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	IL6013072	A. BUILDING: _____ B. WING _____	C 07/15/2021

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S 000	Initial Comments Complaint Investigation 2154471/IL135351 2154638/IL135566 2154655/IL135583	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b)5) 300.1210d)6) 300.7020a)4) 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. 300.1010 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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: 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. 300.7020 Assessment and Care Planning	S9999		

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S9999	Continued From page 2 a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission. 4) The assessment process shall be ongoing by direct care staff or other professionals, as needed, and shall include the assessment components in subsection (a)(2). These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to: a) identify, assess, document, and investigate resident's complaint of pain and potential injury at the time of a transfer, b) failed to investigate a possible fall, and c) failed to use the mechanical lift in accordance with facility policy, which requires 2 qualified staff members for resident transfers for 2 of 10 residents (R4 and R5) reviewed for accidents/supervision in the sample of 10. This failure resulted in R4 being taken to the hospital emergency room with extensive bruising noted to right chest, both breasts, sternum, epigastric region, and right upper arm. Findings Include: R4's Medical Diagnoses include history of displaced fractured right tibia, edema right and left upper eyelid, chronic kidney disease stage 4, history of falls, type 2 diabetes mellitus, and anxiety. R4's MDS (Minimum Data Set) dated	S9999		

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S9999	Continued From page 3 4/6/21, documents a BIMS (Brief Interview Mental Status) score of 7 indicating severe cognitive impairment. R4's progress notes dated 7/4/21 at 11:48AM, documents: Resident left with V29 (Family Member). R4's progress note, dated 7/4/21 at 5:12PM and completed by V17 LPN (Licensed Practical Nurse) documents the following: "Resident still out with family. POA (Power of Attorney) called me and reported that family reported to her that resident (R4) had significant bruising to chest area. Reported to POA that CNA's (Certified Nurse Aide) had not reported bruising to me, had not observed it. (Local Regional Hospital) called to report bruising on resident, asking about recent injuries, possible source of bruising. Reported to (Local Regional Hospital) that I hadn't observed bruising, CNAs had not reported it, and no recent source of injury could be found." R4's hospital records note a triage assessment completed in the ER (Emergency Room) by V34 RN (Registered Nurse) dated 7/4/21 at 1800 (6:00pm) and documents the following: "Pt (patient) (R4) brought into ER by family to be checked out after family noticed bruising to pts (R4) chest. Pt (R4) present and alert but mildly confused .....Pt (R4) has dark red bruising to both breasts, bruising in different stages of healing along her sternum, bruise to the inside of right upper arm that is yellow/green in color. Pt (R4) has a small circle bruise to the outside of the right upper arm. Pt (R4) states she has some discomfort when she takes a deep breath. Pt (R4) states a couple girls were taking her to the restroom, when they lifted her, they bear hugged her and she felt a "stick" and felt as though she was stuck with a needle. Pt (R4) is mildly	S9999		

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S9999	Continued From page 4 confused. No other injuries noted. R4's hospital records also note an ED (Emergency Department) provider note completed by V42 (DO/Doctor of Osteopathic Medicine)/ Physician) dated 7/4/21 at 1819 (6:19PM) that documents the following: "Chief Complaint: Patient presents with bleeding/bruising." HPI (History of Present Illness) documents (R4) "is a 94 y.o. (year old) female who presents with bruised area of the right breast, right chest wall pain and right shoulder pain. Patient's (R4) family members brought patient from the nursing home and are concerned about the bruising patient has on her breast and chest wall. Patient (R4) was able to tell me that when nursing home staff was lifting her up to go to the restroom that she felt pain on the right side when the staff member was lifting her up under her arms. She states since then she has had pain of her right chest wall. States it does hurt to take a deep breath. Patient has evidence of bruising over her right breast and chest area. She does complain of some pain over the chest wall on palpation. Patient states she did not fall. R4's hospital records also include a History and Physical completed by V43 NP (Nurse Practitioner) dated 7/4/21 with time examined at 9:20PM that documents the following under History of Present Illness: "Presents to ED (Emergency Department) with bruising to chest and arms. Family at bedside states last saw patient 3 days ago, was without bruising ...Family took patient to reunion this afternoon, when assisting to bathroom at reunion, patient complained of pain to right breast and rib area, found to have extensive bruising to right breast, sternum, and upper arms ...On arrival bruising to right breast, sternum, upper arm. Upon	S9999		

