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	IL6013106	A. BUILDING _____ B. WING _____	C 08/29/2019

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S 000	Initial Comments 1945057 / IL113863 1945195 / IL114013 1945259 / IL114085 1945321 / IL114146 1945650 / IL114504 1945786 / IL114652 1946000 / IL114879 1946181 / IL115082	S 000		
S9999	Final Observations Licensure Violations 1 of 2 300.610a) 300.1010h) 300.1210b)4) 300.1210d)5) 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 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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. 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:	S9999		

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5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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:

A. Based on interview and record review, the facility failed timely identify, assess and treat wounds related to dermatitis for two of two residents (R16 and R33) reviewed for wounds in the sample of 45. This failure resulted in R16 acquiring multiple wounds.

Findings include:

1. R16's Admission Record, undated, documents R16 has diagnoses of: Obesity, muscle weakness (generalized), difficulty walking, lack of coordination and Localized Edema.

R16's July 2019 Physician's Order Sheet (POS) documented R16 was to have a weekly skin check. The POS did not document R16 was receiving any treatments for skin

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S9999	Continued From page 3 conditions/wounds. R16's Treatment Administration Record for May, June and July up until she was discharged to the hospital on 7/14/19, documented R16 was to have a weekly skin assessment. These assessments did not document R16 had any skin condition or wounds during this time frame. R16's Weekly Skin Record, dated 7/5/2019, documents, "skin remains intact." R16's Shower Sheets dated 7/4/19, 7/8/19 and 7/10/19 have no documentation related to R16 having open areas on her skin. R16's Minimum Data Set (MDS) dated 7/3/2019, documented R16 was cognitively intact. This MDS also documents R16 required extensive assistance of 1 staff member for bed mobility, dressing, toileting and personal hygiene. This MDS documents R16 requires limited assistance of 2 staff members for transfers. This MDS documents R16 is frequently incontinent of bowel and bladder. R16's Care Plan, initiation date of 10/03/2014, documents, in part, "Focus: (R16) has the potential for pressure ulcer development r/t decreased mobility, urinary incontinence, frequent edema to bilateral legs, ankles and history of open areas." The Care Plan documented "Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements or decline to MD." The Care Plan documented "Follow facility policies/protocol for the prevention/ treatment of skin breakdown for (R16). If (R16) refuses treatment, confer with resident, IDT	S9999		

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(Interdisciplinary Team) and family to determine why and try alternative methods to gain compliance. Document alternative methods." The Care Plan documented "Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/s (signs symptoms) of infection, wound size, stage."

R16's Care Plan, initiation date 10/03/2014, documents "She also has refused staff to assist her in showering and getting cleaned up." The Care Plan documented "Focus: (R16) will demonstrate effective coping skills for the next 90 days. Interventions: Analyze of key times, places, circumstances, triggers, and what deescalates behavior and document. Assess (R16's) coping skills. Assess (R16's) understanding of the situation. Allow time for (R16) to express herself and her feelings toward the situation. Monitor/ Document (R16) observed behavior and attempted intervention in behavior log. Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. See the behavior tracking manual for additional interventions."

R16's Care Plan, dated 10/03/2014, documents, in part, "Focus:(R16) has an ADL Self Care Performance Deficit r/t generalized weakness, vision deficit and need for staff assistance to remain clean dry and free of odors." The Care Plan Intervention documented "She requires verbal cue for changing clothes after showering. Toileting: (R16) requires supervision from 1 staff with all her toileting needs. Bathing: (R16) requires extensive assistance of 1 staff for all bathing/showering. (R16) will often refuse her shower and request a bed bath instead. Will consent to a tub bath, however requests to be left alone in the tub for dignity. (R16) needs much

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encouragement to change her soiled clothes on a daily basis."

R16's Care Plan/Behavior Tracking Record, dated June 2019, documents, in part, "Problem Statement: Refusing to allow staff to clean her up and assist with showering. Goal: To have cooperation with showering and staff assistance with cleaning self and personal hygiene. Interventions: 1. one to one/Emotional Support/ Counseling. 2. Calming/ Redirection/Distraction 3. Try at a later time to give care."

R16's June 2019 Care Plan/Behavior Tracking Record documents 37 shifts which staff did not document at all; 52 shifts documenting R16 had no behaviors of refusing staff to clean her or assist with showering; and only one shift which she displayed behaviors of refusing showers or to be cleaned up by staff.

R16's Nurse's Note, dated 07/14/2019 at 06:19 AM, documents, R16 fell out of her wheelchair onto the floor. The Nurse's Note documented R16 was sent to the Emergency Room for evaluation.

R16's Nurse's Note, dated 07/14/2019 at 06:25 AM, documents, "While assisting resident with incontinence care in resident's bathroom, skin assessment completed. Moist, mushy skin noted to bilateral posterior thighs with 10-centimeter (cm) x 10 cm open area noted to posterior right thigh. BLEs (Bilateral Lower Extremities) swollen and discolored, feet purplish in color. Redness noted to bilateral posterior thighs. Emergency Room updated on findings re: skin assessment."

R16's Hospital Wound Flow sheets, dated 7/14/2019 at 11:41 AM, documented the R16 had the following skin conditions and wounds which

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were present upon R16's admission: bilateral gluteal ulcerations, multiple partial opened, some "scabbed and black, dry, purple and reddened"; a gluteal fissure; bilateral thigh abrasions; bilateral, medial groin moisture associated skin damage MASD-moisture associated skin damage-Inflammation and erosion of the skin caused by prolonged exposure to moisture and its contents, including urine, stool, perspiration, wound exudate, mucus or saliva); and a left 5th toe ulceration measuring 1.3 centimeters (cm)by 1.0 cm.

