 154.6 pounds on 2/11/25; 142.8 pounds on 3/23/25; and 132.4 pounds on 4/4/25. R55's EHR showed this was a weight loss of 14.3 percent. R55's electronic health record showed no weight documented following the 4/4/25 weight as of 6/3/25 at 4:00 PM.

R55's 5/21/25 progress note from 12:58 PM (Authored by V4, Registered Dietitian) showed: "Late Entry for month of May. Resident weight for month of May not documented [in] EMR (electronic medical record). Will assess weight trend when June weight measurement received..."

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On 6/04/25 at 1:44 PM, V15, Registered Nurse, stated monthly weights are done for all residents with the first shower of the month. V15 stated the CNAs (Certified Nursing Assistants) will notify her of the resident's weight, and she will enter the weight in the electronic health record. V15 stated the facility does not document weights in any other location other than the electronic health record. V15 stated R55 does not refuse care.

On 6/04/25 at 1:59 PM, V16, Certified Nursing Assistant (CNA), stated CNAs measure residents' weights on their first shower of the month. V16 said the CNA will notify the nurse of the weight. V16 said CNAs can also enter weights into the EHR. V16 said she is R55's CNA, and R55 does not refuse care.

On 6/04/25 at 2:21 PM, V4 stated R55 should have been weighed in May 2025 when she had her first shower of the month. V18 said she had noticed the missing weight in May, and per her normal practice, she would have sent a list of residents with either missing weights or weights that needed to be redone. V18 said monthly weights are important so she knows if her interventions are working and if they need to be adjusted to the unit manager. (The facility was requested to weigh R55.)

On 6/04/25 at 03:42 PM, V2, Director of Nursing, stated R55's weight was 150 pounds.

The facility's Weight Monitoring policy (last approved 6/2025) showed: "Each resident should be weighed daily for the first three days of admission, weekly for the first four weeks, and monthly thereafter..."
3. R41's electronic face sheet printed on 6/5/25

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showed R41 has diagnoses including but not limited to epilepsy, acute kidney failure, Bipolar Disorder, Alzheimer's Disease, and type 2 diabetes.

R41's facility assessment dated 4/24/25 showed R41 has experienced a weight loss and is not on a physician-prescribed weight-loss regimen.

R41's care plan dated 2/25/25 showed, "(R41) has increased potential for weight changes related to fluctuating intakes. Has a history of both significant weight gains and losses ...(R41) is offered diet and oral nutritional supplement as prescribed, see physician order sheet."

R41's Nutrition Risk Assessment dated 5/12/25 showed, "Comments/Recommendations: Interventions: Diet as ordered. Recommend Ensure 240ml once daily. This will provide 350kcal and 20g protein ..."

R41's physician's orders for May 2025 and June 2025 showed no orders for R41 to receive a nutritional supplement.

On 6/5/25 at 9:40AM, V4 (Registered Dietician) stated, "The last time I reviewed (R41's) nutritional status was on May 12th and her weight had stabilized at that point since her previous significant weight loss. She is a picky eater, and I didn't want her weight to go down at all if possible, so I recommended a daily nutritional supplement for her. My recommendations go to the physician or nurse practitioner for each resident to approve. I put the recommendations in their box so they can sign off on it and then nursing enters the orders. I don't see the order for her supplement in her record though so I'm not sure what happened. If there isn't an order, then

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she won't receive it."

The facility's policy titled, "Weight Monitoring" dated 01/2023 showed, "It is the policy of (facility) that appropriate nutritional care shall be provided to residents who have a significant weight change ...E. The RD (Registered Dietician) should make recommendations for nutritional interventions based on the information obtained from the weekly Resident at Risk Review huddle meetings. RD recommendations should be reviewed and initiated by nursing associates ..." (B)

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300.1210d)6)

Section 300.1210 General Requirements for Nursing and Personal Care

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.

These regulations were not met as evidence by:
Based on observation, interview and record review the facility failed to assist a resident at risk for falls with reaching his urinal (R58), and safely transferring a resident with a mechanical lift (R23 and R2). This failure resulted in R58 falling and obtaining a fractured hip and wrist requiring surgery and hospital stay. The applies to three of eleven residents reviewed for safety in the

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sample of 59.

Findings include:
1. The facility face sheet shows R58 was admitted to the facility with diagnoses to include adult failure to thrive, Type 2 Diabetes Mellitus, chronic kidney disease and low back pain. R58's facility assessment dated 3/20/2025 shows he has no cognitive impairment and required maximum assist from staff for standing and toileting.