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evaluation, awake, alert, oriented to person only .... Patient denies falls, states staff at ECF (Extended Care Facility) 'squeezed her and stuck with needle' when going to bathroom. ECF nurse reports taking care of patient last evening, repeats 'she has been fine ...patient had shirt on and did not see her chest. No one told me in report she had bruising ...' reports 2 weeks ago patient 'crawled to closet,' denies any recent falls, 'always restless in bed.'"

This same History and Physical in the hospital records includes 4 photographs of R4's injuries. The photographs show R4's entire right breast covered in a reddish/purple/black colored bruise, purple bruising to the sternum and upper middle abdomen, smaller area of bruising to the left breast close to the sternum and a yellow/green colored area of bruising just above the right breast and sternum area. In addition, R4 has a circular bruise to the back of the right arm above the tricep area and bruising in the shape of 3 lines to the bicep area that are lighter colored purple/green with yellowing around the edges.

On 7/12/21 at 2:50PM, V34 (Emergency Room Registered Nurse) stated that the bruising extended from R4's breast area to above her waist. Some of the bruising was yellow and green but both breasts had areas of bruising that was dark red, black, and purple. V34 said the bruise to her right arm was more yellow and green and looked old in nature, but the bruising to the chest was newer. Family arrived at the ER about 17:45 (5:45PM) with (R4) in a wheelchair. It took 2-3 staff members to transfer (R4) to the patient cart. V34 said the family was adamant that (R4) was to not return to the nursing facility.

On 7/14/21 at 3:45PM, V41 (Family) stated she

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S9999	Continued From page 6 saw R4 on Friday 7/2/21 about 3:00PM and she was wearing a low-cut shirt and no bra. The shirt was loose and R4 was leaning forward. V41 stated she did not see any bruising and that R4 did not complain of anyone hurting her or that her breast hurt during that visit. V41 then stated that during R4's outing with family on 7/4/21, R4 was taken to the bathroom around 4:00PM and the bruising was noted when R4 complained of pain during the transfer to the toilet. V41 stated that she looked at R4's chest and noted dark red/purple bruising to R4's right and left breast as well as some bruising to R4's upper right arm. V41 stated at that time R4 told her that the staff transferred her to the toilet, wrapping their arms around her and they stuck her with something. V41 added that R4 stated the staff continued with the transfer and did not stop to look at her breast after she complained about the 'stick." On 7/14/21 at 4:15PM, R4 (interviewed at another nursing facility) stated that the bruises happened at the other nursing home. R4 stated a person with black hair that was in a "knob" high on her head, was "bear hugging" her in a transfer to the toilet. R4 stated that she did have a gait belt on and during the "bear hug," she felt a "stick" to her right breast and told the person 'you are hurting me.' R4 said "the girl did not stop and put me on the toilet. She would not look at my breast to help me." This surveyor's interview with R4 on 7/14/21 is consistent with R4's interviews documented in the hospital records from 7/4/21 with V34 (ER/RN), V42 (DO/Physician) and V43 NP, as well as the interview with family (V41). Also, on this same date and time, R4 allowed surveyor to observe chest area with reddish/purple bruising still observed to the right breast and chest area. Bruising was observed to have decreased by approximately 50% as compared to the	S9999		