R16's Local Hospital History of Physical, dated 7/14/2019 at 1:04 PM, documents, "Extremities: extremities normal, atraumatic, 2 plus edema and weeping lesions present. Skin: multiple open lesions present."

R16's Skin Wound Ostomy Team (SWOT) Hospital Notes, dated 7/15/2019, documents, in part, "Skin/Wound Assessment: Patient seen in room. Patient has several other apparent vascular ulcers on plantar aspect of left foot and 2nd toe on the right foot. Left thigh has a large open area with 20% slough. Patient bilateral posterior knees assessed. Both areas show reddened areas likely due to moisture. Patient rolled on left side to assess right posterior thigh. Patient has MASD with severe open areas likely due to moisture."

R16's Hospital Notes dated 7/15/2019, documents R16's wound to right posterior thigh was present upon admission. The Note documented R16's wound as MASD with the wound base being 80% reddened, 20% yellow/slough (dead tissue) and scants amount of drainage.

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On 8/14/2019 at 2:24 PM, V36 Certified Nurse Aide (CNA), stated, R16 was incontinent. V36 stated she would wash R16 up in the bathroom every day. V36 stated the day R16 fell "We helped her up with 2 people and a gait belt. I took her to the bathroom and stood her up with the grab bars and washed her up. She had red spots on her bilateral back of thighs. None were open that I remember. She had red spots once before and they went away. They weren't blisters. I thought it was just from her being wet."

On 8/15/2019 at 3:30 PM, V10 CNA, stated, "She (R16 was able to make up her own mind and was determined to do things her way. She was particular about who worked with her. Her posterior thighs and buttocks were peeling, red, mushy with scabbed areas. Her legs were always swollen but they were intact. This was before and after the hospital. We were putting calamine on the areas."

On 8/15/2019 at 11:40 AM, V16 LPN, stated, "(R16) was independent. She was alert and made her own decisions. She transferred herself to her wheelchair. She was incontinent. She would let you know when she was wet, but she didn't like to get changed. It was on going chore to get her changed."

On 8/19/19 at 9:00 AM, V29 LPN, stated, "(R16) would sit on the edge of the bed with the tray table leaning over it with her feet on the floor. Her legs were swollen, and she was very noncompliant with putting them up. She frequently refused care. She only would only let certain people care for her. (V36) could talk her into cleaning up. She would only clean up when she wanted to be cleaned up." V29 stated the morning R16 fell "(V36) did come and get me

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while she was cleaning (R16) up and told me about an open area on her thigh and that her thighs were mushy. Her thigh did have an area to the right thigh and they were mushy. I notified the Emergency Room of this because this was new and there was no treatment in place for it."

On 8/19/19 at 12:05 PM, V1, Registered Nurse (RN/previous Administrator, stated "She did not like to take showers, change her incontinence brief or change her clothes. She was alert and oriented. It (being soiled) didn't bother her. No one ever reported skin issues to me. (V36) took care of her all the time and she is a really good aide. If something was wrong she would let us know. Staff should report any open areas to the nurse."

On 8/19/2019 at 1:50 PM, V51 RN, stated, "(R16) was on introvert. She was alert and orientated with poor decisions. She would sit in urine for long periods of time. She wouldn't let you clean her bed or her room until she was ready. If she didn't want to do it, she wasn't doing it. It was amazing her urine was so strong, but her skin was intact as far as I knew."

On 8/20/2019 at 11:30 AM, V37 CNA, stated, " If (R16) did not like a person she would not let you touch her. She liked me, but I never saw her skin. She would toilet by herself. She never let me help her. I would get her set up. I could get her to take a shower but again she would not let me see her naked. She would do it all by herself. Basically (V36) was the only one that saw her naked."

On 8/20/2019 at 12:30 PM, V43 Physician, stated, "(R16) was set in her ways. If you demanded something she wasn't going to do it. She probably wasn't the cleanest, she didn't like

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to bathe. She had chronic edema of her legs. She had scaly large legs. She refused to wear compression socks. She could verbalize her needs and could ask for help. I was not aware of any wounds." Upon looking at the wound photos from the hospital, V43 stated, "The buttocks looks like it is chronic. The buttocks look like chronic picking or scratching. The thigh wound looks like a new acute abrasion or shearing possibly from a transfer with a pad. Under that wound the thigh looks like it is chronic Incontinence Associated Dermatitis. The gluteal folds look moisture related possible fungal. The toe wounds are vascular. The lateral foot wound is questionable. It is odd. It is not on a place of pressure. Without feeling it and seeing it, I don't know. The heel is odd because she was up using her feet in her wheelchair. I would expect the nursing home to figure out a way to see her skin and report it to me."

On 8/22/2019 at 2:15 PM, V33 New Administrator, stated, "Yes, the doctor should have been notified of (R16's) skin, the nurses should have been notified from the aides and interventions should have been put in place for (R16's) education and treatments. When a nurse charts other on the weekly skin assessment they should follow up with a detailed description of the skin issue."

On 8/27/2019 at 3:40 PM, V12 RN, stated, "(R16) was alert and orientated. She was very independent. She wasn't the most hygienic person. She was noncompliant with hygiene and her ace wraps to her legs. I think it was the way the staff approached her. You had to make her think it her idea. She was using a wheelchair at the end."

