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	IL6001796	A. BUILDING: _____ B. WING _____	C 08/03/2018

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S 000	Initial Comments Complaint Investigations 1884657/IL104238 1884645/IL104224 Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Findings 300.610a) 300.1210b) 300.3240a) 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. 300.1210b) Section 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to follow the their abuse policy and protect and prevent the physcal assault of 1 of 4 residents R2 reviewed for physical assault. This facility failure resulted in R4 physically assaulting and punching R2 in the eye requiring enucleation (removal of the eye) of the left globe (eyeball) due to blunt facial trauma). The facility also failed to prevent injury of unknown origin to a dependent resident (R3) also reviewed for injury of unknown origin. This failure resulted in R3 sustaining a hip fracture with no known mechanism of injury.	S9999		

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S9999	Continued From page 2 Findings include: 1) Review of facility's final incident report of 07.20.2018 documents: "(V9, CAN-Certified Nursing Assistant) reports walking into room after (R4) alerted him in the hallway at around 6:15 A.M. that he had an altercation with someone. (R4) informed (V9) that (R2) was moving his covers while he was sleeping, and (R4) punched (R2). (V9) followed (R4) to the room and observed blood on (R2's) face as well as a red eye." Review of R2's hospital record documents: -07.15.2018 at 9:12 AM (page 11): "Pt (patient) via ambo (ambulance) from (Nursing Home)... pt was assaulted at NH (Nursing Home) by other resident s/p (status post) pt lying in other residents bed. Pt has visible hematoma (bruise) on lf (left) eye, no blood thinners. Also rt (right) arm skin tear, and possible missing tooth d/t (due to) dried blood in pts mouth. Pt's lf eye, visibly reddened and swollen, possibly ruptured ..." -07.15.2018 at 12:16 PM (page 10): "Spoke to (nursing) supervisor, at (Nursing Home)...During the night 11p-7a shift, patient got up and went to his roommate's bed who is sleeping and started folding linens on top of him. His roommate got upset and punched him. His roommate told the nursing staff that he punched him because he was disturbing his sleep." CT (Computed Tomography) Head (07.15.2018, page 21) documents: "Rupture of the left ocular globe with lens dislocation. Supra and infraorbital soft tissue swelling and hematoma." CT (Computed Tomography) Facial bones (07.15.2018, page 22) documents: "Rupture of the left ocular globe with lens dislocation." Physician Discharge Summary (page 123)	S9999		

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documents: "Blunt facial trauma (physical trauma to a body part, either by impact, injury or physical attack) with ruptured left globe (ruptured eyeball) s/p (status post) enucleation (removal of the eye).

Review of R2's ambulance run sheet of 07.15.2018 documents: "(Ambulance) was assigned to an emergency assault call. Upon arrival to the scene patient was found standing up in his room. Upon observation, patient appeared to be in pain. He was covering his left eye with one hand. He had bruises on his left face. He had a laceration on his jaw and on the upper left side of his left eye ...Patient's nurse stated that the patient accidentally slept on (in) his roommate's bed, and his roommate was upset and physically beat the patient up while he was sleeping. Due to the assault, the patient had a bruised face, a laceration, and injuries to the mouth ..."

Review of R2's MDS (Minimum Data Set, 07.05.2018) documents the following:
Diagnoses: Coronary Artery Disease, Hypertension, Hyperlipidemia, Arthritis, Non-Alzheimer's Dementia, Manic Depression, Cataracts, Glaucoma or Macular Degeneration; Muscle Weakness, Difficulty Walking, Lack of Coordination.
-BIMS (Brief Interview for Mental Status): not completed.
-Cognitive Skills for Daily Living: 2 (Moderately impaired).

V9 (CNA-Certified Nursing Assistant, 07.26.2018 at 11:31 AM and 2:00 PM) said R4 approached him between 6:20 Am and 6:30 AM telling V9 "come, come to my room." V9 said he saw blood on R2's head and clothing. V9 said R4 told him that R2 was in his bed (R4's) and was trying to pull the covers away from him. R4 told V9 that he

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(R4) fought with R2.
V7 (CNA, 07.27.2018 at 10:48 AM and 10:59 AM) described R2 as "little violent. He would stand up like he wanted to fight me when I would try to change his (incontinent product)."
V20 (CNA, 07.27.2018 at 2:54 PM) said R4 admitted to her that he struck R2 afer R2 urinated on the floor and then laid down in R4's bed.
V11 (LPN-Licensed Practical Nurse, 07.26.2018 at 3:04 PM) said that he was notified (at approximately 6:00 AM) by V9 that R4 had a fight with R2.