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S9999	Continued From page 7 photographs taken on 7/4/21 but was still present. Bruising to the right arm had subsided at this time. On 7/14/21 at 11:30AM, after viewing the 4 photographs from the Emergency Room and the Initial Emergency Room notes dated 7/4/21, V18 (Physician) stated a gait belt probably pinched or was placed over (R4's) breast area and caused the bruises to the chest. The bruises to the right arm were probably caused by being grabbed by someone. When asked if the bruising could have occurred while out with family on 7/4/21 during the 6-hour visit, V18 stated "Absolutely not." The bruises appear to have occurred sometime earlier than Sunday (7/4/21) but are likely not as old as the 6/18/21 fall or the 6/20/21 closet incident. V18 stated she has received special training regarding Elder Abuse and related injuries in the elderly. On 7/8/21 at 5:00PM, V31 (CNA) stated that he worked Saturday night (7/3/21) and Sunday morning (7/4/21). V31 stated that R4 is very confused and gets agitated when the staff tries to get her up to transfer or in the mechanical lift. V31 stated he got R4 up Sunday morning (7/4/21) and dressed R4 with the help of the V27 LPN. R4 was very active during the night and did not sleep well. She likes to sleep next to the side rails, so he padded them and R4 threw the blankets on the floor. V31 said R4 also slept with her legs out of bed and is in a low bed with floor mats to prevent injury. V31 stated that on Sunday morning 7/4/21, R4 had some old bruising and discoloration on her right chest and right upper abdomen but there was no new bruising at the time he got R4 dressed to be taken out of the building by the family. On 7/7/21 at 10:10AM, V17 LPN stated that R4	S9999		

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has dementia and is often very confused. She has an alarm in her chair and bed and fall mats beside her bed. The staff runs when R4's alarms go off to prevent her falls as R4 sits with her chest and head forward most of the time. R4 can be transferred with a pivot transfer but her right leg is very weak. Transfers with R4 are not the best, but R4 has a fear of the mechanical lift and thinks the machine will kill her. So, to transfer R4, the facility uses 2 assist and a gait belt.

V1 (Administrator) provided a written statement from V27 LPN dated 7/5/21 that documents the following: (R4) is restless through the night. She will grab hold of grab bar to pull self over to it, if her back hurts will curl self-up in a ball. (R4) is in a low bed with floor mats, will put legs over the edge and roll onto mat then crawl across the room. (V27) have not noticed any bruising to upper chest area or has any been reported to me. On the morning she (R4) was to go out, CNA got her dressed and (V27) helped get her into W/C (wheelchair). She stood fine, no fighting or resisting. She had a shirt on with low neck, didn't see any purple color to upper chest, was flesh toned. (R4) hasn't had a recent fall, has safety alarms to let staff know of unsafe transfers.

On 7/10/21 at 11:45AM, V16 RN stated that R4 is confused and combative at times. R4 was always very active and therefore we used a chair and bed alarm to notify us when she was getting up. R4 would crawl out of bed, turn herself sideways in bed with her head and feet hanging off the side of the bed. R4 had grab bars on her bed and would position herself against the grab bars. We tried to pad them, but she would throw the padding on the floor. R4 would crawl out of bed onto the floor mat and then refuse to get up off the floor. V16 said R4 did have some old bruises

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S9999	Continued From page 9 due to the grab bar, restless activity at night and the gait belt. On 7/10/21 at 10:30AM, V1 (Administrator) stated that R4's last fall was June 18, 2021 and was investigated. V1 stated there was no incident report or investigation of R4 being found in the closet on 6/20/21. V1 said R4 does have some yellow and green bruising to ribs and abdomen related to gait belt use. On 7/13/21 at 10:00AM, V1 (Administrator) stated that there was no report or documentation of R4 having an injury to her breast or right arm over the July 4th weekend or since the fall of 6/18/21 or being found in the closet on 6/20/21. On 7/5/21 at 2:05PM, V14 ADON (Assistant Director of Nurses) stated R4 does not have trouble with bruises or issues with injuries. V14 stated they are not aware of how these old bruises occurred as reported by the Emergency Room. On 7/5/21 at 1:30PM, V11 CNA stated she is not aware of dark bruising on R4 and said that a nurse from the hospital called and questioned the facility staff about bruising to R4's sternum and right side. V11 said R4 is to get up with help only and has not fallen recently. V11 stated that R4 did have yellow and green bruising on abdomen and ribs that she noted in the past month. On 7/13/21 at 2:30PM, V37 CNA stated she saw the bruise on Friday 7/2/21 in the evening and told V6 LPN. V37 said it was a small bruise, 2 inches in diameter around the right nipple. There were no bruises to the right upper arm. V37 stated that V29 (Family) sent her the pictures of R4's breast on her phone on Sunday. V37 stated	S9999		