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On 8/28/2019 at 10:22 AM, V33 stated, "I did not know (R16). I never even laid eyes on her. For someone with her skin issues, I would think the nurses would discuss and consult with the physician and maybe consult with a wound doctor."

2. R33's Face Sheet, dated 8/22/19, documents R33 was admitted on 3/13/2016 with diagnoses of Tubulo-interstitial nephritis,

R33's MDS, dated 7/5/2019, documents R33 has a BIMS of 5 indicating R33 is severely impaired.

R33's Nurse's Note, dated 5/3/2019, documents, in part, "Note Text: New orders re: hydrocortisone cream to rash every shift to chest, back, and bilateral upper and lower extremities."

R33's Nurse's Notes, dated 8/12/2019, documents, "Received call from (V55, R33's daughter) regarding "sores all over her body." States that she has a sore under her neck, on left upper shoulder, between breasts. Assessed resident. Sores noted to left neck, left upper chest, between breasts, under left breast, and left groin. "The Note documented "called (V43's, R33's Physician) office and spoke with (staff). Updated on resident status. Will inform (V43). Called (V55) and updated on resident status."

R33's Nurse's Note, dated 8/12/2019, documents, in part, "Note Text: (V43) informed of open areas on upper left chest and sternum and rash in groin area on left side and under left breast. Order given for TAO (triple antibiotic) and band aide to open areas daily and antifungal powder to breast and groin bid (twice a day) until healed. "

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S9999	Continued From page 11 R33's Nurse's Note, dated 8/18/2019, documents, "Called (V56 Nurse Practitioner). Updated on healing blisters on left breast and sternum with appearance of 1 more blister. Sites continue to heal. NNO received." R33's TAR, dated June 2019, documents, in part, "Weekly Skin Assessment on Fridays. C - Clear, R -Red Rash, O- Other, P - Pressure, S - Skin Tear." This TAR has "O" documented for 6/7/19, 6/14/19,6/21/19 and 6/28/19. There is no documentation regarding what the "O" is on the TAR. There is no Nurses Note regarding what the "O" is. R33's TAR, dated June 2019, documents, Lotrisone cream 1% Apply cream to affected areas on back, upper thighs, BID (twice a day). There is no documentation the cream was applied to R33 for on the 7 AM - 3 PM and 3 PM - 11 PM shift for 6/8/19, 6/9/19, 6/16/19, 6/29/19 - 6/30/19, the 7 AM - 3 PM on 6/15/19, 6/24/19, and the 3 PM - 11 PM shift on 6/22/19 and 6/23/19. R33's TAR, dated July 2019, documents, in part, "Weekly Skin Assessment on Fridays. C - Clear, R -Red Rash, O- Other, P - Pressure, S - Skin Tear." This TAR has O documented for 7/5/19, 7/12/19, 7/19/19 and 7/26/19. There is no documentation regarding what the "O" is on the TAR. There is no Nurses Note regarding what the "O" is. R33's TAR, dated June 2019, documents, Lotrisone cream 1% Apply cream to affected areas on back, upper thighs, BID (twice a day). There was no documentation R33's cream was applied during the 7 AM - 3 PM and 3 PM - 11 PM shift for 7/2/19, 7/3/19, 7/30/19 and the 3 PM - 11	S9999		

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PM shift on 7/12/19, 7/16/19, 7/17/19, and 7/28/19/-7/30/19.

R33's TAR, dated June 2019, documents, Apply Hydrocortisone 1% cream to BUE (bilateral upper extremities) and BLE (bilateral lower extremities and chest rash every shift. There was no documentation R33 received Hydrocortisone during the 7 AM - 3 PM and 3 PM - 11 PM shift on 7/2/19, 7/3/19, 7/30/19, the 7 AM - 3 PM shift 7/5/19 and 7/29/19 and 3 PM - 11 PM shift on 7/16/19, 7/28/19 and 7/30/19.

R33's TAR, dated August 2019, documents, in part, "Weekly Skin Assessment on Fridays. C - Clear, R -Red Rash, O- Other, P - Pressure, S - Skin Tear." This TAR has O documented for 8/2/19, 8/9/19 and 8/16/19. There is no documentation regarding what the "O" is on the TAR.

R33's TAR, dated August 2019, documents, "TAO and Band aide to open areas daily Left upper chest and sternum. There is no documentation this was done on 8/16/19.

On 8/20/2019 at 12:30 PM, V43 Physician, stated, "There is no reason why (R33's) treatments should not be done. She does not refuse treatments." V43 stated she expected the treatments to be completed as ordered.

On 8/20/2019 at 2:05 PM, V33, Administrator, stated, "I would expect the nurse to follow doctors' orders and document that the treatment has been done."

The facility policy and procedure Eight Rights for Administration of Medications, dated 12/31/14, documents, in part, "Sign out medications as

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soon as they are given. Always use your medication book. Documents if the medications are refused and the reason."

The facility policy and procedure, dated January 2014, documents, in part, "Policy: To provide preventative skin care through repositioning and careful washing, rinsing drying, and observation of the resident's skin condition to keep clean, comfortable, well- groomed, and free from pressure ulcers. Procedures: 1. All residents will be assessed using the Braden Pressure Ulcer Scale at the time of admission and weekly x 4 then will be reassessed at least quarterly and / or as needed. 2. Staff on every shift and as necessary will provide skin care. 3. After thorough cleansing of the skin, lotion may be applied, and observations of any reddened areas will be reported to the Charge Nurse. 4. A thin layer of body lotion and / or barrier cream may be applied as a protective barrier to area(s) exposed to incontinence. 14. Keep incontinent residents clean and dry."