On 6/04/25 at 2:18 PM, R58 said he was standing up at the foot of his bed reaching for his urinal. R58 said his legs gave out and he fell. R58 said he had his call light on because he could not reach his urinal. R58 said after half an hour he tried to do it himself and fell. R58 said he felt his hip break when he fell. R58 said he had to yell for help from the staff. R58 said because he is younger and "has his wits about him" the staff thinks he is independent.

On 6/05/25 at 8:44 AM, V10 Registered Nurse (RN) said she was in the hall passing medications, when she heard someone yelling "help me." V10 said she walked up and down the hall trying to find the source of the yelling and heard R58 yell out his room number. V10 said she found R58 on the floor at the foot of his bed near the bathroom door. V10 said she performed an assessment and felt due to the pain level, he probably had a fracture to his hip. V10 said R58's urinal was on the other side of the bed from where R58 had been sitting. V10 said she phoned 911 and R58 was sent to the hospital.

On 6/5/25 at 11:22 AM, V9 Unit Manager said she investigates the falls for the facility, but if there is an injury, the Director of Nursing (DON) takes

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over the investigation. V9 said she did not talk to R58 about his fall, she just copied some papers for the DON.

On 6/5/25 at 11:22 AM, V2 DON said during the facility investigation into the fall they determined R58 did not have his call light on. V2 said she believed R58 was in his wheelchair when the fall happened but wasn't sure. V2 said all falls are investigated to find the root cause of the fall so interventions can be put in place. The new interventions for R58 were to keep his personal items within his reach and provide R58 with a reacher/grabber tool.

The facility investigation showed R58 was trying to grab something, stood up and fell. A reacher/grabber was to be given to R58 and all personal items needed to be within his reach.

The nursing progress note dated 4/21/25 for R58 showed the nurse could hear someone yelling for help and she found R58 on the floor lying on his right side. The nurse (V10) wrote that R58 said he was moving around in his chair and slid out of the wheelchair. R58 said after the fall he rolled onto his other side. R58 said he broke his fall by putting down his left hand so he wouldn't hit his head. The note shows R58 was complaining of pain to his left hip.

The fall risk assessment completed on admission dated 3/14/25 shows R58 was a moderate risk for falls.

The hospital records dated 4/29/25 shows R58 arrived at the hospital on 4/21/25 with complaints of left hip pain after a fall at the facility. Diagnosis after x-rays showed an acute mildly displaced left hip fracture. Surgery to repair the hip was

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completed on 4/22/25. An x-ray of R58's left wrist was completed on 4/21/25 and a fracture to his left wrist was also found.

The care plan for R58 dated 4/29/25 for falls shows the interventions to have personal items within his reach due to his risk for falls, repeated falls, weakness and malnutrition. The same care plan shows R58 required one staff assistance for toileting.

2. The facility face sheet for R2 shows she was admitted to the facility for diagnoses to include Type 2 Diabetes Mellitus, peripheral vascular disease, muscle weakness and stress incontinence. The facility assessment for R2 dated 5/24/25 shows R2 to be cognitively intact, requires a wheelchair for mobility. The same assessment shows R2 is dependent on staff for toileting. R2's care plan dated 2/25/25 shows a sit to stand mechanical lift is used for transfers.

On 6/4/25 at 10:0 AM, R2 said she was being moved in the sit to stand lift from her bed to the bathroom one morning and she slipped out of the lift and fell on the floor. R2 said there were two staff in the room with her and she did not get hurt. R2 said her feet slid and now she is supposed to wear her tennis shoes when she gets up in the lift. R2 said she was wearing her house shoes when the fall happened.

On 6/05/25 at 10:16 AM, V19 Certified Nursing Assistant (CNA) said she was pushing R2 in the sit to stand lift to the bathroom from her bed and R2 just slipped out. V19 said R2 was wearing house shoes and R2 never said anything to her before she fell, or after she fell.

The written statement given by V19 after the fall

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shows R2 was strapped onto the lift and was being pushed into the bathroom, when R2 began telling the staff to bring the lift up higher. Then V19 wrote she began to see R2's weight begin to go to one side and R2 kept saying to raise the lift, but the lift was as high as it goes. (V19 denied this conversation with R2 when I spoke with her on the phone.)

On 6/05/25 at 11:05 AM, V20 Licensed Practical Nurse (LPN) said she was called to R2's room after her fall. V20 saw R2 on the floor with her arms out of the stand slings and her feet over the leg of the lift. V20 said R2 told her she felt herself slipping and told the staff to raise her up.

On 6/5/25 at 11:16 AM, V9 Unit Manager said R2 told her feet just slipped while she was being transported to the bathroom. V9 said R2 was wearing her house shoes.

The nursing progress note dated 5/17/25 shows the CNA informed the nurse that R2 had fallen out of the sit to stand lift and was on the floor. The nurse (V20) wrote R2 was found on the floor with both legs in front of her body and on top the legs of the machine. R2 told the nurse she felt herself slipping.