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S9999	Continued From page 10 she did not report it to any other staff member in the facility. On 7/13/21 at 2:45PM, V6 LPN stated that the bruises to R4's breast were not reported to her by V37 CNA on 7/2/21 or at any other time. V6 said she investigates all resident bruises and injuries reported to her. On 7/12/21 at 3:00PM, V32 POA (Power of Attorney/Family) stated that V29 (Family) took R4 to the Emergency Room approximately 6 hours after taking R4 from the facility to a reunion. R4's Total Body Skin Assessments, dated 6/19/21, 6/26/21, and 7/3/21 do not document any bruising or wounds. No documentation of any bruising, new or old could be located in R4's medical record for June or July 2021. The facility's policy for Investigations, undated, documents: E. It is the policy of (facility name) that.... injuries of unknown source are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened. R4's Nurse's Notes, dated 6/20/21 at 12:01 AM, documents the following: Resident has been up all evening. Very confused. Doesn't know where she is or who we are. Wandering up and down the halls and repeatedly trying to go into other residents' rooms. Redirected several times back up to nurse's station. Was assisted to bed once. Resident has a low bed. She climbed out of it and crawled into her closet naked. Took extensive assistance of two to safely get resident out of closet. On 7/10/21 at 10:30AM, V1 (Administrator) stated	S9999		

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that R4's last fall was June 18, 2021 and was investigated. V1 stated there was no incident report or investigation of R4 being found in the closet on 6/20/21. V1 said R4 does have some yellow and green bruising to ribs and abdomen related to gait belt use.

On 7/13/21 at 12:35PM, V6 LPN stated that on 6/20/21, R4 was noted to be sitting in her closet and no one observed how she got there. V6 said this was not treated as a fall and investigated, because R4 was in a low bed and has a fall matt. R4 was assessed and noted to be covered in BM (Bowel Movement). V6 said R4 did not have a bruise, red mark, or any injuries. V6 said R4 was assisted back to bed and no neuro checks were done.

Facility's Post Fall Protocol, dated 4/24/18, documents the following: #5 Any resident that has an unwitnessed fall and is not orientated enough to state that they did not hit their head, is presumed to have hit head and neuros checks are initiated. #9 Complete the incident report in PCC (Point Click Care). #10 Put a new intervention in place. Every fall must have a new intervention generated at the time of occurrence to prevent future falls.

On 7/1/21 at 1:00PM, V3 and V7 (both CNA's) were seen lifting R5 via mechanical lift to bed.

On 7/7/21, at 1:45PM, V3 and V22 (both CNA's) were seen transferring R5 via mechanical lift from bed to wheelchair.

On 7/1/21 at 11:00AM, V1 (Administrator) stated V3 CNA has been reported for using the mechanical lift with a resident without another staff member to help. V1 stated that V3 has been

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST VILLAGE, NORTH CAMPI	2101 JAMES STREET LAWRENCEVILLE, IL 62439

(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 12 educated and reprimanded. On 7/1/21 at 10:00AM, V2 DON (Director of Nurses) stated that CNA's are in charge of getting the sling and pads under the resident and then getting another staff member to make the transfer. The transfer is not to occur without two staff members. V2 stated that V3 CNA has been written up because he prefers to transfer residents with a mechanical lift without the assistance of another person. On 7/1/21 at 12:00PM, V14 ADON stated mechanical lifts require 2 assists at all times. The staff member receives a written reprimand if only one person does a mechanical lift without assistance. On 7/7/21 at 1:40PM, V3 CNA stated that he has transferred residents with a mechanical lift without help because the resident needed to go to the bathroom and there was no one to help him. V3 stated that he has transferred R5 without assistance. The Mechanical Lift Policy, dated 2/22/2016, documents that to use the lift requires two qualified staff members for transfer. (B)	S9999		