B. Based on interview and record review, the facility failed to assess for possible changes in condition, monitor vital signs and oxygen saturation levels (SpO2) after hospitalization of one of one resident (R16) reviewed for quality of care after hospitalization in the sample of 45. This resulted in R16 not receiving nursing care and dying 35.5 hours after readmission.

Finding includes:

1. R16 Admission Record documented she had admitting diagnoses of Essential Hypertension, Heart Failure and localized Edema and Chronic Kidney Disease Stage III.

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S9999	Continued From page 14 R16's Care Plan, dated 10/03/2014, documents, in part, "Focus: (R16) is has the potential for complications R/T renal insufficiency and is incontinent of urine at time. Interventions: Assist (R16) with ADL's (Activities of Daily Living) and ambulation needed. Auscultate heart and lung sounds per MD (medical doctor) orders or as condition warrants and document findings. Elevate feet when sitting up in chair to help prevent dependent edema. Monitor and report changes in mental status: lethargy; tiredness; fatigue; tremors; seizures. Monitor vital signs as directed by MD." R16's Nurse's Note, dated 07/14/2019 at 06:19 AM, documents, R16 fell out of her wheelchair onto the floor. The Nurse's Note documented R16 was sent to the Emergency Room for evaluation. The Nurse's Note documented "This LPN (Licensed Practical Nurse) was summoned to 400 hall per (V36 CNA (Certified Nurse's Aide)). (V36) states she observed resident on floor." The Nurse's Note documented "Neuro-checks initiated and findings WNL (Within Normal Limits). Resident c/o pain to posterior scalp. 6 cm x 6 cm bruised hematoma noted to upper forehead." The Nurse's Note documented "(V43, Physician) called with new orders to send to ER (Emergency Room) for evaluation." R16's Local Hospital ED (Emergency Department) Notes, dated 7/14/2019 at 6:54 AM, documents, "Summary statement: 89 yo (year old) female presenting with C1 and odontoid fx (fracture vertebrae of the neck) after falling from her wheelchair. Given these injuries, plus her peripheral edema and mild hypothermia upon arrival, will admit for further workup, Spine consultation."	S9999		

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R16's Hospital Discharge Summary, dated 7/16/2019, documents, in part, "Discharge Diagnoses: 1. C1 (cervical #1) ring fracture and odontoid base fracture. 2. Right neck mass appears to be arising from the thyroid gland. 3. hypothermia initially patient was hypothermic of unknown etiology. 4. Acute on chronic diastolic CHF (Congestive Heart Failure) poa (present on admission). 5. CKD (chronic Kidney Disease) stage III present on admission."

R16's After Visit Summary dated 7/16/2019, documents, in part, "Discharge Instructions: Cervical collar must be on at all times."

R16's Care Plan, dated 7/16/19, documented R16 had a fracture to her C1 vertebrae. The Care Plan did not address that R16's cervical collar must be on at all times and what staff were to do if she did not wear it.

R16's Nurses Note, dated 7/16/19 at 6:58 PM, documented R16 refused to eat supper, her cervical collar was on as ordered and she was receiving oxygen per nasal cannula at 2 liters. The Nurse's Note documented her vital signs as 97.7 (temperature) 80 (pulse) 20 (respirations) 124/70 (blood pressure) wt (weight) 202."

R16's Weight and Vital Summary, dated 7/17/19 at 8:53 AM. No other vital signs were documented as being completed. There was no documentation R16's vital signs and oxygen saturation levels were monitored on the 3rd shift on 7/16, 2nd shift on 7/17, and 3rd shift on 7/17/19.

R16's Nurse's Note, dated 7/17/19 at 5:44 PM, documents, "Resident refusing o2 (oxygen) combative when trying to encourage to apply

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S9999	Continued From page 16 refuses to get oob (out of bed) refusing to eat or drink dr. (Doctor) phoned awaiting return call." R16's Nurse's Note, dated 7/17/2019 at 5:54 PM, "Dr. (Doctor) updated on refusal of o2 eating and getting oob nno (no new orders), Dr. to see 7/18." R16's Nurse's Note, dated, 7/18/2019 at 3:35 AM, documents, "Note Text: This nurse was called into resident's room, to verify absence of a pulse and lung sounds. No aeration heard throughout lungs fields and no heart sounds auscultated. Resident was cool to the touch and no pulse palpable. Resident code status is DNR. (do not resuscitate). This nurse and 2nd nurse call time of death at 3:37 am on 7/18/19." On 8/14/2019 at 2:24 PM, V36 Certified Nurse Aide (CNA), stated, "When she (R16) came back, I worked with her on 7/17/2019. She was refusing everything (eat, get out of bed). She would always eat for me and she normally had a tendency to stay in bed. She wasn't complaining of pain. She just said she was sleepy. She had her neck brace on, we would do a really easy roll and then perform incontinent care on her. On 7/18/2019, I came in at 3:00 AM, and I found her dead on my first rounds. (V37, CNA) stated she saw her not long before that." On 8/15/2019 at 11:40 AM, V16 LPN, stated, "On 7/17/19, she (R16) became uncooperative she was taking her oxygen and collar off. She would refuse to eat and get out of bed. Her vital signs were stable. I updated the doctor. The doctor said she would come the next day. (R16) stated she wasn't in pain. She would say 'No, I don't want to do anything. Leave me alone.' This was not out of character for her. She had bruising to the bilateral There were no neck/spine precautions just to	S9999		

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keep the neck collar on."