The care plan for R2 dated 5/14/25 for falls shows an intervention to ensure R2 has non-slip footwear at all times. A new intervention was added after the fall on 5/17/25 to ensure R2 has tennis shoes on before using the sit to stand lift.

The fall risk assessment for R2 dated 2/16/25 shows a significant risk for falls.

The facility fall investigation showed R2 felt herself slipping from the lift because her shoes

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did not have a good grip. The new intervention put in place was for R2 to wear tennis shoes when using the lift.

3. The facility face sheet shows R23 was admitted to the facility with diagnoses to include congestive heart failure, chronic obstructive pulmonary disease and cerebral infarction. The facility assessment dated 4/11/25 shows R23 to be cognitively intact and requires substantial assistance from staff for dressing and transfers. The care plan for R23 dated 5/15/25 shows he needs two assist with a gait belt for transfers.

On 6/03/25 1:04 PM, R23 was observed with a black left eye. R23 said he hit by the lift when transferring out of bed. At 2:01 PM that same day, R23 said he was connected to the sit to stand lift and as he was being lifted up, he reached for a shirt that was hanging on the lift and as he was falling forward, he hit his head on the bar of the lift.

On 6/5/25 at 11:08 AM, V20 LPN, said she was called to the room after being told R23 fell. V20 said she found R23 on his back with his legs crossed. V20 said the CNA told her he was not in the lift yet, but he fell when he reached forward to grab his shirt off the lift. V20 said the CNA said she left R23 sitting on the edge of the bed while she went to his closet to get him some clothes and she saw him lean forward and fall. V20 said R23 had a cut to his left eyebrow area that was beginning to swell, a scrape to his left knee and left ankle.

On 6/5/25 at 11:19 AM, V2 DON said she had not interviewed R23 about his fall and was not aware R23 was saying he was already in the lift when he fell. V2 said she was told R23 was reaching for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25	S9999		

clothes while sitting on the edge of the bed and he fell forward off the bed.

The facility investigation shows R23 was being assisted by staff with his morning routine, he reached for his shirt and fell to the floor. A written statement written by the CNA involved from the initial facility investigation shows R23 was sitting on the edge of the bed and the CNA V21 was at the closet getting clothes out, and the resident leaned forward and fell hitting his eye on the lift. The intervention added was to ensure the residents clothes are within his reach when sitting him up for AM care.

The facility policy for fall prevention with a revision date of 7/2023 shows to provide an environment that is free from accident hazards, over which there is control, and provide supervision and intervention to residents to prevent avoidable accidents. (A)

4 of 4
300.615 e)

Section 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008817	A. BUILDING: _____ B. WING _____	06/05/2025

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S9999	Continued From page 26	S9999		

identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

These regulations were not met as evidence by:
Based on record review and interview, the facility failed to check the Illinois sex offender registry, national sex offender resident and the Illinois Department of Corrections (IDOC) website within 24 hours of admission for 5 of 7 residents (R231, R116, R330, R129, R335) in the sample of 10.

Findings include:
From the facility CMS (Centers for Medicare and Medicaid Services) form 807 dated 6/3/25, the admission date for R231 was 5/24/25. The Illinois Sex Offender Registry, National Sex Offender Registry and IDOC website were checked on 5/26/25, 2 days later.

From the facility CMS form 807 dated 6/3/25, the admission date for R116 was 5/20/25. The Illinois Sex Offender Registry, National Sex Offender Registry and IDOC website were checked on 6/4/25, 15 days later.

From the facility CMS form 807 dated 6/3/25, the admission date for R330 was 5/24/25. The Illinois Sex Offender Registry, National Sex Offender Registry and IDOC website were checked on 5/26/25, 2 days later.

From the facility CMS form 807 dated 6/3/25, the admission date for R129 was 5/24/25. The Illinois Sex Offender Registry, National Sex Offender Registry and IDOC website were checked on 5/26/25, 2 days later.

From the facility CMS form 807 dated 6/3/25, the admission date for R335 was 5/23/25. The Illinois Sex Offender Registry, National Sex

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S9999	Continued From page 27 Offender Registry and IDOC website were checked on 6/4/25, 12 days later. On 6/5/25 at 10:30 AM, V11 admission coordinator, said the website for the sex offender check, national and Illinois, and the corrections website all should be checked with 24 hours of admission. She said if she happens to be out, V1 (administrator) will complete the checks. She said it was especially important to have sex offender registry checks since that have a school next door. V11 said during the time of the admissions from the end of May, she was off work for family. On 6/5/25 at 12:15 PM , V1 said the facility does not have a written policy, they follow the state regulations. "C"	S9999		