Review of R4's hospital record (07.15.2018, page 1) documents:.."Pt (patient) became angry at his roommate this morning and punched his roommate."
Review of R4's MDS (07.13.2018) documents the following:
-Diagnoses: Anemia, Atrial Fibrillation, Hypertension, Renal Insufficiency, Renal Failure, or End Stage Renal Disease; Hyperlipidemia, Thyroid Disorder, Non-Alzheimer's Dementia, Anxiety Disorder, Cataracts, Glaucoma, or Macular; Sensorineural Hearing Loss, Bilateral.
-BIMS: 10 (moderately impaired).
-Physical behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that puts others at significant risk for physical injury. Current behavior status is worse compared to prior assessment.

2) Review of the facility's initial incident report of 07.14.2018 documents: "Resident (R3) was noted with swollen right hip, sent to (local hospital) for evaluation. Staff followed up with resident at (local hospital), spoke with the charge nurse and staff was informed that an x-ray was

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done and revealed fracture of right femur."

Review of "Radiology Results Report" (Date of Service: 07.12.2018) for x-ray of R3's right femur documents: "Impression: Acute distal femoral fracture (broken thighbone just above the knee joint)."

Review of R3's medical record (MDS-Minimum Data Set, 06.28.2018) documents the following:
Diagnoses: Cancer, Seizure Disorder, Manic Depression, Mild Intellectual Disabilities
BIMS (Brief Interview for Mental Status): "4" (severely impaired).
Bed Mobility, Transfer: "3/3" (Extensive assistance/Two plus persons physical assist).

V4 (CNA-Certified Nursing Assistant, 08.02.2018 at 11:21 AM) said she does not know how R3 sustained a femur fracture. V4 said R3 is dependent on staff for transfers and repositioning, requires mechanical lift for transfers and doesn't walk.
V13 (Registered Nurse Supervisor, 07,27.2018 at 3:42 PM) said she does not know how R3 sustained a femur fracture.
V3 (CNA, 08.02,2018 at 1:05 PM) and V15 (Registered Nurse, 08.02.2018 at 1:16 PM) both said that they heard that R3 fell.
V23 (LPN-Licensed Practical Nurse, 07.27.2018 at 3:50 PM) said after receiving R3's x-ray results, she immediately interviewed the CNA who denied any issues for the resident.
V24 (LPN, 08,02.2018 at 3:21 PM) said V2 (Director of Nursing) called her and asked her if R3 had fallen on her shift. "I asked the CNAs if she fell, they said "no." I would know if she fell on my shift."
V22 (Physician, 07.31.2018 at 11:23 AM) said he was concerned that a bedbound resident

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sustained a femur fracture with no clear mechanism of injury. He said he spoke with a nurse at the facility who was not able to tell him what happened; there was no injury, no loss of consciousness, no seizure activity.
V10 (Physician, 08.01.2018 at 9:59 AM) said: (regarding the mechanism of injury for R3's femur fracture) "We don't know for sure. It's usually caused by a fall or twisting injury."

(A)

2 of 2 Findings

300.690 b)c)

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall

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S9999	Continued From page 7 notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to implement their "incident reporting" policy and procedure by failing to report a serious injury to the Illinois Department of Public Health Regional Office within 24 hours for one of four residents (R3) reviewed for abuse in the sample of 6. Findings include: Review of R3's Radiology Results Report documents an x-ray was performed on 07.12.2018 of R3's right femur. The finding, acute oblique fracture of the distal femoral diaphysis, was reported to the facility on 07.12.2018 at 8:16 PM. Review of R3's Progress Note (07.12.2018 at 11:07 PM) documents: "X-RAY result relayed to (V8-Physician) with order to send resident to (local hospital ER) for evaluation." Review of the facility's initial incident report of 07.14.2018 (the date was previously written over as well as lined though) documents: "Resident was noted with swollen right hip, sent to (local hospital) for evaluation. Staff followed up with resident at (local hospital), spoke with the charge nurse and staff was informed that an x-ray was done and revealed fracture of right femur."	S9999		

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S9999	Continued From page 8 The report was faxed to State Agency on 07.14.2018 at 3:06 PM, approximately 40 hours after the fracture was identified. Review of the facility's "Incident Reporting" policy and procedure (Revised February 20, 2017) documents (under Procedures): "1. Any serious injury sustained by a resident that is not an expected outcome of the disease process will be reported to IDPH Regional Office...Physical harm includes a fracture or blood flow not stopped by band aid or hospital treatment that involves more than diagnostic evaluation. 2. The facility shall by fax or phone notify the regional office with 24 hours after each reportable accident or injury." V13 (Registered Nurse Supervisor, 07.27.2018 at 3:42 PM) said the initial incident report was sent in late "because we didn't know what happened." "The date it was sent, was the date that was used for the incident date." (AW)	S9999		