On 8/15/2019 at 1:05 PM, V49 LPN, "On 7/17/2019, I had her for 4 hours on the evening shift. She had a cervical collar on. She had no complaints of pain just said that she just wanted to be left alone and she just wanted to rest. She refused to get up. Her breathing was fine, and she was not sweating. I didn't see her skin nothing was told to me about her skin. I didn't get report when I came on."

On 8/15/2019 at 3:30 PM, V10, CNA, stated, "When she (R16) came back from the hospital on 7/16/2019 she was confused but alert. She wouldn't eat dinner. On 7/17/2019, she started screaming she said she was dreaming she was falling. She was ok she was talking to me. I left that night at 10:00 PM."

On 8/19/19 at 9:00 AM, V29 LPN, stated, I remember taking care of her when she came back maybe the night she came back. She let us lay her down, she had oxygen on and her cervical collar."

On 8/19/19 at 12:05 PM, V1 RN previous Administrator, stated, "When she (R16) came back she seemed a little different. She kept trying to take off her neck brace."

On 8/20/2019 at 11:30 AM, V37 CNA, stated, "When she (R16) came back, I did see her with a neck collar on. She wasn't comfortable. She was taking the neck brace off. She has always been feisty and needed to be in control. She just wasn't comfortable. I told the nurse. The nurse went and spoke to her about it. On 7/17/2019, I had her that night shift. On the first round maybe 11:00

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PM, I saw her. She was asleep and had the neck brace on. I thought 'Oh, that's how that goes on.' The second round between 1:00 AM and 1:30 AM, she was still asleep and breathing, I checked because at first, I thought she was dead. She was just sleeping peacefully. I didn't wake her up because she slept so badly the night before. (V36) came in at 3:00 AM. She came to me around then and told me (R16) isn't breathing would I go and check. I went in and she wasn't breathing. I was touching around her neck and chest area she was warm to the touch."

On 8/20/2019 at 12:30 PM, V43 Physician, stated, "The nursing home did not call the office during the day about her refusing oxygen, her cervical collar or not eating. They probably got a hold of the after-hour doctor on call and they (the on-call physician) are going to say watch them, maybe send to the emergency room and they know I am in the nursing home on Thursdays, so they would say I will see them tomorrow. Vital signs should be done 3 times a day with oxygen saturations if they are on oxygen. If I have ordered blood pressures I expect them to be done. If someone comes back from the hospital with a broken neck or a toenail you should be assessing them and getting vital signs at least 3 times a day. The aide that just let her sleep instead of getting vitals, was she just sleeping, or was she sleeping because her oxygen, heart rate, blood pressure was low or high. We don't know because the vitals or the assessment was not done. They did not get vitals, assess or notify me of (R16's) delusions. Your seventh vital sign is a change in mental status. That is almost neglect. A neck fracture is difficult enough to heal with the best of nursing care. The fall that R16 had did hasten her death that is what I put on the death certificate as the cause. The quality of care she

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received after returning from the hospital also hastened her death. I am concerned that the night the aide didn't wake her up (R16) couldn't wake up. It is very difficult to say what her cause of death was; did she move her neck wrong, heart attack, pneumonia or atrial fibrillation we just don't know."

On 8/20/2019 at 12:40 PM, V48 CNA, stated, "When (R16) came back, I helped clean her up on 7/17/2019. I gave her a bed bath and changed her sheets. She kept saying 'I want him up and out of here'. No one was there. I did tell the nurse about this. I think it was (V49 Licensed Practical Nurse/LPN) the new nurse that just came on shift. Delusions were unusual for her. I thought it was just the pain medication. She did have her neck collar on."

On 8/22/2019 at 2:15 PM, V33 New Administrator, stated "The doctor should have been notified of (R16's) new onset of delusions."

On 8/27/2019 at 1:25 PM, V52 CNA, stated, "We have a sheet that lists who needs vitals that day from the nurse."

On 8/27/2019 at 1:30 PM, V30 LPN, stated, "If someone is back from the hospital they get vital signs, a head to toe nursing assessment and SpO2 every shift for 3 days. We (the nurses) have vital sign sheets that we fill out for the residents that need them. The aides get the vitals and we chart them in the computer."

On 8/27/2019 at 1:54 PM, V24 CNA, stated, " The nurse will write out a vital sign sheet with the name of the resident. We get the vitals and give them to the nurse when done. The nurses do the SpO2's."

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On 8/27/2019 at 3:40 PM, V12 RN, stated, " I was the only nurse here on 7/17/2019 night shift another nurse (V32 LPN) came in later. When I walked through the building she was asleep. I did not assess her. (V32) called me on my phone and told me (R16) was dead. I went to (R16's) room to verify the death. She was cool to the touch. No rigor mortis had set in. She wasn't even totally gray yet. She did have her cervical collar on. I would be doing vital signs with SpO2 every 4 hours for someone like (R16). Any readmission gets vital signs and a nursing assessment every shift for 72 hours. The previous shift makes up the list of residents that need vital signs for the CNAs."

On 8/27/2019 at 3:50 PM, V16 LPN, stated, "On a readmission vital signs, SpO2 (oxygen saturation levels - amount of oxygen in the blood) if on oxygen and a head to toe assessment is done every shift for 72 hours." When questioned why there is no documentation of a head to toe assessment done on 7/17/19 and why no SpO2 values were charted for R16, V16 stated, "I would have physically done these. I probably forgot to chart it."

On 8/28/2019 at 8:15 AM, V32 LPN, stated, "I am never on (R16's) hall. On 7/18/2019 I came in at 2:20 AM. (V12 RN) was the only nurse here, someone must have called off. I did not get any kind of report. I did know she had a broken neck. I did not see her at all until (V36 CNA) came and told me (R16) was dead. I went and check her code status, she was a DNR. I went into her room and confirmed she was deceased. She was gray, and she was warm. No rigor mortis had set in. Her cervical collar was on. There was no oxygen on her. With a readmission vital signs with a head

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to toe assessment is done every shift. I would check the SpO2 at least once a shift. I would have assessed her and gotten vitals, but I hadn't gotten to her yet."

On 8/28/2019 at 10:22 AM, V26 stated, "For an admission from the hospital, a head to toe assessment, vital signs and SpO2 should be done every shift for a minimum of 3 days."

On 8/28/19 at 3:00 PM, V26, Regional Corporate Nurse Consultant, stated that the facility does not have a policy and procedure on when nursing assessments and vital signs are done.

C. Based on interview and record review, the facility failed to obtain provide sliding scale insulin to 1 of 6, (R1) reviewed for quality of care in the sample of 45.

1. R1's Minimum Data Sheet (MDS) dated 8/01/19, documents, R1 has a Brief Interview for Mental Status (BIMS) of no cognitive impairment.

R1's Admission Record, undated, documents R1, has multiple diagnoses significant for Type 2 Diabetes Mellitus with Hyperglycemia.

R1's Care Plan dated 6/05/19 documents, "Resident has diabetes mellitus. Receives insulin injections. Often refuses insulin and fingerstick."

R1's Physician Order Sheet (POS) dated June and July 2019 documents, "Accu-checks before meals (AC) and at bedtime (HS) with Admelog sliding scale (ss). Admelog Sliding Scale 151-200 = 2 units, 201-280 = 4 units, 281-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units.

R1's Glucose Monitoring Record, dated June

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S9999	Continued From page 22 2019 documents R1's blood glucose was checked 3 times on 6/01/19 at 11AM, 4 PM, and 8 PM; 3 times on 6/02/19 at 8 AM, 11 AM, 8 PM; 3 times on 6/5/19 at 9 AM, 4 PM, 8 PM. R1's Glucose Monitoring Record, dated July 2019 documents blood sugar checks 2 times on 7/17/19 at 11 AM, and 10 PM; and 3 times on 7/19/19 at 8 AM, 12 PM, 4 PM. On 7/19/19 at 11:30 AM, R1 stated, she has orders for blood sugar check at 9 AM, 12 PM, 5 PM, 9 PM. R1 stated, she was only checked for her blood sugar twice on 7/17/19 and 3 times on certain days in previous months and stated, she could die if her blood sugar is too low and gets very sick if it is too high. R1 stated, she went out for an appointment around 11 AM and returned around 3 PM and the staff could have checked her blood sugar at 9 AM and 4 PM that day. R1 stated, nobody came to ask her to check her blood sugar at all at 9 AM and at 4 PM. R1 stated, she never refused blood sugar checks because, she could have very high or very low blood sugar with serious consequences. 2. R11's POS dated 7/2019 and 8/2019 document, "Blood Glucose Monitoring Check and Record Before Meals and at Bedtime. Call MD if greater than 300." R11's Glucose Monitoring Record for July 2019 documents, "Accu-checks AC and HS." R11's blood sugar was checked only 3 times on 7/02/19, 7/03/19, 7/04/19, 7/05/19, 7/06/19, 7/07/19, 7/10/19, 7/12/19, 7/15/19, 7/16/19, 7/18/19, 7/20/19, 7/21/19, 7/22/19, 7/25/19, 7/26/19, 7/28/19; and 2 times on 7/08/19, 7/17/19, and 7/30/19.	S9999		

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S9999	Continued From page 23 R11's Glucose Monitoring Record for August 2019 documents, "Accu-checks AC and HS," and R11's blood sugar was checked twice on 8/06/19 at 6 AM, and 11 AM; 3 times on 8/07/19 at 6 AM, 12 PM, 4 PM. 3. R32's POS dated 7/2019 and 8/2019 documents, "Blood Glucose Monitoring Before Meals (AC) and at Bedtime (HS). The Glucose Monitoring Record dated July 2019 documents R32 blood sugar was checked 3 times on 7/20/19 at 6 AM, 11 AM, 4 PM; 3 times on 7/26/19 at 6 AM, 4 PM and 8 PM; 2 times on 7/28/19 at 6 AM, 11 AM, and 7/30/19 at 6 AM and 11 AM. R32's Glucose Monitoring Record dated, August 2019 documents R32's blood sugar was checked twice on 8/06/19 at 6 AM, and 11 AM. 4. R30's POS dated August 2, 2019 documents, "Blood Glucose Monitoring AC and HS." R30's Glucose Monitoring Record dated July 2019 documents blood sugar was checked 3 times on 7/09/19, 7/22/19, 7/26/19, 7/28/19 and 2 times on 7/30/19 at 6 AM, 11 AM. R30's Glucose Monitoring Record dated August 2019 documents R30's blood sugar was checked 2 times on 8/06/19; and 3 times on 8/07/19. On 8/28/19 at 11:25 AM, V57, Physician, stated it is very important to follow physician's orders for accu-check, the need to be done at the ordered specific times because that is the only basis the physician can determine whether the treatment is accurate.	S9999		

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S9999	Continued From page 24 (A) Licensure Violations 2 of 2 300.610a) 300.1210b)4)5) 3001210d)6) 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 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and	S9999		

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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.

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.

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 prevent falls, analyze root causes of falls and failed to provide progressive interventions to

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prevent future falls for 2 of 4 residents (R14, R17) reviewed for falls in the sample of 45. This resulted in R17 falling and sustaining a fracture to the shoulder twice.

Findings include:

1. R17's undated Admission Record documents she was admitted on 5/13/19 with diagnoses of Dementia, orthostatic hypotension, repeated falls, unsteadiness on feet and spinal stenosis, gait abnormality, lack of coordination.

R17's MDS dated 7/31/19 documents R17 has moderate cognitive impairment. The MDS documents R17 requires extensive assist (resident involved in activity, staff provide weight-bearing support) of one-person physical assistance with all activities of daily living including bed mobility, transfers, and totally dependent on staff for locomotion on and off the unit.

R17's Fall Assessment dated 8/15/19 documents a Fall Risk score of 15 (Score of 10 or greater, the resident should be considered at High Risk.).

R17's Care Plan, with initiation date of 5/21/19 documented "At High Risk for Falls related to decreased safety awareness related to confusion. Primary mode of locomotion is wheelchair, incontinent of bladder at times. Family assist resident to the bathroom and with mobility at times. Has a history of falls and orthostatic hypotension prior to admission. She will attempt to transfer self at times and has decreased safety awareness. Goal: Will remain free of falls causing hospitalizations related to injury thru next review." The Care Plan Intervention, dated 5/19/19, documented "Resident educated on use of call

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light and not transferring self without staff present."

R17's Progress Note, dated 5/19/19 at 9:00 AM documented "This nurse entered resident's bathroom to observe resident on the floor." The Note documented "Stated she was trying to self-transfer from the toilet to her wc (wheelchair) and slipped on the floor." The Note documented "Resident re-educated to use call light for staff assist when needed to transfer.

A Final Illinois Department of Public Health (IDPH) Incident Notification undated documents, "Date of Incident: 5/21/19. On 5/21/19 (R17) was noted with a 6 centimeters (cm) by 5 cm discoloration on her right shoulder. Review of medical record reveal resident had a fall on 5/20/19. She was observed on her right side in her bathroom. Resident complained of right shoulder pain on 5/21/19 and orders for X-ray were obtained. Revealed acute distal clavicular fracture (collar bone). The facility concluded that the discoloration was from her fall that occurred on 5/20/19,"The facility was not able to provide the Fall Investigation Report for 5/20/19 or the X-ray result done on 5/21/19.

There was no documentation in R17's medical record that the facility reassessed R17 for possible causes of R17 falling. R17's Care Plan Intervention, dated 5/21/19, documented "Nurse educated resident on using and waiting for staff assistance."

R17's Progress Note, dated 6/13/19 at 11:05 PM documented "Resident observed lying on floor between bed and bathroom. Resident states that she was trying to get OOB (out of bed) unassisted and lost her balance. Small

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hematoma noted to right upper forehead with no active bleeding noted."

Incident Report dated 6/13/19 documents R17 fell at 11:05 PM. The Report documented "Nursing Description: Fall in resident's room. Resident Description: Fell while trying to get up unassisted to use the bathroom. Description of Action Taken: First aid unnecessary. Neuro checks initiated. and findings within normal limits."

Investigative Conclusion, undated, documents, "Resident observed laying on floor when asked what happened resident reported she was trying to go to bathroom. Bed in low position. Plan of Action to Prevent Reoccurrence: Floor mat next to bed."

There was no documentation in R17's medical record that the facility reassessed R17 for possible causes of R17 falling or need for increased supervision. No progressive interventions were documented to prevent R17 from falling again.

The Final IDPH Incident Notification, undated documents, "Date of Incident: 6/14/19. Resident was observed attempting to ambulate unassisted to her room. Comprehensive investigation concluded as nurse was going down the hall she observed (R17) up going to the restroom and before she could get to her, she began losing her balance causing her to fall. Resident was immediately assessed. Resident complained of left shoulder. No other injuries identified. (Physician) and POA (Power of Attorney) notified. New orders were received to send to ER for evaluation. Resident was treated and released from hospital with left proximal humeral diaphysis fracture (shoulder) the same day. Resident

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returned to facility with a left arm sling and medication for pain management."

Incident Report, undated, documents," Date of Incident: 6/14/19 06:55. Immediate Action Taken: Call EMS Emergency Medical Service)."

The Hospital Radiology Report dated 6/14/19 documents "X-ray Supine Chest: Impression: Pacemaker, atherosclerosis, and left humeral neck."

There was no documentation in R17's medical record that the facility reassessed R17 for possible causes of R17 falling or need for increased supervision. There were no progressive interventions developed to R17 from falling again.

Incident Report undated documents, on 7/5/19 at 11:17 PM "Nursing Description: Resident found on restroom floor in a room in 500 Hall. Sitting upright. Admits to hitting head and lump found to posterior scalp noted. Denies pain with assessment with the exception of left shoulder pain with previous injury. Neuro checks within normal limits. Neurochecks to continue per protocol. Resident Description: 'I was trying to use the restroom.'"

Investigation Conclusion, undated, documents, "Plan of Action to Prevent Reoccurrence: Midnight shift to ask/assist resident to restroom at beginning of shift."

There was no documentation in R17's medical record that the facility reassessed R17 for possible causes of R17 falling No root cause analysis conducted for this fall. No progressive intervention formulated to prevent fall recurrence.

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Final IDPH Incident Notification undated, documents, "Date of Incident: 7/12/19. Comprehensive investigation completed. (R17) was sitting on commode with staff in attendance. As staff turned to reach for wipe to provide pericare resident attempted to stand, lost her balance causing her to fall before staff member could get to her to lower her to the floor or prevent fall. Per X-ray report from hospital, impression was comminuted left humeral fracture. Also noted to have Osteopenia. Per History and Physical from hospital indicates resident has broken left humerus multiple times. Resident has returned to facility, continues at her prior level of function.

The Hospital X-ray Chest Result dated 7/12/19 documents, "Impression: 1, Comminuted proximal left humeral fracture."

Incident Report, undated, documents," Date of Incident: 7/12/19 03:00. Nursing Description: Fell in bathroom. Resident Description: Fell in bathroom. Immediate Action Taken: Sent to ER for evaluation and treatment."

No root cause analysis conducted for this fall. No progressive intervention formulated to prevent fall recurrence.

On 8/14/19 at 3:45 PM, V26, Regional Nurse, stated she expects all fall investigations to include root cause analysis and to have progressive interventions in place.

On 8/28/19 at 11:45 AM, V57, Physician, stated R17's falls could have been prevented, there is a need for staff education which is very important. V57 stated it is everybody's responsibility, not just

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the nursing staff to ensure if they see a resident trying to get up to get to them right away and ask if they need something and call for help from the nurse or CNA.V57 stated the facility needs to analyze the root causes of the falls and formulate individualized interventions according to each patient's need.

The Facility Policy on Fall Management reviewed 3/2015, documents," Policy: It is the policy of this facility to have a fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Standard Fall/Safety Precautions: All Residents 1. At the time of admission and in accordance with the plan of care of the resident will be oriented to the nurse call device. The nurse call device will be placed within the resident's reach at all times. The location of the placement will be verbalized for those residents with visual deficits. Residents will be observed approximately every 2 hours to ensure the resident is safely positioned in the bed or chair and provide care as assigned in accordance with the plan of care."

2. R14's Minimum Data Set (MDS) dated 7/2719 documents R14 requires two plus physical assistance extensive assist (resident involved in activity, staff provide weight -bearing support) with transfers and extensive assistance of one-person physical assist for bed mobility. R14's MDS documented he had no cognitive impairment.

R14's Fall Risk Assessment dated 7/22/19

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documents R14 has a score of 22 (Total score of 10 or greater, resident should be considered at High Risk for potential falls).

R14's Care Plan undated, documents, "At risk for falls related to his weakness lack of coordination and cognitive status." The Care Plan documented "Goal: Will have falls/injuries minimized by management of risk factors while maintaining maximum independence/quality of life through next review.

R14 had 7 fall incidents from 5/2019 through 7/2019 as follows:

a. R14's Nurse's Note dated 5/10/19 10:17 AM documents, "Resident found sitting on buttocks on floor in front of toilet in room. Resident trying to transfer self to chair unassisted. Denies any pain or discomfort, range of motion is within normal limits. Will continue to monitor."

Investigation Conclusion, undated, documents, "Resident found sitting on floor in front of toilet in Bathroom in his room. When asked what happened reported he was trying to go to bathroom. Nurse assessed no injuries noted, denied pain/discomfort. Floor noted to be dry. MD (Medical Doctor) and POA (Power of Attorney) notified. Plan of action to prevent Reoccurrence: Resident brought to common areas for closer monitoring."

R14's Care Plan intervention, dated 5/10/19, documented "Resident out to nurse's station for closer monitoring."

b. Initial Incident Notification dated 5/28/19 documents,"79-year-old alert and oriented resident independent with wheelchair mobility

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S9999	Continued From page 33 was propelling self near nurses station leaned forward in chair, lost balance and fell at 6 PM on 5/28/19. Nurse immediately assessed resident noting having hematoma to left forehead and complaints of pain to his head and hip. POA and MD notified, order received to send to ER (Emergency Room) for evaluation. Facility Administrator notified at 6 AM on 5/29/19 that resident was being admitted to hospital for intracranial bleed." R14's Hospital CT (Computed Tomography: special x-ray that uses cross sectional images of body using x-ray and computer) of Head without Contrast dated 5/28/19 documents, "Findings: Acute subarachnoid hemorrhage (bleeding between the brain and surrounding membranes) is seen within the posterior right frontal sulci (frontal lobe of brain)." There was no reassessment of R14's to determine why R14 fell and what interventions would be implemented to prevent him from future falls. R14's Care Plan Intervention, dated 5/28/19, only documented he was sent to ER. The Care Plan did not document any progressive intervention to prevent him from future falls. On 8/28/19 at 11:45 AM, V57, Physician, stated R14's falls could have been prevented, there is a need for staff education which is very important. V57 stated it is everybody's responsibility, not just the nursing staff to ensure if they see a resident trying to get up to get to them right away and ask if they need something and call for help from the nurse or CNA.V57 stated the facility needs to analyze the root causes of the falls and formulate individualized interventions according to each patient's need.	S9999		

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